Maternity services. Volume II, Minutes of evidence.

wellcome collection

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

HOUSE OF COMMONS Session 1991–92

HEALTH COMMITTEE

Second Report

MATERNITY SERVICES

Volume II

Minutes of Evidence

Ordered by The House of Commons *to be printed*
13 February 1992

LONDON: HMSO

£28.50 net

29–II

HOUSE OF COMMONS Session 1991–92

HEALTH COMMITTEE

Second Report

MATERNITY SERVICES

Volume II

Minutes of Evidence

Ordered by The House of Commons *to be printed*
13 February 1992

LONDON: HMSO

£28.50 net

29–II

The Health Committee is appointed under SO No 130 to examine the expenditure, administration and policy of the Department of Health, associated public bodies and similar matters within the responsibilities of the Secretary of State for Northern Ireland.

The Committee consists of eleven Members, of whom the quorum is three.

The Committee shall have power:

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint persons with technical knowledge either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

(c) to communicate to any such other Committee, or the Public Accounts Committee, its evidence and other documents relating to matters of common interest; and

(d) to meet concurrently with any such other Committee for the purposes of deliberating, taking evidence, or considering draft reports.

Unless the House otherwise orders, all Members nominated to the Committee continue to be members of the Committee for the remainder of the Parliament.

Monday 21 January 1991

The following were nominated as Members of the Committee:

Mr Tom Clarke
Mr James Couchman
Mr Jerry Hayes
Mr David Hinchliffe
Alice Mahon
Sir David Price
Mr Andrew Rowe
Mr Roger Sims
Rev Martin Smyth
Mr Nicholas Winterton
Audrey Wise

Mr Nicholas Winterton was elected Chairman on Wednesday 30 January 1991.

Mr Jerry Hayes was discharged and Sir Anthony Durant was added on 10 February 1992.

The cost of printing and publishing this Volume is estimated by Her Majesty's Stationery Office at £44,872.

HEALTH COMMITTEE

MATERNITY SERVICES

MINUTES OF EVIDENCE

WEDNESDAY 6 NOVEMBER 1991

Members present:

Mr Nicholas Winterton, in the Chair

Mr David Hinchliffe	Mr Andrew Rowe
Alice Mahon	Rev Martin Smyth
Sir David Price	Audrey Wise

Memoranda submitted by the Department of Health

URBAN PROGRAMME SUPPORT

SUMMARY

1. The Urban Programme (UP) has a co-ordinated approach to urban renewal with the main emphasis being on economic regeneration. Maternity services are *not* a specific category within the Programme and few projects are funded in the main areas of interest to the Committee. However, about £10m each year is spent on health related schemes mainly on health promotion etc of which £1.25m (1990–91) was allocated to projects providing maternity services and related support.

DESCRIPTION

2. The Urban Programme is a 75 per cent grant from Department of the Environment to 57 local authorities in England to support approved urban renewal projects. The balance of the costs comes from the local authority (LA). Projects are carried out by statutory agencies (eg LA departments, health authorities) and voluntary organisations.

3. The UP's main aim is the economic and environmental regeneration of inner cities through a *co-ordinated* and tightly targeted programme in each eligible LA to secure long-term improvements to the quality of life of people in those areas and to the local environment. Spending on health, and health related projects, is a limited, though valuable, part of the programme.

4. The priorities for UP spending on health and personal social services, within the Government's overall priorities for health policies are: health promotion and disease prevention, health care (especially co-operation between health and social services authorities), homeless mentally ill people and personal social services for ethnic minorities and children and young people. Annex C sets this out in more detail. Health projects are included in a LA's UP after discussion with the local DHA.

5. There is no requirement that each LA should spend a set proportion of its UP allocation on maternity services. The pattern of all the UP projects in an area will depend on the needs of each area and the LA's priorities for renewal.

6. The UP should only be used to support projects which would not have gone ahead at all, or to the same scale and timetable, without grant assistance. UP should not normally be a substitute for LA main programme funding or used to fund projects which are eligible for other grants.

7. In 1990–91 total UP resources were £269m; of this £1.25m was allocated to approved projects providing maternity services and related support. UP projects supporting maternity services do not fall neatly into the categories identified by the Select Committee; some do. However, the largest area of UP funding was for health education and other indirect maternity support (about £800,000 in 1990–91). Of the balance about £100,000 was spent on delivery/birth (three projects including two for Bangledeshi midwives) and about £200,000 was spent on paediatric care.

8. Annexes A and B attached show the total UP approved spend for the various kinds of maternity projects for England and by region.

9. Examples of the kinds of projects supported include:

- a link worker/family planning nurse in West Birmingham (£19,200 in 1990–91) to improve family planning services and reduce the high level of abortion.
- £9,000 to Blakelaw Mother's Support in Newcastle to provide ante- and post-natal support to high risk women whose needs are not met by traditional services.
- The provision of a consumer sensitive midwifery service to Bangladeshis in Newcastle which could influence future patterns of midwifery care (£44,500).
- Production of leaflets for inner city schools in Birmingham on parent craft education and other health issues for teenage mothers (£7,000).

— A case study in health promotion in Salford (£15,000) to increase the uptake of vaccinations and immunisation against childhood infections.

— North Tyneside Community Health Promotion Task Force (£18,400) includes the aim of improved ante-natal care.

ANNEX A

RELEVANT PROJECT IN PROGRAMME BY REGIONS 1990–91

MATERNITY PROJECTS FUNDED BY URBAN PROGRAMME

£'000s

CATEGORY	TOTAL UP FUNDING 1990–91
i. Pre-conception Care	59.3
ii. Ante-Natal Care	63.0
iii. Delivery/Birth	106.6
iv. Post Natal Care	22.6
v. Paediatric Care	199.3
vi. Health Promotion/Education	604.0
vii. Other Indirect Interest	203.7
TOTAL	1,258.5

ANNEX B

RELEVANT PROJECT IN PROGRAMME BY REGIONS 1990–91

MATERNITY PROJECTS FUNDED BY URBAN PROGRAMME

£'000s

CATEGORY	LONDON	WEST MIDLANDS REGION	MERSEYSIDE* TASK FORCE AREA	NORTHERN REGION	NORTH WEST REGION**	YORKSHIRE AND HUMBERSIDE REGION	TOTAL £ UP FUNDING
i. Pre-conception	7.9	51.4					59.3
ii. Ante-Natal Care		39.0	15.0	9.0			63.0
iii. Delivery/Birth	28.0			55.6	23.0		106.6
iv. Post Natal Care		22.6					22.6
v. Paediatric Care		133.9			65.4		199.3
vi. Health Promotion and Education	4.5	178.8		100.3	156.5	163.9	604.0
vii. Other Indirect Interest				129.0	19.0	55.7	203.7
TOTAL	40.4	425.7	15.0	293.9	263.9	219.6	1,258.5

SOUTH WEST REGION: Nil Return
EAST MIDLANDS REGION: Nil Return

* define LAs involved
** excluding Merseyside Task Force

ANNEX C

HEALTH AND PERSONAL SOCIAL SERVICES

Priorities for Health

1. The Government's priorities are to develop policies designed to:
   - improve the health and well being of the population;
   - reduce and where possible prevent illness;
   - ensure that excellence in the quality of care is combined with value for money in its delivery and service to the customer.

These objectives provide the framework for recent policy White Papers and legislation. An objective specifically related to improving primary health care in inner cities is to introduce measures to encourage doctors, dentists and pharmacists to remain or to set up in deprived areas. One of the White Paper themes was a greater emphasis on identifying and meeting individual needs and making the Health Service more responsive to the needs of patients by delegating as much power and responsibility to local level as possible.

Priorities for Personal Social Services

2. The Government's priorities are:
   - to encourage care for vulnerable individuals wherever possible within their own homes, with support which is least disruptive to ordinary living;
   - where home support is no longer adequate, to make alternative arrangements to maintain normal lifestyles and, as far as possible, satisfy the full range of physical, emotional and social needs.

Role of the Urban Programme

3. There are opportunities for local authorities to support, through UP health and personal social services projects, the objectives outlined above and those for the UP as a whole. They will complement economic and environmental initiatives to encourage self-reliance within communities as part of comprehensive strategies to bring about inner city renewal.

4. The following are examples of the types of projects which might be supported through the UP.

Health Promotion and Disease Prevention

5. A variety of UP projects, based on local priorities, can heighten awareness of the factors affecting good health and develop preventive strategies to promote health and minimise instability among elderly people and those at risk from mental illness, mental handicap or alcohol abuse.

Health Care

6. Local Authorities may be able to play an important role in helping primary health care teams to acquire suitable and easily accessible premises. Projects in which local authorities can work in co-operation with Family Health Authorities to assist doctors in deprived areas will help to reduce the variations in health and health care. Projects which assist co-operation between health and social services authorities in the implementation of the Government's community care proposals will be a priority in inner cities.

Homeless Mentally Ill People

7. An initiative for central funding of additional specialised hostels and counselling for single homeless people in London in need of psychiatric treatment was announced in July 1990. It is hoped that this initiative will encourage both statutory and voluntary agencies in other areas, including inner cities, to arrange projects offering suitable servies to the homeless mentally ill.

Personal Social Services: Children and Young People

8. The Children Act 1990 should refocus work with families and children in need. Examples of the types of projects which the Government would particularly wish to encourage are those designed to promote:
   - parental involvement by informing parents and encouraging them to take up services and to participate;
   - community involvement in the planning and delivery of services and in identifying need;

— day care through out-of-school clubs to reduce number of latchkey children and support parents under stress, day nurseries to enable parents to participate in training schemes and employment, and information and referral centres.

9. Projects complementing specific initiatives to prevent homelessness among young people under 18 may be appropriate for UP funding. These could include counselling services aimed at reconciling young people with their families or helping young people leaving care to find suitable alternative support. Co-ordination of a number of agencies locally will be required.

Health and Personal Social Services for Ethnic Minorities

10. Difficulties in obtaining appropriate health and personal social services can be accentuated for the large proportion of people from ethnic minorities who live in socially deprived conditions of unemployment, poverty and overcrowded accommodation. UP projects aimed at improving access to these services by ethnic minority communities might, for example, promote the use of interpreters or linkworkers, the provision of development officers for black self-help groups, or the provision of information in appropriate languages on health promotion and local health and personal social services. Close liaison will be needed to ensure that such projects are co-ordinated the mainstream services provided by health authorities and social services departments and have regard to different needs and expectations of people from a variety of races and cultures.

CURRENT CONTRACTING AND FUNDING ARRANGEMENTS FOR REGIONAL NEONATAL INTENSIVE CARE AND PERINATAL CENTRES

The attached table sets out the latest information available to the Department about current contracting and funding arrangements for Neonatal Intensive Care (NIC) for each Regional Health Authority and the one Special Health Authority specialising in maternity and neonatal care. (While the term used throughout the table is Centres for Neonatal Intensive Care, these are also sometimes known in the field as Regional Perinatal Centres.)

NEONATAL INTENSIVE CARE (NIC)

Contracting/Funding Arrangements

Northern Region

NIC at Regional Centre based in Newcastle included in obstetric contracts in 11 DHAs; in five other DHAs referrals dealt with extra-contractually. Clearing house for NIC based in Newcastle.

Yorkshire Region

Purchasers contract with three Regional Centres (two in Leeds, one in Hull). Leeds GH and Hull RI on a cost per day basis; St. James' Leeds on cost per episode basis. RHA allocated £286K for 1991–92 to increase staffing in units. Following recent review, Bradford RI recognised as fourth provider of NIC. Work in hand to develop level of services and the co-ordination between all four provider units.

Trent Region

Three Regional Centres. Majority of NIC provided in block contracts and some through extra-contractual referrals. Separate contacts with DHAs outside RHA boundaries. Most contracts based on average cost of neonatal care (special care and NIC likely to be separated for 1992–93 contracting process). Informal clearing house for NIC in operation.

E Anglia Region

All NIC dealt with through DHA contracts, including some outside RHA. Rosie Maternity Unit in Cambridge acts as informal Regional Centre.

NW Thames Region

Five Regional and three sub-Regional Centres. All NIC dealt with through extra-contractual referrals earmarked in advance on an average cost per episode basis (need rather than historical pattern of referral).

NE Thames Region

Two Regional Centres. RHA intends to have 56 intensive care cots—of a planned total of 62—in place by March 1992. To cope with current shortfall, referrals outside RHA dealt with as emergency extra-contractual referrals. Working towards contracts on basis of individual cost per case per day basis.

SE Thames Region

Four Regional Centres. NIC funded centrally by RHA through top-slicing on basis of agreed number of cot days activity reviewed regularly within year. Those treated from outside RHA dealt with extra-contractually.

SW Thames Region

Block contracts currently, though likely to be devolved to DHAs by 1993–94. Referrals outside RHA dealt with through DHA's extra-contractual reserves. One Regional Centre (St. George's), though hopes to establish three more by end of 1991–92. Clearing house based at St. George's.

Wessex Region

One Regional Centre. Block contracts between individual purchasers and providers.

Oxford Region

One Regional Centre. NIC referrals to Centre by DHAs based on previous patterns of usage and funded accordingly; otherwise, contracted for by individual DHAs and included within paediatric contracts.

S Western Region

One Regional and seven sub-Regional Centres. Contracts arranged by individual DHAs within paediatrics. Likely that this will be contracted for separately in future.

W Midlands Region

One Regional and three sub-Regional Centres. Contracts at these centres administered and funded by RHA's Specialties Agency until March 1993; elsewhere, by individual DHAs. Referrals outside RHA dealt with extra-contractually.

Mersey Region

One Regional and four sub-Regional Centres. Block contracts in operation for all referrals to Regional Centres; otherwise, covered by individual DHA contracts. Additional £270K allocated to Regional Centre in 1991–92 to increase number of cots and staffing.

N Western Region

Two Regional Centres. Block contracts for NIC at centres for next three years; otherwise, individual DHA contracts. RHA intend to set up a bureau in Oldham DHA and further two intensive care cots planned during 1991–92.

SHAs (Hammersmith and Queen Charlotte's)

Majority of referrals from DHAs in NE Thames. Current funding arrangements reviewed (additional funding from NE Thames but not from SW Thames whose target referrals for 1991–92 have been reduced as a result).

August 1991

MANAGEMENT OF THE NHS

1. *Introduction*

1.1 This paper is concerned with the way in which the Department oversees the delivery of services by the National Health Service and how it monitors them. It describes the new management structure and lines of accountability which have been put in place and are being developed following implementation of the NHS and Community Care Act 1990.

1.2 The Department is currently developing new strategic health targets for the NHS, which will entail targeting resources at specific objectives. Proposals have been circulated to health authorities and a wide range of other interests for consultation in the document "The Health of the Nation"[1]. Regional Health Authorities, District Health Authorities and Family Health Services Authorities (FHSAs) will need to identify the key health issues for the populations they serve and develop a framework of strategic priorities which reflects local health needs, wishes and priorities as well as the proposed targets in "The Health of the Nation". These strategic priorities will guide the development of shorter term targets and objectives and should set the context for, and be taken forward by, Districts' service contracts with providers and FHSAs' service development plans with Family Health practitioners.

2. *The Management Executive and the NHS*

2.1 The NHS Policy Board advises the Secretary of State on policy formulation for the NHS and on the strategic oversight of the NHS. It advises Ministers on the policy framework within which the NHS Management Executive (ME) will operate and the management objectives it is required to deliver. It monitors the ME's stewardship and implementation of those policies and objectives. The NHS ME is an integral part of the Department and is accountable to Ministers for the implementation of their policies for the management of the NHS.

2.2 The ME is in day to day contact with Regions. In addition the ME has monthly meetings with Regional General Managers (RGMs) to discuss the effective management of the service in order to maximise health gains for the population.

2.3 The ME agrees annually with the Secretary of State and the NHS Policy Board key objectives for the year ahead, and reports back at the year's end on achievement. The ME then issues annual guidance to Regions, setting out national priorities (and, where appropriate, targets) for the forthcoming financial year (or years) taking account of Ministerial policy and the ME's objectives. The ME then agrees firm objectives with each Region to ensure that national priorities will be delivered and holds them to account for delivery of these. The ME holds Regions to account for the delivery of agreed objectives and for their management of Districts and FHSAs and hence for the planning and provision of health care services for the population served.

2.4 The ME holds Regions to account for performance and delivery of agreed objectives through the annual accountability review process. The review process is a continuing cycle into which information on Regions' progress is fed throughout the year both through formal submissions (such as plans or outturn reports on the previous year's plan) and more informally through close and continuing contact between ME officials and Regional management. Problems are explored rigorously and management action is agreed through meetings between the ME and Regional Directors or at the annual review meeting between the ME Chief Executive and the RGM. The review process is a vital part of the development of new Regional objectives for subsequent financial years.

2.5 Management time is limited and the NHS cannot make major improvements to services on all fronts simultaneously. Rather than spreading management resources too thinly, progress will best be made by concentrating on a few, carefully defined and measurable, key objectives at a time. In future, therefore, corporate contracts betweeen the ME and Regions will focus on a small number of key objectives to deliver improvements to health. The ME will, however, continue to monitor a wider range of services and initiatives to deliver improved health. The new Director of Performance Management in the ME will monitor Regions' overall performance and review them on a continuing cycle (see section 4 below).

2.6 Corporate contracts with Regions will be supported by quantified indicators, key elements of which will be monitored quarterly to track progress. The ME will require end year reports from Regions on the outturn of these indicators to measure achievements, hold Regions to account and to be accountable to Parliament.

2.7 Although the Department will continue to disseminate "good practice", it will emphasise *what* Regions should do and not seek to dictate centrally *how* authorities should meet their objectives; the differing circumstances of various areas mean that local needs can best be met by solutions devised by the management teams at local level.

3. *The Allocation of Funds*

3.1 Maternity and neonatal services are provided from general health authority allocations. In the current financial year health authorities' general allocations have increased by almost £1.5 billion, or 10.7 per cent.

3.2 To help the transition to the new contract system no Region is getting less than a 10.24 per cent revenue increase. This still allows much higher allocations (up to nearly 12.5 per cent) for Regions with expanding populations.

[1] The Health of the Nation (Cm 1523) Published in June 1991 by HMSO, price £11.80. ISBN 0-10-115232.

4. Purchasers and Providers

4.1 The reorganisation of the NHS, with effect from 1 April 1991, into a system which has a clear demarcation between purchasers and providers will promote efficiency and give each set of managers a clearer focus on their aims and objectives, with particular reference to the health needs of the local population in the case of purchasers. Purchasers will need to ensure they obtain the most cost effective services available and will be more easily able to secure managerial objectives because of the clearer accountability for performance which contracts provide.

4.2 RHAs support purchasers in developing local strategies and producing purchasing plans which translate Regional and local priorities into action. They will agree standards for improvements in health with FHSAs and Districts against which performance in achieving health objectives can be monitored.

4.3 Districts have a duty to purchase a comprehensive range of high quality health care services within the resources available to meet the needs of their local populations and achieve optimum desirable health outcomes. This requires them to plan health promotion and disease prevention services in addition to services for diagnosis, treatment, care and rehabilitation. Directors of Public Health will need to collect, analyse and interpret information about the health of the population and prepare annual reports which contain analyses of current health problems in their areas. This will inform their purchasing strategy.

4.4 FHSAs also have responsibility for assessing local needs for family health services and for planning and developing services to meet those needs. They will work closely with Districts, particularly in tackling major local health priorities in an integrated way across primary, community and hospital care.

4.5 Provider units, whether directly managed, NHS Trusts, or in the private sector are those from which Districts will purchase health care services. Their primary contribution is to provide high quality services to patients as required by District and GP Fund Holder contracts. Their need to attract contracts is a powerful incentive to achieve greater efficiency.

4.6 The Department believes day to day management decisions should be made at local level. Effective targets for health outcomes must be set in the context of local resources, needs and priorities, taking into account local health problems and the profile of the local population. The ME therefore sets the general direction for service development (eg to reduce stillbirths and infant deaths) and discusses Regions' objectives with them to ensure they are achievable, but challenging. Regions then set targets for individual Districts and FHSAs which reflect their current position and the health needs identified in their Director of Public Health's annual report. Regions monitor the performance of Districts and FHSAs against their targets and the ME, in turn, monitors the performance of Regions.

5. Performance Management: Planning and Review

5.1 The ME has been working with NHS managers to develop new planning and review processes to reflect the changes introduced by the NHS and Community Care Act 1990. The ME will manage down the purchasing line through Regions. Planning and review are complementary elements within a single process of performance management; objectives (see section 2) will form the focus for performance management and review of Regions by the ME.

5.2 The ME is establishing a new Performance Management Directorate (PMD). Its task will be to manage NHS purchaser performance by negotiating and agreeing annual corporate contracts with each Region, and monitoring their performance, both in achieving these and overall. As well as containing agreed targets, contracts will set out milestones by which progress towards those targets can be monitored. This will enable PMD to identify problems and seek remedial action before the year's end.

5.3 PMD will conduct an ongoing programme of rigorous performance review, monitoring Regions' overall performance against plan in year and year-on-year. This will enable problems to be identified and remedial action to be taken in year. This will involve regular face to face contact between PMD and Regions at all levels, including quarterly meetings between the Director of Performance Management (or his deputy) and individual RGMs. Where issues are identified which the ME considers should be addressed in greater depth, PMD will seek and disseminate solutions, using special task forces where appropriate.

6. Health Service Priorities

6.1 The consultative document, "The Health of the Nation", lays out the Government's priorities and targets for health. The future objectives which are set for the NHS will reflect the priorities which emerge from the consultation process.

6.2 One of the objectives for 1992/93 will be to reduce stillbirths and infant deaths. All Regions will be required to agree with the ME a specific objective to reduce stillbirths and infant deaths. Regions will need to ensure that Districts and FHSAs pay particular attention to specific problems (whether cultural or socio-economic) which might impede access to maternity services for certain groups of women, especially those from ethnic minorities.

OCCASIONS SINCE 1979 WHEN THE SECRETARY OF STATE UPHELD A COMMUNITY HEALTH COUNCIL OBJECTION TO THE CLOSURE OF A GENERAL PRACTITIONER MATERNITY UNIT

1. Since 1979 thirty proposals for partial or full closure of GP maternity units have been referred for decision to the Secretary of State because of Community Health Council (CHC) objections. The Secretary of State did not uphold the CHC's objection in the case of twenty-nine of the thirty referrals. During the same period the full or partial closure of seven GP maternity units went ahead without objection from the CHC.

2. The statistics on closures do not take account of the consequential use of additional facilities in new or existing NHS units. However approval to a closure would not be given unless the Secretary of State was satisfied that appropriate provision was available after the closure.

3. Attached for information is a copy of an NHS Management Executive booklet entitled "Consultation and Involving the Consumer". Pages 3 to 5, which outline the procedures for consultation on substantial changes in service provision, will be of most interest to the Committee in the context of this note.

August 1991

EXPENDITURE ON THE MATERNITY SERVICES

1. This note has been prepared in response to the Health Committee's request for clarification of the expenditure figures included in the Department of Health's memoranda.

2. We now have more up-to-date estimates than those quoted in the Department's memoranda. The increase between 1980–81 and 1988–89 in total expenditure (real terms) was 15.0 per cent (not 15.6 per cent as stated in paragraph 1.2 of memorandum No. 3 on delivery) and between 1980–81 and 1989–90 was 11.9 per cent (not 12.1 per cent as stated during evidence from the Department taken before the Committee on 3 July).

3. Attached are two tables setting out at constant 1989–90 prices expenditure on maternity services between 1979–80 and 1989–90. Table 1 allows for pay and price inflation in the hospital and community health service (HCHS) and Table 2 allows for general inflation. The increase in expenditure after allowing for changes in HCHS pay and prices is a measure of the growth in the volume of resources employed by the maternity services, while the increase in expenditure after allowing for general inflation is a measure of the additional cost to the economy as a whole of funding the services.

4. The Health Select Committee asked for an explanation for the fall in the estimated expenditure between 1988–89 and 1989–90. The Committee will wish to note the following features:

(a) There was a 0.8 per cent fall in the number of births between 1988 and 1989 (after an 8 per cent increase between 1980 and 1989). There was also a fall in the average length of hospital stay per birth, from 5.7 days in 1988–89 to 5.5 days in 1989–90. There was a similar percentage reduction in the volume of Obstetrics Inpatient expenditure between these two years.

(b) Expenditure on community midwifery has doubled in the period under review. This suggests, in the absence of growth on the hospital side, increasing activity outside hospitals.

(c) Since 1981 the numbers of nursing staff engaged on maternity services have declined by 1 per cent but the number of qualified midwifery staff has increased by almost 18 per cent[1] since 1981. There are therefore more *qualified* staff working in maternity services.

5. On the question of efficiency savings, it is not possible to be specific in terms of sums saved. However a general picture is emerging for the period 1979–1990 of

— increasing use of community midwifery and GP practice based services

— a steady reduction in length of stay in the relatively expensive hospital setting

— a continuing fall in the rate of perinatal and maternal mortality

— a steady increase in the birth rate over the decade with the possibility of a flattening out in recent years.

September 1991

[1] This is a correction of the figure of 18.9 per cent in paragraph 1.2 of the Health Department's memorandum on delivery.

ESTIMATED EXPENDITURE ON HCHS MATERNITY SERVICES

£ Million

		1979–80	1980–81	1981–82	1982–83	1983–84	1984–85	1985–86	1986–87	1987–88	1988–89	1989–90
TABLE 1	1989–90 PRICES (after allowing for HCHS pay and price inflation)											
	Obstetric inpatients	565.2	568.4	585.3	593.6	576.2	565.5	575.4	554.6	583.7	573.7	546.0
	Obstetric outpatients	81.1	84.4	85.3	91.7	88.1	94.6	91.5	104.4	99.4	81.9	74.6
	Community midwifery	83.0	90.6	93.9	95.8	96.2	100.1	104.2	110.4	123.3	132.9	141.6
	Total Maternity	729.3	743.4	764.5	781.1	760.5	760.2	771.1	769.4	806.4	788.5	762.2
	Cumulative increase since 1979–80 (%)		1.9%	4.8%	7.1%	4.3%	4.2%	5.7%	5.5%	10.6%	8.1%	4.5%
TABLE 2	1989–90 PRICES (after allowing for general inflation)											
	Obstetric inpatients	478.6	520.6	529.0	533.3	520.1	514.0	521.7	519.8	563.1	569.8	546.0
	Obstetric outpatients	68.6	77.3	77.1	82.4	79.4	86.0	82.9	97.8	95.9	81.4	74.6
	Community midwifery	70.4	83.0	84.8	86.0	86.9	91.0	94.5	103.5	118.9	132.0	141.6
	Total Maternity	617.6	680.9	690.9	701.7	686.4	690.9	699.0	721.2	777.9	783.2	762.2
	Cumulative increase since 1979–80 (%)		10.2%	11.9%	13.6%	11.1%	11.9%	13.2%	16.8%	26.0%	26.8%	23.4%

NOTE 1 Figures from 1987–88 onwards may not be entirely consistent with those for earlier years, owing to the change in the data collection systems. Figures for 1987–88 itself are unreliable.

NOTE 2 The increase in expenditure after allowing for changes in HCHS pay and prices is a measure of the growth in the volume of resources purchased (i.e. changes in the numbers of staff employed, or goods and services purchased). The increase in expenditure after allowing for general inflation is a measure of the additional cost to the economy as a whole of providing the services.

/Continued

DEVELOPING A SPECIFICATION AND CONTRACT FOR OBSTETRICS AND GYNAECOLOGY—LEWISHAM AND NORTH SOUTHWARK HEALTH AUTHORITY

Enclosure 1—GENERAL CONTRACT DOCUMENT COVERING ALL SPECIALTIES IN 1991-92

Enclosure 2—EXTRACT FROM CONTRACT WITH GUY'S/LEWISHAM TRUST RELATING TO O & G (Includes volumes purchased for 1991-92 year for populations of Lewisham and North Southwark, West Lambeth and Camberwell)

Enclosure 3—DRAFT SPECIFICATION FOR O & G

[NOTE—For the following reasons, the decision was taken last November by the health authority to shelve work on refining further the service specifications and to concentrate on the preparation of contracts with providers:

— the scale and timescale of the contracting process;

— the need to operate in a "steady state" condition during the first year of contracting; and

— the fact that there was only a small, newly created purchasing organisation.

It was acknowledged that more detailed development of specifications would arise only gradually as experience of the contracting procedures increased.]

Enclosure 4—CRITICAL COMMENTS BY RCM ON DRAFT SPECIFICATION

Enclosure 5—REPORT TO DH ON LESSONS LEARNT FROM THE PROJECT

September 1991

Examination of Witnesses

MRS VIRGINIA BOTTOMLEY MP, A Member of the House, the Minister for Health, DR DIANA WALFORD, (Deputy Chief Medical Officer) Medical Director, and MR JOHN SHAW, Deputy Director of Performance Management, NHS Management Executive, DR IAN LISTER-CHEESE, Senior Medical Officer, MISS JOAN GREENWOOD, Nursing Officer, Midwifery, Department of Health, and MR BRIAN EDWARDS, Regional General Manager, Trent Regional Health Authority.

Chairman

797. Minister, can I welcome you to this, the first meeting of the Select Committee in the new Session. You know the reason for your being here. Would it perhaps be appropriate, Minister, if I ask you to begin by perhaps giving the Committee a preliminary response to this Committee's Report on Preconception which was published earlier today?

(*Mrs Bottomley*) Indeed, Chairman, I should be only too happy to do so. Obviously we will want to study the report with great care before responding officially but at a preliminary stage certainly we welcome the Report. We appreciate the recognition of the significance of the "Health of the Nation" and the endorsement of the Government's approach. Clearly, in preconception care the whole question of prevention is of the very greatest importance. We welcome the acknowledgement that preconception care is one facet of health promotion. A number of recent developments affect the report. We have, indeed, recently produced a report "While you are Pregnant: Safe Eating and How to Avoid Infection from Food and Animals". That was published by the Department on 22nd October. It gives advice about the risks from listeriosis and salmonellosis and offers other dietary and food hygiene advice. Also in recent weeks there has been a commitment from the Secretary of State for Education and Science that teaching about HIV and AIDS should be included in the National Curriculum for 11-14 year olds. I should also refer to the Aids Action Group, which I chair. This was set up in response to extremely worrying findings that one out of 200 pregnant women in, for instance, Lambeth are HIV positive, a very different picture from other parts of the country. There is a great need to address the question of health promotion and prevention and certainly your comments about the significance of education are important. No doubt the Secretary of State for Education and Science himself will wish to consider the Report carefully. Similarly, the comments in the Report about family planning services are significant. We have already begun to incorporate many of them in the guidelines that we are producing for the regional health authorities to assist them in their family planning reviews. As you know, the provision of family planning has changed over the years. It is only sixteen years since GPs first became involved in NHS family planning provision. Two out of three women go to their GP for advice. We must make sure it is high quality advice and that family planning clinics also fulfil their role—especially offering an alternative source of advice for younger members of the community. Similarly, the Report makes clear the important advice on the dangers of smoking, of drinking, of drug misuse in pregnancy. They are areas where, with Ministerial colleagues, we are involved in a number of initiatives. My colleague, Baroness Hooper, is involved in initiatives

[**Chairman** *Cont*]
concerning drug misuse and women and alcohol. As far as smoking is concerned, we recently launched a two year £1 million programme with the Health Education Authority on the very real dangers to the mother, and even more so, the baby, of smoking in pregnancy. We are pleased that we have had great co-operation from the nursing and midwifery professions on that programme. That is a preliminary, off the cuff answer.

798. May we expect a prompt reply, Minister?
(*Mrs Bottomley*) It would be our earnest endeavour to give you a prompt reply.

799. Hopefully with many affirmatives to the recommendations and conclusions which apparently you seem to agree with?
(*Mrs Bottomley*) It is early to say but my hopes are your hopes. The other person who would want to consider the Report is our Director of Research and Development, Professor Michael Peckham, who has the responsibility for carrying forward the overall research strategy for the NHS. One and a half billion pounds a year is spent on research, but we have not always been as good at disseminating the lessons about the value of health interventions through the service. I would certainly endorse the conclusion of the Report that there is a great interest in the question of nutrition. But some of the evidence is not conclusive and these are areas where I believe we will see progress in future. It would be wrong to change the procedures before we are sure that the advice and evidence is clear. There are some important research elements in your Report.

800. Could I go straight on to costings and put this question to you: what information does the Department have about the relative costs of different ways of organising maternity services? For example, is organising midwives into teams which can provide continuity of care, such as the "Know your midwife" system, more or less expensive than the normal model of care? Is it more or less expensive to offer "domino" midwifery and if it is more expensive why is it more expensive?
(*Mrs Bottomley*) These are important questions. At present we have insufficient information to give you a definitive response. Our concern in developing maternity services is to maintain the remarkable achievements we have seen in the past ten years of having record low perinatal and infant mortality figures. We have achieved perinatal figures lower than those achieved in the Netherlands. That is something which might surprise our predecessors from some years back. Our overwhelming concern has been to achieve safety for the child and the mother, to achieve choice and to achieve cost-effectiveness. Over the last 10 years we have seen a great increase in qualified midwives to the order of something like 24%. We have also seen a great increase in obstetricians of the order of about 20%. If I am able to send you more precise costings I shall do so. It is extremely difficult because, of course, team midwifery is organised in different ways in different parts of the country. In some areas the team midwives will be part of the Community Health Services, in other parts they will be part of the hospital service. The way in which the domino movement, which I think all will agree has great merit, is organised is quite different from district to district. What I am able to tell you is that the team midwifery research initiative which our team referred to on 3rd July has now begun working. I shall ask them particularly to address questions of costing. What we are looking for at the moment is a clarification about the different models of team midwifery and the way they work. You will be aware some of the costings are related to the hospital budget, some to the Community Health Services and, indeed, in other cases, some of the costings come through the GP payments. I would like to be able to provide greater clarity. It may be we have to wait until the research project is completed.

801. I asked the question for a number of reasons, not least the reforms currently being introduced by the Government to improve the Health Service rely so much on being able to provide proper costings of everything that is going on. I would have thought it is rather strange you cannot in this area of maternity services—very importantly—provide in the foreseeable future the sorts of costings I have just requested.
(*Mr Edwards*) That was not the way this developed. This was professionals finding new ways of doing things. That is how team midwifery has developed. The managers have got along behind that. The facts are about a quarter of births in my region are domino or domino type schemes. Common sense suggests they are cheaper than hospital patterns but we do not have the details.

802. What about "Know your Midwife"?
(*Mr Edwards*) I would have thought that was cheaper too.

803. Cheaper than the normal system?
(*Mr Edwards*) I would have thought so.

Audrey Wise

804. I am glad your common sense and my common sense actually meet up on this. The domino system has been in operation for a very considerable time and since common sense suggests it is cheaper and since women, where they have the opportunity, are very keen on it, why then are there so many areas of the country where it is not available? Why is the Department not doing something about spreading the use of something which is cost-effective, possibly even cheaper, and popular?
(*Mrs Bottomley*) Of course, Mrs Wise, the priority for the Department is to look to the safety of the mother and the child.

805. Let us take it step by step: are you suggesting the domino system is in any way less safe than any other system?
(*Mrs Bottomley*) What I am suggesting is that its cost-effectiveness or its cheapness alone would not be sufficient for us to want to dictate that as the model of choice throughout the country. I would not want to fall out with you about it, Mrs Wise, because I think the clear merits of women knowing their midwives and having the security and the confidence of knowing the person who will take them through what is an extremely important event in their lives scarcely needs underlining. What is evident though is that there are different patterns in different parts of

[**Audrey Wise** *Cont*]
the country. Correct me if I am wrong, I think I read the evidence which suggested that you, on a previous occasion, thought there was no domino scheme in Preston?

806. I know there is not. I know there is something called a domino scheme which is not in fact a domino scheme.

(*Mrs Bottomley*) I think we begin to identify why it is so important that the Institute of Manpower Studies at Brighton helps us clarify the range of schemes throughout the country. In preparation for coming to give evidence to you, like the Select Committee, I have been on a number of visits to different maternity units. Like most women I have had some experience of maternity units and my feeling is there is a great range of interpretation as to what precisely a domino scheme is. What all are agreed about I believe is that midwives have very important skills, training and qualifications. Indeed I think many of us would argue our midwifery system is a model many other countries around the world could follow. We have to make sure we have a clearer mapping of what the different models are before seeing how we can then carry them forward.

807. Minister, domino is domiciliary, in and out. The patient has a named midwife, or midwives, who visits or sees the patient during pregnancy, takes that patient into hospital, delivers the baby, brings the patient out. It has in some areas been in operation for a long, long time. It is popular, it is cost-effective, I would suggest, cheap in a genuine sense. Have you not ever collected any costings and used those costings as an additional inducement to spreading this system?

(*Mrs Bottomley*) I am going to ask the midwifery officer, Joan Greenwood, if she wants to come in.

(*Miss Greenwood*) The answer is we have not collected costings at present but as Mrs Bottomley was saying, it might be something we can do when we have the results of this research study.

808. Why wait? Why not do it now and then we could have the results in time for our Report?

(*Mrs Bottomley*) Mrs Wise, I have to come back on this. I really do not think we are sufficiently clear as to what you would be comparing with what. It is very clear what the blue print is but if you go to different districts or talk with different maternity services many claim—and I am sure you have found this—to have a domino scheme. Yet, as in your own case, you do not have the agreement that it is a domino scheme in the way you envisage it. In other parts of the country it has been said that it is a domino scheme but of course the midwife is part of a team of Community Midwives and she might be able to go herself or maybe her partner would attend instead. Actually the point where the definition in your terms ceases to be a domino scheme would, I think, be difficult to establish. If I may say, Chairman, I think Mrs Wise makes an excellent point because what we want to do is to continue to build on the success we have seen over the last ten years. I would argue maternity services have really led other parts of the Health Service in encouraging patient awareness and consumer awareness through the participation of mothers in the way in which they want the service delivered, the whole movement towards birth plans, and the whole dialogue increasingly in which mothers become engaged. Mrs Wise made reference to the named nurse or midwife. That is one of the commitments made in the Patient's Charter. The issue Mrs Wise is raising is very much going with the grain of the progress we are already making. If we can try and develop that further so we have more precise costings I think that would help.

Chairman

809. Supporting what Mrs Wise has said to you, and being very happy you agree with so much of what Mrs Wise has said to you, is it not surprising, Minister, you have not got some better basic understanding of the costings bearing in mind everybody to do with the Health Service currently is based on costings and operating within budgets, and the maternity services are a very large part of the activity of the Health Service? With Mr Edwards here from the Severn Trent area, would he not be able to help the Committee a little more about just what costings they have in that particular region of the country? Because Mrs Wise has come on to the issue of the domino system which has been about for five, six, ten or even more years, why have we not got costings bearing in mind you, Minister, and the Secretary of State and other Ministers are favourably indicating we need the costings of the Health Service?

(*Mrs Bottomley*) I am going to ask Mr Edwards to speak but it is an essential principle of the Health Service that professionals should make their maximum contributions, and that we should seek cost-effective ways of providing treatment. Certainly I would hope that, in deciding on the best form of maternity care, these matters would be very evident to the purchasers and to the providers. The question you are raising with me is whether we can establish some centrally determined or evaluated system of costing. We would clearly want those actually providing the care in the district and in the unit to make those assessments. But I think there is great merit myself if the form of maternity care that is established addresses the concerns of the mother, of the professionals, and is safe and cost-effective. Is there more we can do from the centre? You will know for this year, and indeed for the last three years, the Management Executive have been particularly looking at the maternity services. For example, in our Memoranda of evidence we talked about the role of paediatricians and pathologists, and the whole question of the review of the maternity services and the setting up of targets. We are also establishing a task force to carry forward that work and to help the Management Executive set targets and in monitoring services and the dissemination of good practice. It seems to me that is another area where Mrs Wise's suggestion could very well have validity if it is about disseminating good practice. That is an aspect of information which would be of great use to them.

810. Mr Edwards, can you shed any light?

(*Mr Edwards*) The first range of the contracts this year for the maternity services has tended to be block contracts with a fixed sum. They have restrictions on the current services within them, they do not break that down by individual cost elements. As we move forward I think you will find district health authorities will be wanting to break the elements

[**Chairman** *Cont*]
down. That will not drive the services, it is part of the equation but the service ought to be driven by what women choose and what their professionals advise for them. By the end of this year we will have to have some harder, sharper information.

811. This calender year or this financial year?
(*Mr Edwards*) During the course of this financial year. We have some data about the hospital at home schemes in areas like that. We have to have more about alternatives to—

Rev Smyth

812. As I understand it, and I welcome the improvement in the whole maternity services, dealing with perinatal mortality rates, as I understand it, some 70% of births are normal and healthy but 30% have difficulties, that is a rough figure. We have discovered in particular one place where they paid tribute to the midwives, but kept them in their place. When we talk about the professional advice and the choice for women, if they have any choice, that is the real issue we are trying to bring before you. Professionals who are invariably the obstetricians are leading the service, and if they have too big an influence on the decisions and guidance that is being given. That is part of the thinking behind our questioning, whether we cannot give greater choice and more effective choice and ultimately even a safe choice?
(*Mrs Bottomley*) It is the case that most births are supervised by midwives, including those in hospitals. The vast majority are supervised by midwives. We have to consider choice but we also have to consider the safety aspect and cost-effectiveness. In our view maternity services are rightly the concern of multi-disciplinary teams and women need, so far as possible, to make an informed choice.
(*Mr Shaw*) If I may add something there. At our last hearing the point about consumer choice and involvement came up and I think we did not perhaps emphasise sufficiently the major point behind the NHS reforms which is by all means cost-effectiveness and quality but also consumer choice. What people want is a very important element of the NHS reforms and the district health authorities as purchasers are going to enormous trouble and taking great care to canvass the views of the population themselves, in this case pregnant women, and mums-to-be. Secondly, through detailed consultation with the general practitioners who, to some extent, act as a proxy on behalf of their patients. I wanted to make the point now because I do not think we emphasised it sufficiently strongly at our last appearance that the element of consumerism is a very important element in the whole programme.

813. If that is the case why do more women not have their children at home? The views expressed to us are that many, many women would like to have their children at home. The situation in the Netherlands is 35% of babies are born at home, here it is only about one and a half per cent, or one per cent. Why are not more born at home if, as you are saying, consumer opinion is important?
(*Mr Shaw*) I can only offer a lay opinion on that and a father's opinion, which is that the Departmental guidance, the "Pregnancy Book", actually goes to some lengths to express that mums-to-be have a choice but nevertheless goes out of its way to stress the safety aspect.
Chairman: Can I suggest perhaps Alice Mahon can come in and David Hinchliffe. We all feel that strongly on this matter.

Alice Mahon

814. Can I go back to the costings? The Minister referred to the Patients' Charter and said there were similarities and there was a promise of named nurses in that.
(*Mrs Bottomley*) And named midwives for our births, Mrs Mahon.

815. Is the Department putting any resources into the costing of that proposal and if so when will we get the results of that study?
(*Mrs Bottomley*) Perhaps Mrs Mahon was not in the Chamber to hear the Autumn Statement. She will probably be aware of the results of the Autumn Statement: a 9% cash and 4.2% real term increase in spending on the Health Service in the next year.

Chairman

816. 4.2% I think on capital, the hospital and community service was 5%.
(*Mrs Bottomley*) I stand corrected, Chairman*.

Alice Mahon

817. How much of that will be going into the costing? Is there a specific proposal?
(*Mrs Bottomley*) The Health Service has a number of priorities. It is not the case that each and everyone, as Mrs Mahon full well knows, is separately costed and financed from the centre as it is carried forward. This is part of quality improvement and ensuring we can provide a service which is more responsive to patients' needs and their interests. I have every confidence they will be able to achieve that. Indeed, Mrs Wise's advocacy for the domino scheme is all about people knowing exactly who their midwife is.

818. Why is why I would have thought it would be easy to earmark money. I would have thought it would be simple if we had named midwives to say how much of the budget will be allocated.
(*Mrs Bottomley*) I think we have debated these matters before. The issue for all of us at the centre is the extent to which you ring fence and earmark and separately identify small sums of money which undermine the autonomy and flexibility of those in the health authorities. Our procedure is to specify quality objectives (and that is why it is so useful to have Brian Edwards here who has led in that field) and then leave the health authorities with greater flexibility as to how they achieve those outcomes. In the Patient's Charter we have said clearly what we want to achieve in terms of information. Maternity service information is particularly important as the whole development of the birth plan depends on the mother having information about the availability of options. So that is the direction in which we are

**Note by Department of Health:* The figures quoted by the Minister were correct. See DH Press Notice H91/524

[**Alice Mahon** *Cont*]
moving and we are fully confident the Health Service will need those very clear targets.

Alice Mahon: I think people's expectations of the Patients' Charter in that particular area will be downed by that reply, Mr Chairman.

Chairman: I think the Minister's comments have been noted.

Mr Hinchliffe

819. Can I return, Minister, to the key issue of choice. Mr Shaw referred to consumerism, Mr Edwards said earlier the service ought to be driven by what women choose. I have recent experience of a constituent and a personal friend telling me that she desperately wished to have her child at home. There were no factors in terms of her own health, her husband's health, or her family background that would give indicators that would suggest there would be problems. She had had a previous child normally. She was told there was no way she could have that child at home. I am saying it is not a realistic choice—

(*Mrs Bottomley*) Who told her that?

Mr Hinchliffe: She was told by the GPs in her area that it came down to obtaining a GP who would be prepared to offer the cover and it simply was not available in her area. Now, realistically there is no choice for many people and I feel the Department ought to be taking some initiatives in this respect. I would like to know what initiatives you are taking in respect of genuinely offering women choice as far as home births are concerned?

Chairman

820. Before you do answer that perhaps the statistic which I quoted already, that only 1% of births in this country are in the home, clearly indicates in reality there is not the choice, Minister, you have indicated there is. The whole system works to channel a pregnant woman into hospital for the birth rather than having it at home.

(*Mrs Bottomley*) Health authorities, Chairman, have an obligation to provide midwifery services for home births so I would like—if Mr Hinchliffe wants to give me the example—to know precisely what the local midwife's view of that event was.

Mr Hinchliffe

821. It is not the midwifery cover, it is the GP's cover.

(*Mrs Bottomley*) But the midwife is able to take responsibility.

822. The sticking point in this particular case, which I am happy to talk to you about, was specifically on the GP cover. That was the sticking point.

(*Mrs Bottomley*) They do not have to have GP cover.

Mr Hinchliffe: That was the reason given in this particular person's case.

Audrey Wise

823. They are told they must.

(*Mrs Bottomley*) Who by?

824. By GPs.

(*Mrs Bottomley*) But they do not need it. I am very sympathetic with this case.

Chairman

825. Dr Walford, can you shed any light on why only 1% have their babies at home if what David Hinchliffe has said is not correct. I personally think it is correct.

(*Mrs Bottomley*) It is correct they provide a midwifery service. The midwives are able to take responsibility for that birth and yet Mr Hinchliffe is saying in this particular case the woman did not accept. Is this because she was more in fear?

Audrey Wise

826. No.

(*Mrs Bottomley*) As the midwifery officer is saying, midwives do not need the cover of the GPs in order to take responsibility for the birth, so long as the mother and baby are normal.

Mr Hinchliffe

827. I am happy to pass on to the Minister the details of this particular case. This person was an articulate middle class woman who knew her rights and what the Department stated were her rights, tried it out in practice and failed miserably.

(*Mrs Bottomley*) This is such an important area. I very much welcome the discussions of the working group going on at the moment from the Royal College of Midwives and the Royal College of General Practitioners.

Chairman

828. Can you tell us, mentioning that, what the state of play is in that particular situation? I understand it is stalemate or have they gone in for another innings?

(*Mrs Bottomley*) I very much hope they have. I have seen both of them within the last fortnight. I have great confidence that progress is going to be made. I believe really what Mr Hinchliffe is talking about is the lack of agreement between those two professions. I do not think Mr Hinchliffe's point has anything to do with Departmental policy.

Audrey Wise

829. Of course it has.

(*Mrs Bottomley*) It has to do with the relationship between those two professions and particularly the relationship in his part of the world. If there are difficulties in the discussions between the Royal College of Midwives and the Royal College of General Practitioners, perhaps they could begin on that case to get the discussions moving.

Chairman

830. Can I suggest Dr Walford comes in quickly?

(*Dr Walford*) I was going to come in exactly on the point Mr Hinchliffe made. It is a question of inter-relationships locally and what I would like actually to congratulate the Committee about is the fact you have acted as a catalyst to the two professional groups involved. You will have seen, will you not, recently the press release from the Royal College of Midwives and the Royal College of General Practitioners—each released a press release—both say happily the same thing. In the light of the Committee's interest in the possible duplication of roles and professional tensions, if you will, within maternity care in the Community they have set up a specific and particular group to look at the delivery of maternity care in the Community. I will remind the Committee of the points they proposed to look at which will address many of your concerns. The first is they will jointly work on the "...formulation of a programme to guarantee high quality care from confirmation of pregnancy until the post natal examination.." They will work on "... defining the complementary contributions of the general practitioner and the midwife to the delivery of maternity care with the aim of resolving needless duplication of services." They will work through "... ensuring continuity of care for mothers through conception, pregnancy, birth and through to the infancy of their child..." They will examine "... ways in which mothers can be kept informed about the process, and making sure that their choices about maternity care are heard and activated.". They hope to report by 1992, early, and this is a new initiative in relation and in response to this Committee's particular interest in this area. We anticipate nothing but good coming out of it and no problems.

831. Nobody as yet has answered my question as to why only 1% of mothers have their babies at home as against the 99% in hospitals or nursing homes?

(*Dr Walford*) This almost certainly reflects the long held view that one can never be certain about the outcome of a pregnancy until that pregnancy is over. You can only know it was going to be without complication in retrospect. It is the case that the vast majority of pregnancies proceed fully without complication but you never know which one is going to be in that happy state. That is the basis of the advice we have received over many years and it has never been rescinded. It has been reinforced, because of the unforeseeable nature of events which can go wrong during the delivery process, that delivery is best undertaken where the full emergency services are available.

832. I have to draw it to your attention—you may say from the bodily aspect the Dutch are different—why do 35% of them give birth at home and only 1% here?

(*Mrs Bottomley*) The difficulty is you have identified a subject on which not only all of your Committee have strong feelings but my officials have very strong feelings.

833. I hope we have not only just strong feelings but will help give well founded views.

(*Mrs Bottomley*) Indeed, Chairman.

(*Miss Greenwood*) Dr Modle and I made a visit to the Netherlands because of the Select Committee's interest in the situation. Two of the officials who work for the Government department assured us one of the reasons why home confinements are going down in the Netherlands, which they are fairly rapidly, is that women see more quality and safety in a short-stay in hospital. I put it to you that is something that has already happened in this country.

(*Mrs Bottomley*) Chairman, I have not myself been to the Netherlands, I know your Committee has been and indeed I know Miss Greenwood, as she was saying, and Dr Modle have been. I wonder if subsequently it would be helpful if I ask whether we could send you a note putting some of these slightly different experiences that our officials received of the services in the Netherlands? I think we should be essentially concerned with the developments of the services in this country but as the Netherlands is taking on such significance I wonder whether it would be helpful for us to prepare a memorandum?

Chairman: You could also quote Sweden in support of people and choice and the role of midwives and the whole maternity situation.

Mr Rowe

834. Let me, first of all, say to the Minister I am, as she knows, not in favour on the whole of earmarking funds. I think when one agrees with a policy one is desperate to have the funds earmarked but when one disagrees with the policy one wants it to be constantly devolved. When the Royal Colleges were here they shocked the Committee with their anxieties about insurance. It seems to me that one of the problems about giving women a real choice is that the professionals, and indeed the parents-to-be, themselves may well be anxious about the degree of risk. Dr Walford said you cannot predict which are going to be the 90% or whatever it is of births that go reasonably well. I just wondered, I am shocked, and I think we are in danger in this country of going down a path which has led to enormous difficulties in other countries where insurance claims against the medical profession, even where the patient has chosen of their own free will to have a particular procedure, are going to make this sort of thing very difficult. What does the Department think about it?

(*Mrs Bottomley*) If I may, I will answer the points about insurance and then perhaps come back. There are some other aspects I would like to spell out in answer to these questions about one per cent and what is choice and what is informed opinion. As far as the question of insurance and increasing litigation in the Health Service is concerned, that is inevitably a concern for those in the profession and certainly Health Authorities. No fault compensation was debated last year and the Secretary of State referred to a number of proposals. We have recently gone out to consultation on some proposals for arbitration to try and ease some of these particular difficulties. We are also awaiting a report from the Conference of Medical Colleges on defensive medicine. Mr Rowe will also note that the Health Authorities have taken on responsibility for meeting negligence settlements. Whether or not delivery takes place at home or in a hospital should not have any effect. There is no evidence it has an effect on the incidence of litigation.

[**Mr Rowe** *Cont*]
It is of concern for midwives as much as for obstetricians. There is a whole discussion about litigation. I do not think that is what is impinging on these matters. I think there is a longstanding tradition of concentrating maternity services in hospital. That seems to me to be linked with what women perceive to be the safest and most appropriate route. I detect from the Committee a certain strength of feeling that one per cent is a very small percentage figure and they would feel that there was more genuine choice if that figure was rather larger. That is a matter of judgment as to what women really want: whether they want to go into hospital for shorter and shorter times to deliver the baby or whether they really want to have the child delivered in their own home. It seems to me we have to continue to take all possible steps to ensure women are well-informed, and, to take opportunities to enable women to put their views, whether through Maternity Service Liaison Committees, through the consumer surveys increasingly being undertaken by health authorities, or by ensuring that different professional groups are giving clear and balanced information. That, it seems to me, is a point that comes back to Mr Hinchliffe. What is wrong is for the woman to feel she is at the centre of a demarcation dispute. We do not want duplication nor do we want women to be confused because they are getting different information from different groups. I think the most effective way of ensuring that it is the woman's choice, which is enshrined in the Patient's Charter and in the birth plan as a whole, is for the policy to be reinforced by clearer statements by the professions about what their respective roles are.

Mr Hinchliffe

835. In response to the Minister, I do not want to give the impression from a personal point of view that I am necessarily pushing one form of birth as opposed to another. My own personal experience of my own two children is I was damn glad my wife had them in hospital, for reasons I will go into with the Minister in private. My understanding is the Department's policy enshrined in "Maternity Care in Action" states women should be encouraged to have their babies delivered in hospital. Am I right or wrong, that is official policy according to our advisors? Can I take this a little further, Chairman: we want to look at the issue of choice vis a vis the new Patient's Charter and the Minister having been a mother on three occasions, am I right?

(*Mrs Bottomley*) I still am!

836. I will try and rephrase that!

(*Mrs Bottomley*) Unless you know something I do not know and I ought to leave now.

837. You have had personal experience of delivering three children. You are obviously aware that—

(*Mrs Bottomley*) I am not briefed on this subject.

838. It is an extremely personal issue whereby the mother is the best person to make the choice as to the process she goes through in terms of individual midwives having different approaches, individual hospitals having different approaches. The one worry some of us have is the increasing evidence of the way that reforms have constrained that choice by virtue in some areas, and an example was quoted in the Chamber yesterday, women who have had a child in hospital and choose to return there for the second child no longer can do so. That is worrying and this is a point that needs clarifying. I have women saying to me in my area that their choice is now constrained through the placing of contracts. There was a choice of three hospitals in my area, that constraint is on the one where the contract is. I would be grateful if this point could be clarified because if the understanding I have is incorrect people need to be told at a local level that understanding is incorrect because it appears that choice is no longer the case.

(*Mrs Bottomley*) Chairman, if I may, just to start off with Mr Hinchliffe's first point that it is Departmental policy to encourage women to have their babies in hospital. The Department's view is based on the advice of the Maternity Services Advisory Committee and is very clearly spelt out in the Pregnancy Book. I would refer Mr Hinchliffe to them. It sets out the choices and their merits as clear and simple as possible. I would resist the statement that choice is constrained by contracts. I do not accept there is any evidence that there has been any difficulty over choice due to the implementation of the reforms. What I would accept is that in the first year of implementation there has really been an unprecedented level of discussion between the districts and the GPs about the traditional referral patterns, what are their aims, what are their objectives. Of course as they then discuss the contracts for next year they have, for the first time, the opportunity to specify the quality improvements they want to see. The district has never had that before: the position of really championing the interests of their local GPs and their local women in the establishment and in the detail of the contract. All districts have set aside money for extra contractual referrals but the aim and the objective would be to achieve year on year incremental quality improvements. We know the sort of quality improvements we are talking about are often not resource related. They are to do with thoughtfulness and information, the way you are treated, all sorts of details concerned with maternity services. It is not only a question of money. As I say we do not have the impression that even in the first year there have been difficulties about choice. Certainly if it is extra contractual referral then the processes have to be gone through but there is no suggestion that there is difficulty there. Mr Edwards may wish to speak particularly, as a Regional General Manager about to how it is working in his region.

(*Mr Edwards*) We all were concerned that there was a theoretical possibility that that might happen. I can confirm it has not happened in my region and I see no possibility it will. We seem to be able to cope with the traditional flows, they have not been changing very much and the reserves we have have been coping with the occasional difficulties. We have not had any problems at all.

Chairman: There will be problems and Mr Hinchliffe referred to the one raised in the House yesterday. We would like to receive that note you promised in respect of the Netherlands and other matters your experts can help us on.

Audrey Wise

839. On that, I think since this evidence will be published I should make it quite clear what was explained to us with figures was that home births are on a plateau, they are not now declining in the Netherlands. That is not why I wanted to come back, Chairman. We were not on choice, we were on costings and since such emphasis is put on cost normally, it seems to me to be remarkable that we can get so little information now. However, the point about safety was raised by the Minister and her advisors in a context to which it had no relevance whatsoever. Since it was raised can I refer the Minister and ask for a fairly succinct reply, not taking in the whole remit of health care, as is her wont, but actually sticking to the question. Is she and her advisors aware of the work of the National Perinatal Epidemiological Unit which is, I believe, funded—

(*Mrs Bottomley*) By us.

840. By the Department. Dr Walford said the advice that is given by the professionals about the safety question and hospital births has not been rescinded. Could I refer her to the two very large tomes published in 1989 which have a great deal of detail but which conclude with very, very clear appendices which give 61 forms of care that should be abandoned in the light of the available evidence and one of those is failing to provide continuity of care during pregnancy and child birth and another one is insisting on universal institutional confinement. That comes from an evaluation of all the available worldwide research in this field. It is academically extremely well regarded. Has the Department of Health taken any notice of it at all? If so why is it that women are still repeatedly told it is not safe for them to have their babies at home? Why is it, going further, that small units are continually still being closed down, those few which are left, because of claims they are not as safe as large district generals? Why is it that continuity of care is not actually being campaigned for, pushed by the Department? Why is it that in July when I asked about this I was told it is a matter for local decision by the DHA. If things are safe, if women want them, if there is evidence funded by the Minister's own Department, why is no notice taken or if it is taken what exactly is done?

(*Dr Walford*) We would certainly endorse the two statements that Mrs Wise read out and we would expect that health authorities, in setting specifications for maternity services, would make appropriate specifications to ensure so far as possible there is continuity of care. This does not necessarily mean by one person, it cannot always be by one person, but continuity of care within a team, often by a multi-professional team. We would accept that. We would accept it would be entirely wrong to insist on universal confinement in institutions. We do not insist on it now. We believe there should be choice. We totally endorse that.

Chairman

841. 1%—choice, Dr Walford?

(*Dr Walford*) More importantly we believe the consumer surveys which more and more health authorities are undertaking to ascertain what women in their populations would like will reveal to health authorities the sort of service women want. It will then be for the health authorities to make provision for that service, provided it is a safe service of course.

842. Thank you for that succinct reply. Mrs Bottomley, do you want to add anything or can we pass on to Sir David?

(*Mrs Bottomley*) I think it is a difficult area.

843. Are you going to leave it at that?

(*Mrs Bottomley*) The only aspect we have not addressed on this is the presumption that it is easy to predict which women are going to have complicated births and which are not. I know there is a body of opinion who believe this is a simple and straightforward matter. There is also a body of opinion who feel it is a less straightforward matter. They feel it is important to point out up to 20% of those who had been booked to have their babies at home or in isolated GP units were, in the event, transferred to hospitals. I say this, Chairman, not because I do not believe strongly women should be able to choose, but because I believe from the tone of the questioning I would like to redress the balance a little.

Chairman: I think you have done that.

Sir David Price

844. Can we move on to the rather more macro review of all these matters. Your Department's paper on expenditure on maternity services shows a fall in expenditure, in real terms, on maternity services between the financial year 1988-89 and 1989-90. Measured against that very particular inflation index for hospitals and community services it would appear to be lower in 1989-90 than it was in 1986-87?

(*Mrs Bottomley*) Yes.

845. We wonder whether you expect this trend to continue and indeed why is there this trend? Can you explain it? Also if there is any good news. You mentioned the global figures which we heard from the Chancellor a little earlier this afternoon. I have got your press handout but you have not gone into sufficient detail for me to work out if more is going to the maternity services. Maybe you do not feel that is a priority, there are other priorities within the health expenditure?

(*Mrs Bottomley*) We have looked carefully at the figures Sir David has identified and there are a number of issues relevant to that same year. Perinatal and infant mortality figures continued to fall to a record low. There was a fall in the number of births, against the trend throughout the 1980s. What we also understand for the year is that there was an increase in the activity in maternity services, measured by in-patient maternity episodes. The average length of hospital stay per birth fell from 5.7 to 5.5 days. There was an increase of £1 billion in cash into the hospital and community health care services. It was also, interestingly, a year in which the increase in money going into paediatric care increased by 6.4% from £430 million to £490 million. I cannot give a clear explanation precisely how one would explain or identify the figures for that particular year. What I want to emphasise very strongly is what we are demanding from the health authorities is steady

[**Sir David Price** *Cont*]
improvements, and that really relates to the second part of this question. It is excellent that one of the healthiest places in the country to be born is Huntingdon. Huntingdon has now, I think, been beaten by East Dorset. Obviously we wish to see the same achievements in other parts of the country. That is the significance of the targets being set by the Management Executive for the regions and by the regions for their districts, and that is very much the work of the task force. We will not be allocating money specifically for maternity services. We will be demanding improvements from the Health Service to make sure we build on the remarkable successes we have seen over the past ten years.

846. Do I understand implicit in what you are saying, although you are not explicit about it, that as we improve all of these other factors, particularly the things we were dealing with in the first part of our inquiry, the health of parents and the preconception stage, that in fact we should accept for a given number of births there should be an actual reduction in the amount of care you have to deliver and, therefore, a reduction in the expenditure?

(*Mrs Bottomley*) I do not think you can assume that. Certainly there is an extension of perhaps Mrs Wise's point on community midwives. Although we have not been able to provide you with the figures, an increasing amount of work is done in the community, whether antenatal, at the delivery or post-natal is cost-effective and there would be cost savings.

(*Mr Shaw*) I think what the Minister has been saying can be summed up in two words: "increased productivity".

847. I tried to avoid using that word, it did not seem appropriate in connection with maternity services!

(*Mr Shaw*) Would "efficiency" be better?

848. Cost-efficiency?

(*Mr Shaw*) I think it is slightly dangerous to take one year and look at it in that way rather than looking at the trend as a whole. In taking the particular year in question, as all are agreed, the expenditure in total went down but as the Minister has suggested actually, certainly, in hospital activities the in-patient activity increased by 1.8% over 1988/89 and 2.2% over 1989/90 in 1990/91 so there is considerable efficiency in that example. But turning from the individual years to the trend of the thing, we know that the overall trend in improvements in perinatal infant mortality are impressive and that there was real term growth in expenditure of 11.9% between 1980/81 and 1989/90. The Minister said there was a fall in the average length of stay from 7.5 days per birth in 1980 to 5.7 in 1988/89 and 5.5 in 1989/90. Thirdly and finally, there was a dramatic increase in community midwifery and expenditure there doubled in real terms over the period from 1979/80.

(*Mrs Bottomley*) The other element of the question is whether we would anticipate those figures being part of a trend. We do not feel able to comment or predict on that front. I would be surprised, partly because the birth rate has gone up again. What happened was there was this significant fall in the birth rate in that particular year. But we do not anticipate that to be part of a change in direction.

849. Obviously if the birth rate goes up you expect the expenditure to go up but I am asking about the quality element in the general improvement we hope there is in the health of the nation, particularly of pregnant women. In fact one would hope, because it is natural health and not illness, having babies, one would expect there would be a gradual downward trend if all the other factors are improving as you have suggested they are. This is not a sickness service this is a health service.

(*Mr Edwards*) What I think we are missing out of this equation, Sir David, is that it is certainly true of the maternity side itself that in my region in 1990/91 we had a 4% increase in activity and a 2% reduction in overall cash input and we are investing quite separately in areas like intensive neonatal care and we are not adding those into the equation but maybe we should.

Chairman

850. Is Huntingdon in East Anglia?

(*Mrs Bottomley*) Yes.

851. You might be interested to know that East Anglia has the highest percentage of home births. You referred to it in glowing terms!

(*Mrs Bottomley*) If I may, I will see if there is a significantly higher proportion of home births in Huntingdon itself.

(*Dr Walford*) The Committee were very impressed with Hinchingbrooke Hospital.

(*Mrs Bottomley*) Mr Edwards was giving a list of items not covered in the figures we were looking at. The other aspect is GP payments. They are not part of the overall picture so if there was a change in the pattern and role of GPs that is another element to be considered. Overall, we are that we do not have the comprehensive data on costings to make predictions. What we have is the absolute determination to see those figures continue to improve.

Sir David Price

852. In a way we should not take those figures you gave us on the maternity services too seriously?

(*Mrs Bottomley*) You can take seriously indeed there are 24% more midwives and 20% more obstetricians and paediatricians, more members of the team providing maternity services.

853. With respect, those are the output figures but not the input. Select Committees have to look at the input because we are using public money.

(*Mrs Bottomley*) We are not in a position at present to comment on the significance of that particular figure in that particular year. But we had to see it in the context of a number of other factors which are extremely positive, and certainly in terms of the only outcome we are really talking about which is improving the perinatal infant mortality figures.

Sir David Price: We would agree with you on that.

Mr Rowe

854. It is a very complex issue and of course everybody wants to see increasing improvements as the Minister has just said. On the other hand there must come a point at which the question is how much incremental improvement you can achieve for a given

[**Mr Rowe** *Cont*]
input of money? I just wondered whether the Department has in this field or any other any ratio of input for a desired improvement in the service?

(*Mrs Bottomley*) Mr Shaw?

(*Mr Shaw*) The best I can offer is not in the context of maternity services, but whether in the Civil Service or public service at large or in the NHS we do look for a 1% per annum efficiency improvement across the board. That would be the best I could offer.

Chairman

855. While we are on basic financial matters could, Minister, you or one of your officials tell the Committee why general practitioners receive a separate fee for providing maternity care and has your Department any plans to review such fees?

(*Dr Walford*) In fact GPs can receive a number of fees for providing different aspects of maternity care. They may provide the full maternity care, and as you have pointed out that is reasonably uncommon, most GPs provide antenatal care usually on a shared basis with the hospital and with the midwives. Many GPs provide post natal care, they certainly provide the post natal examination but not necessarily post natal visits. There is a separate fee for a visit and the examination. There is a fee schedule, if you like, for general practitioners and they make claims according to the services they have actually delivered. GPs fees are paid in relation to the services provided.

856. Fine, but can you indicate or can the Minister indicate, because this may perhaps be a policy matter, has the Department considered instead extending the system of capitation payments to give GPs a payment in respect of the number of their patients who are women of reproductive age?

(*Mrs Bottomley*) We have not considered that option but certainly if this Committee makes recommendations in any of those areas we would look at them very carefully. GP remuneration and terms of service is the subject of discussions with general practitioners. I am quite sure were recommendations to be made in that area we would look at them very seriously.

857. It looks as if Dr Walford has been handed a useful piece of paper?

(*Dr Walford*) I endorse what the Minister has said wholeheartedly.

858. Can we move on to contracts because although this is important it has come up not least in relation to a matter raised earlier by David Hinchliffe. Can you tell us, Minister, what problems, if any, have arisen in the operation of contracts for maternity services between purchasers and providers? How are cross-boundary referrals for specialist services (antenatally or for neonatal care) being organised? Are admissions to neonatal centres "extra contractual referrals" and if so, is there a guarantee that the parent health authority will always agree to pay the bills?

(*Mrs Bottomley*) This is an area that has not caused difficulties. It is an area which clearly, with the implementation of the reforms, we wanted to be satisfied would work effectively. I think the most sensible and helpful approach for the Committee is to ask Mr Edwards to comment on the way in practice it is working in his particular region.

(*Mr Edwards*) I have with me, and I am happy to make available—because they are public documents—the contracts available between the district health authorities and provider units in my region. They specify the range of services, they specify the range of choices they would like to offer to women in the district. They give an indication of the range of volumes and fix a price. They also have a lot of quality standards which you might be interested in which they negotiate. I think for the first time we can see much more clearly a clear relationship between what the DHA think the community needs and what the hospitals are commissioned to and willing to provide. As far as neonatal intensive care is concerned we have not had any financial problems. We do have problems occasionally as the units hit peaks in activity this year and we do occasionally have to arrange for transfers. That is an occurrence which happens from time to time. We have not, however, had any financial barriers put in the way thus far, I do not expect we would. These are very ill babies and we would normally expect the professionals to get on with it and we will sweep up after them.

859. On that matter, Mr Edwards, I believe I am reliably advised neonatal intensive care services are being charged for at a flat rate. Why is that? Because obviously some babies are very much more ill than others and therefore why are these babies being charged for at a flat rate which I understand is the position? Am I correct, first of all, in stating that the neonatal services are being charged for at a flat rate and if I am why is that?

(*Mr Edwards*) There is not, I do not think, a uniform national position on this currently. In some regions the services are contracted for regionally on the basis of an agreed sum which is top sliced and allocated. This is the pattern across most of the country. In some parts of the country these specialist services are handled at the level of the district, in most parts they are handled at the level of the region and in that respect they are a free good.

(*Dr Walford*) In the note we provided for the Committee about the contracting position in regions, you will probably see in many regions although these cases are being handled under a block contract this year the intention is to move to cost per case.

860. At the moment you are confirming they are being charged at a flat rate?

(*Dr Walford*) In a block contract, yes; not the same rate for each contract necessarily.

861. Does this not encourage units to admit the maximum number of babies who need a short stay to the inevitable disadvantage of the most ill babies who might need to stay in intensive care for several months?

(*Dr Walford*) I consider that is a most unlikely scenario, Mr Chairman. These units exist to serve acutely ill, seriously ill babies and to suppose any financial consideration, where the contract exists and the baby can be taken in, determines which baby can be taken in I think to be a highly unlikely proposition.

862. I am reassured. Obviously commenting on Mr Edwards I understand his is the only region which has a block contract for this area of activity?

[**Chairman** *Cont*]

(*Dr Walford*) No, I think a vast majority of regions actually have block contracts between the districts and the regional units so there is a contract actually established between a purchasing district and the unit, only a few regions now themselves have a block contract with the unit. The contract has been established on the basis of previous referral patterns and previous expenditure. There has been no cutting back whatsoever on the funding of these centres.

863. I understand, coming back to Mr Edwards, no other region in fact. Is this to do with top slicing?

(*Mr Edwards*) I doubt if your information is correct. We need to check it.

(*Mrs Bottomley*) We could check this.

864. I think there could be some misunderstanding and we may not have the information that actually would be most helpful and most accurate for us. This clearly is very, very important to us, I hope you will understand, not least because this Committee or its predecessor carried out an in depth inquiry and a subsequent follow up inquiry into perinatal and neonatal mortality and we are waiting for the Government to accept some of the recommendations we made many years ago. Can I continue on the matter of neonatal intensive care? Is it the Government's policy that smaller maternity units may provide neonatal intensive care or is the regional structure of such specialist services to be retained?

(*Dr Walford*) Chairman, the levels of service for neonatal intensive care are basically either three in certain regions or two. The three tier service is a regional highly specialised service, a number of sub-regional services and basic specialised care but not highly intensive care delivered in each district. Each district has to have the capability for a minimum period of 24 hour emergency care for babies, if you need a more specialised service this may be in the regional level or at the sub-regional specialist unit. We have no plans to change that arrangement, we believe certain babies must go to specialised units and it would be quite wrong for that district to try and duplicate those services at that level.

865. Following up my question and your answer, do you think a scheme of accreditation of neonatal intensive care units should be introduced basically to prevent small units taking a hand on the grounds they may be able to do it more cheaply?

(*Dr Walford*) Purchasers have a responsibility not to purchase care that is not of the standard required. If purchasers refuse to purchase the service from their district because the service is not appropriate, and the service is not there, hospitals are not going to go it alone. The money will not follow the patients and hospitals, as providers, cannot set up in this field. It will be for Health Authorities to purchase for their recipients the best possible care. It is quite possible this will not be in the local maternity unit for intensive care, it will be in another district or at regional level.

866. Are you supporting this scheme of accreditation or not?

(*Dr Walford*) Accreditation per se is not necessarily the answer. We, of course, support the concept of medical audit and we know in order to have the best possible outcomes you have to have a certain throughput of patients in any given area and in a unit which is likely to treat only a small number of patients you can anticipate in advance the outcome will not be as good. A system of accreditation is not in contemplation and is quite likely to be unnecessary in this area.

(*Mrs Bottomley*) This is one of the standards the Clinical Advisory Group are interested in considering but their thoughts on how to carry this forward are not yet finalised. I want to reinforce what Dr Walford said about the significance of audit, but also the forthcoming Confidential Enquiry into Stillbirths and Deaths in Infancy. There will be a number of measures to make quite sure we are achieving the quality of service for these fragile early infants all of us would want to see. It is not our experience at this stage that it is causing difficulties. But this is an area we would want to watch very carefully indeed.

867. If there is, therefore, no accreditation, and Dr Walford has said she thinks there will not be, and it is unnecessary, how can the purchasers of these vital technical services know what they are getting?

(*Mrs Bottomley*) The development of effective purchasing, and of quality purchasing guidelines is part of the work of the Management Executive. We have talked about the task force for maternity services generally. It is important that purchasers become increasingly aware of the criteria they would to address in carrying forward their purchasing strategy. It is no different in that respect whether it is neonatal intensive care or maternity services generally. I do not know whether Mr Edwards wants to add anything more on that.

(*Mr Edwards*) These decisions are not made in that manner. When you get a doctor in a peripheral hospital with a distressed child they do not worry about where the contract is, they make the decision whether their skills are enough or whether they ought to go to a different clinical territory, that is where the difficult decision making goes on. You have differential decision making, some units are building up their skills to a point where they feel comfortable, others are not. This is where professionals work together with the dedicated centres and they clearly know when to refer and they are working together.

868. That is the way the world actually works. We accept that, but obviously costs always feature in anything that is done with the Health Service purely on the grounds we have to get better value for the Service. Clearly in dealing with neonatal intensive care and these specialised units you are actually dealing with a great deal of money and I am wanting to hear, as Chairman of this Committee, and I suspect my colleagues too, that at no time will the cost of dealing with one of these distressed, vulnerable babies ever be taken into account, it will be the distress of the baby?

(*Mrs Bottomley*) Chairman, it may be the case that the perception you have of the reforms is of an emphasis on cost, but that is only so we can improve care. The true revolution, surely, is the new emphasis on outcome figures. The development of audit is about making sure we have those figures readily available and are committed to continuing to increase the number of babies who survive infancy. Any question of costs is secondary.

[**Chairman** *Cont*]

869. I think you and this Committee are going to be on common ground. One final question: can I ask if you would be prepared to come again, we have a number of questions we are not able to ask because we allowed the first hour of this meeting to be dominated by very important issues which prevented us going on to other issues? Would you be prepared to come again?

(*Mrs Bottomley*) Yes.

Rev Smyth

870. Following on the answers given, and reflecting the concerns about the direction of health provision, if a young obstetrician with tremendous gifts in a small hospital uses the undeniable skills and support of the local people to provide neonatal facilities, can they be stopped by the regions not providing the money to follow the patient?

(*Mrs Bottomley*) The region needs to be satisfied they are providing a qualified service.

871. In other words they can still go on ahead to build up their own particular empire, if I might use that term?

(*Dr Walford*) The fact is that nowadays—with contracts—the unit will not be funded to provide that service. Now, neonatal intensive care is costly, as we have established, and it is not simply what the obstetricians or paediatricians want to do, it is the whole team of intensive care nursing and therefore it is extremely unlikely now in a unit where this service has not been established before—and there is no money to establish it, unless there is a lot of soft money or research money coming in—it is very unlikely the empire will start to build. It was the case in the past people built up their own interest because the costs were less transparent, these days it is less likely it will happen. What Mr Edwards said is right, where it is appropriate to develop expertise locally the consultants become seconded to other units and when they are ready and able to take on these new techniques they can bring them back to their own unit provided the purchaser wants them to do that.

Chairman: Minister, and your officials, can I thank you all for coming today. We have had quite a motivated and invigorating session. I am grateful to you for indicating you will come before us again for a further session. Thank you for your attendance this afternoon.

APPENDIX

DEPARTMENT OF HEALTH'S RESPONSE TO SUPPLEMENTARY QUESTIONS

1. The Minister gave a number of undertakings during her oral evidence of 6 November to provide notes on certain issues to the Committee. These were:—

(a) More precise figures which may be available on the relative costs of different ways or organising maternity services (Q800).

Department's response:

The Committee are aware of the research project on team midwifery commissioned by the Department from the Institute of Manpower Studies at Sussex University. This project is already collecting some information on costs. The Department will be discussing with the researchers possible ways of extending this element of the study. (More information about the study is given in response to question 2(c) below.

Health Authorities, as "purchasers" of services, will themselves encourage local costing mechanisms as the new provider/purchaser arrangements develop from block contracts into more sophisticated purchasing systems. It is for health authorities to decide what detailed costings they require when entering into contracts.

(b) The Department's own conclusions from the visit of Miss Greenwood and Dr Modle to the Netherlands (Q833).

Department's response:

Miss J Greenwood, Nursing Officer (Midwifery), and Dr W J Modle, Senior Medical Officer, of the Department of Health, made a study visit in September 1991 to the Netherlands to look at the provision of maternity services. The programme was arranged by the Netherlands Ministry of Health and consisted of visits and discussions with professionals and officials representing the following:

The Ministry of Welfare, Health and Cultural Affairs—State Inspectorate of Public Health, Rijswijk;

Academisch Medisch Centrum, Amsterdam;

Midwifery Training School, Slotervaart Hospital, Amsterdam;

Department of Standards Setting, Nederlands Huisartsen Genootschap (Association of General Practitioners), Utrecht;

Midwife in private practice—at her practice premises in Lisse.

As a result of their visit, Dr Modle and Miss Greenwood have concluded that there are some aspects of maternity services in the Netherlands which are better than those in the UK, but rather more which show no advantage. In their opinion:

In the UK:

(i) We are maintaining a consistent fall in the perinatal mortality rate whereas the Dutch rate has shown no marked change for several years. In 1990 the perinatal mortality rate in the Netherlands was 9.7 while that in England was 8.1. Commenting on the trend in perinatal mortality rate in the Netherlands as early as 1986 the Dutch statistician Hoogendoorn wrote—"The Netherlands has shown a remarkable decrease to the extent that the rate for 1982 was only 25 per cent of the 1940 figure. Since 1982 however this rate has stagnated".

(ii) Professionals in the UK have a policy of offering universal screening for fetal abnormality but there is no such policy in the Netherlands where Government policy is to offer tests to the small proportion of women in groups at high risk of fetal abnormality.

(iii) There is better liaision between midwife, GP and obstetrician, i.e. women get the advantage of multidisciplinary team "shared care" more commonly than in Netherlands.

(iv) All women in childbearing episode, wherever they are, receive care from a midwife in UK and all these midwives practise the activities as laid down in the EC Midwives Directive. However, not all pregnant women in the Netherlands receive care from a midwife.

(v) Pain relief in labour is readily available here but is not normally offered in the Netherlands.

(vi) The one third of women in labour in hospitals in the UK who, if they were in the Netherlands might have been labouring at home, are observed more closely by Midwives than they would be in the Netherlands. Midwives in the Netherlands are few in number and do not tend to stay with the woman throughout the first stage of labour after they have responded to a home call.

In the Netherlands

(vii) Continuity of Care, i.e. commonly from the same person throughout the pregnancy, (usually by a midwife, less often by a GP) is achieved in about 50 per cent of cases, i.e. more commonly than in the UK.

(viii) Women who have a problem in labour have care by or are closely supervised in person by a specialist more commonly than in the UK. Not all those specialists will have the same level of training or experience as a consultant in the UK but in all cases they have had their level of achievement formally assessed and recognised.

(c) The proportion of home births in Huntingdon (Q851).

Department's response

In 1990 the proportion of home births in Huntingdon Health Authority was 1.13 per cent (23 births) of total births. This compares with 1.59 per cent (423 births) in East Anglia as a whole.

(d) Copies of the contracts between DHAs and providers of neonatal care in the Trent Region (Q858).

The information requested is at Annex A.

---

2. The Committee wishes to follow up the following points arising from the Minister's oral evidence of 6 November:

(a) Could the Department give a fuller account of the terms of reference, the progress and the anticipated date of reporting of the review of research priorities referred to in the Minister's answer to Q799. The Committee would also be grateful for a note of any preliminary conclusions or indications which the Director of Research and Development might be able to provide.

Department's response:

A Central Research and Development Committee (CRDC) has been established to advise on the setting of priorities for NHS research and development; the membership and terms of reference of the Committee are set out in the brochure "Research for Health" published on 23 September (Annex B) (not reported). The Committee met for the first time in October when a Priorities Working Group was set up to help determine the way in which priorities should be set; it will be reporting to the CRDC next Spring. An Advisory Group on Setting Priorities in Mental Health Research has also been established and will be reporting to the CRDC

at the same time on priorities in that field. A full set of R & D priorities will be developed over time, with the Committee co-ordinating contributions from a range of sources. It is premature at this stage to provide any preliminary conclusions.

(b) Could the Department give more precise figures for the increases in qualified obstetricians and midwives referred to by the Minister in her answer to Q800. What targets has the Department set for the future, or what trends has it identified?

Department's response:

Increases in Qualified Obstetricians:

Between 1979 and 1990 there was an increase of 25·6 per cent in consultants in Obstetrics and Gynaecology. The actual numbers of consultants expressed in whole time equivalents (WTE) increased from 586·5 to 736·4. Over the same ten year period the incease in all hospital medical staff in Obstetrics and Gynaecology was 19·2 per cent, from a total of 2,361·8 to 2,814·9 (WTE).

Increases in Qualified Midwives:

The figures already given to the Committee by the Minister refer to the growth in the number of qualified midwives. The table at Annex C provides data for qualified midwives over the period 1981 to 1990 and show an increase of 24 per cent.

Targets for the Future:

"Achieving a Balance—Plan for Action" (Annex D) (not reported) envisages a rate of consultant expansion in all specialities of at least two per cent per year. It is for individual health authorities and units to decide the appropriate level of expansion in the various specialities based on local needs and priorities.

The Joint Planning Advisory Committee (JPAC) advises the Secretary of State on quotas for Senior Registrar and Registrar numbers in each specialty. In making their recommendations, full account is taken of wastage rates and consultant expansion. The composition of the Committee is at Annex E.

The specialty of obstetrics and gynaecology was last reviewed in Spetember 1990; the Royal College of Obstetricians and Gynaecologists are, in general, content with national JPAC targets for Senior Registrars and Registrars. If the College request it the Committee will consider an earlier review than the 1993 date previously set. It is planned that the target of 179 Senior Registrars should be reached by 1994 and the target of 257 Registrars attained by 2000.

(c) What are the terms of reference of the team midwifery research project (Q800) and how does it relate to the apparently broader review referred to at (a) above? Will it seek to establish what is and what is not a domino system (Q808)?

Department's response:

"Mapping Team Midwifery" is the title of the study commissioned from the Institute of Manpower Studies, Brighton, the successful tenderers for the research grant.

The aims of the study are:

(i) To identify, through a descriptive mapping exercise, what midwifery staff management practices are being carried out in England and Wales in the name of team midwifery.

(ii) The study should identify how the different "team midwifery" models function, and what, in the opinion of the service providers and managers, facilitates or hinders their midwifery services.

As stated in the answer to 1(a) above, the Department will be discussing with the Institute the ways of developing the costing aspect of this study. The study will seek to describe all methods of team midwifery including domino schemes or continuity of care/carer schemes on which researchers receive information from Health Districts in England and Wales. The study is being funded as part of the Department's own centrally commissioned programme of research. It is due to report in the Autumn of 1992.

(d) What is the relationship between the statements on the availability of home births on page 21 of the HEA book "Pregnancy" and that in chapter 7 of the Maternity Services Advisory Committee's

"Maternity Care in Action" that "As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are readily available" (Q838).

Department's response:

The Pregnancy Book and the reports of the Maternity Services Advisory Committee (MSAC) are intended for different audiences. The Pregnancy Book is aimed at parents and reflects the recommendations of the MSAC's reports which combine the views of all the professions with the views of users. The MSAC reports are intended for use by professionals and health authorities as a guide to good practice and in planning the development of maternity services.

On page 19 of the current edition of the Pregnancy Book the advantages of a hospital birth are stated as being that:

"both expertise and equipment are on hand in case they are needed. If something goes wrong during labour (and no-one can be 100 per cent sure it won't) then you don't have to be moved."

On page 21 however, it is acknowledged that some women will wish to have a home birth because:

"they feel they will be happier and better able to cope in a place they know and with their family around them".

This is entirely consistent with chapter 7 of the MSAC's report, "Maternity Care in Action, Part II: Care during childbirth" which states that:

"As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are readily available. Some mothers might prefer to have their babies at home, despite the possible risks, feeling that these are outweighed by the benefits they perceive to themselves and their families."

and

"Some mothers want a home birth because they feel that they will be more relaxed and in control at home or because they regard childbirth as a family event and do not want to be separated from their families."

Both documents make it clear that a woman has a right to a home birth and recommend that, before deciding, a woman should talk to her GP and midwife. A woman may also be encouraged to have a consultant opinion but all the professions involved recognise that the final decision is the woman's not theirs.

(e) Can you given the evidence on which was based the figure of 20 per cent of those booked to have babies at home or in GP units being transferred to hospital (Q843).

Department's response:

Paragraph 2.6 of the Department's Memorandum on Delivery mentioned that studies show that up to one-fifth of women booked for delivery at home or in an isolated GP unit are transferred to a hospital consultant unit because of complications that arise after labour has begun. The memorandum gives two references to transfers from GP units. There are several other papers which quote GP unit transfer rates and home to hospital transfer rates and a fuller list is attached. (Annex F).

(f) When was the current system of remunerating GPs for maternity services introduced, and when was it last reviewed (Q856)? What is the system for renegotiating it?

Department's response:

The current system of remunerating GPs for maternity medical services was in place in 1966. Since then it has undergone periodic reviews in consultation with the profession, and minor amendments made. Regardless of where the initiative comes from, any renegotiations would be a matter for discussion between the Department and the General Medical Services Committee of the BMA.

(g) Could the Committee have further details of the progress and expected publication dates of the inquiries of the Clinical Advisers Group and into stillbirths and deaths in infancy (Q866)?

Department's response:

Clinical Standards Advisory Group

The Clinical Standards Advisory Group (CSAG) has been asked by the United Kingdom Health Ministers to advise on the standards of clinical care for women in normal labour. Their investigations will include variations in clinical protocols for and practice in the management of women having their first child in a representative sample of labour wards in NHS hospitals. They will also investigate the use of corticosteroids in cases of premature labour. CSAG expects to report to the Health Ministers next Summer.

Confidential Enquiry into Stillbirths and Deaths in Infancy

The Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), a unique initiative worldwide, will be a continuous programme of selecting for detailed enquiry a proportion of the around 10,000 late fetal losses, stillbirths and deaths in infancy which occur each year in England, Wales and Northern Ireland. Ministers will be advised by a National Advisory Body (NAB) about the proportions of such deaths which should be studied in any one year. The NAB will be set up shortly and will comprise representatives of professional bodies, voluntary organisations and NHS management. In 1992 the NAB will advise the NHS of the systems needed to conduct the Enquiry and the first full year's data will be collected in 1993. A national report of findings and recommendations is expected to be published in 1994.

(h) The Department's table on current contracting arrangements for regional services for perinatal and neonatal intensive care indicates that the previously regionally funded services have largely been devolved down to district block-contracting. The data suggest that only SE Thames has top-slicing and a regional contract. However, Mr Edwards said on 6 November (Q859) ". . . in my own particular region the services are contracted for regionally on the basis of an agreed sum which is top sliced and allocated. This is the pattern across most of the country . . .". This appears to contradict the Department's earlier evidence, which suggests that in Trent there is no top-slicing. Dr Walford, commenting on this later in the evidence, suggested that they do not have the power to stop small neonatal units being established. At Q879 she indicated that regions could not force DHAs to make appropriate contracts, but in Q864, Dr Walford states that the DH supports the three-tier (or two-tier) structure. How is this structure to be maintained without top-slicing and a regional contract?

Department's response:

Prior to April 1991 top-slicing was used for funding neonatal intensive care and money for the service went direct to sub-regional centres from regions. Since the introduction of contracting arrangements regions have adopted a variety of approaches and, in some instances, this still involves top-slicing. The Department's earlier supplementary note on the subject made clear that *all* regions have either a two or three tier structure for neonatal intensive care, though in East Anglia the Regional Centre based at the Rosie Maternity Hospital operates informally. These centres are the responsibility of the regions concerned. They have built up considerable expertise over the years and regions will continue to have an interest in ensuring that their resident populations are best served by all the services that are purchased.

Block contracting by purchasers simply means that access is given to a range of care at a specific price e.g. maternity and paediatrics, within which neonatal intensive care may or may not be separately identified. As the contracting process becomes more sophisticated, purchasers will begin to identify particular aspects of care separately and some are already doing this. Block contracts can be held at regional level and therefore their existence does not indicate any particular type of funding.

In the first year of contracting for neonatal intensive care, the contracting arrangements have been largely based on the previous pattern of referrals and purchasers have been funded accordingly. Because of the expertise that has built up over the years in regional and sub-regional centres, these are even better placed than before in a system where the money follows the patient.

As Dr Walford stated in her response to Q871, it is the purchasers' responsibility to enter into the most appropriate contracts for their residents. In some cases, where residents live some distance from their own regional centres, this may even be with centres situated outside the region itself.

(i) Babies admitted to neonatal intensive care units seem not to be being classified as "emergencies" and admissions are being charged as part of a block contract (Q860). Is it the Department's policy that ill newborn babies are "emergencies", and that potential disputes about payment should be avoided; and is it the expectation of the Department that the charge should be sensitive to the care given in future contracts?

Department's response:

The majority of referrals to neonatal intensive care units will be covered in advance by contracts and so the question of where financial responsibility rests will rarely arise. In emergencies, the baby will be treated promptly and the funding arrangements made at a later date. An emergency extra contractual referral is clearly defined in legislation (section 3(5)(b) of the NHS and Community Care Act); that is, where

> "the condition of the patient is such that he needs those goods and services and, having regard to his condition, it is not practicable before providing them to enter into an NHS contract for their provision."

What is practicable in terms of arranging a contract will depend on the individual circumstances of the case. It is a matter for the individual purchasers to decide the level of detail. However, where the referral is an emergency and does not fall within an existing contract (ECR), the charge made will be in accordance with a published tariff.

(j) In Q866, Dr Walford rejected the idea of accreditation of regional units. Does the Department expect to review this policy?

Department's response:

The NHS Management Executive believe that purchasers should continue to secure improvements in the quality of service delivered through the negotiation and specification of quality terms in contracts. DHAs are able to negotiate and agree with providers quality terms which reflect their particular local needs and circumstances. It also enables clinicians to become actively involved in discussions about the standard of service they deliver leading to greater "ownership" of the quality terms agreed in contracts. Accreditation of national minimum standards runs the risk of ensuring that the minimum standards are the only standards people bother with.

The Committee also wishes to obtain the Department's response to the following supplementary questions:

3. What has been the impact to date of the findings and recommendations of the Maternity Services Advisory Committee?

Department's response:

The Maternity Services Advisory Committee's three reports, "Maternity Care in Action", provide detailed guides to good practice and checklists for action in the areas of antenatal care, interpartum care and postnatal and neonatal care. The Committee's advice forms the basis of Government policy for maternity and neonatal services. It is a matter for health authorities to determine how best to implement the advice contained in the MSAC reports using their detailed knowledge of local needs and circumstances but, as stated already in the Memoranda submitted to the Committee, the reports have been commended by Ministers to the NHS and their impact on service delivery has been monitored by special surveys conducted in 1986 and 1988 into selected aspects of care.

The results of these surveys have shown that health authorities have taken steps to improve their maternity and neonatal services in the light of the MSAC reports and they have enabled the Department to identify areas where there was room for improvement. This in turn, has led to maternity services being accorded a high priority in the annual planning guidelines issued to the NHS since 1990–91. For instance, for 1992–93 all regions have been required to agree targets with their districts and FHSAs to reduce stillbirths and infant deaths and to play a full part in the national confidential enquiry. The NHS Management Executive has asked regions to pay particular attention to reducing smoking among pregnant women; issues of access to services for certain groups of women—eg those from ethnic minorities; and arrangements for consultant cover of labour wards.

---

4. Have Maternity Services Liaison Committees been successful in achieving the aim of greater user involvement in the planning of local maternity services? Can you give us examples of where significant advances have been made as a direct result of the work of a Maternity Services Liaison Committee?

Department's response:

Most Maternity Services Liaison Committees (MSLCs) have succeeded in involving user representation with, for example, members from Community Health Councils and the National Childbirth Trust. Most of the success of user involvement seems to be connected with the operation of services rather than in planning; with discussions of issues, such as the "Maternity Care in Action" reports and "The Breast Feeding Initiative" and conducting consumer surveys being the most prominent activities. In general terms the balance that users

can bring to issues where there may be conflict amongst providers is seen as extremely valuable. A list of advances made as a result of MSLC involvement is shown in Annex G.

---

5. Are link workers employed by all providers of maternity services in districts with large populations whose first language is not English?

Department's response:

The Department does not keep central records of the location and numbers of link workers. However, anecdotal evidence suggests that they are employed widely and increasingly where there are large ethnic minority populations.

The use of link workers was piloted by the Department of Health through the Asian Mother and Baby Campaign (1984 to 1988) which encouraged their appointment by health authorities to overcome barriers of language and culture between patients and health service professionals. It was a successful exercise in providing a model for health authorities to follow. Its results were widely publicised to health authorities and this will have contributed to their widespread use.

---

6. What consideration has the Department given to the Welsh Health Planning Forum's publication "Protocols for Health Gain for Maternal and Early Child Health"; and what is the Department's policy towards developing its own parallel protocols?

Department's response:

The Welsh Health Planning Forum was established in 1988 by the Secretary of State for Wales as an advisory sub-group of the Executive Committee of the Health Policy Board of the NHS. Its role is to give expert advice on the planning of health services. The "Protocol for Investment in Health Gain: Maternal and Early Child Health" is one of a series of 10 Protocols, four of which have been published by the Welsh Office NHS Directorate.

The Department has studied the Welsh Health Planning Forum's interesting and informative protocol for maternal and early child health which includes guidance on the lines of that included in the Maternity Services Advisory Committee reports. It also lays stress on health gain targets which it acknowledges is a central theme of the Department of Health's "Health of the Nation".

In the Department of Health's view, protocols and good practice guidelines can be very useful tools for improving patient care and making better use of resources. However, these should not be over-prescriptive. There needs to be room for local flexibility to ensure that health authorities arrange the most appropriate balance of care to meet the needs and wishes of local people. Protocols and good practice guidelines are certainly areas the proposed task force on maternity services will consider.

---

7. What is being done to develop routine methods of follow up of children who have been in intensive care to assess the prevalence of disability among the survivors?

Department's response:

The vulnerability of very low birthweight babies (who have been treated in intensive care units) to sensory, physical and developmental impairments is now well recognised. The experience of a child during labour and in the neonatal period is a key item of information in the preparation of a child health surveillance (CHS) programme and practitioners will pay special attention to children "at risk" as a result of an unfavourable early life experience. They will be at particular pains to ensure that these children do not miss any of the developmental examinations in a programme of CHS. The recommended programme is set out in "Health for all Children" (The Report of a Joint Working Party on Child Health Surveillance Edited by Dr David Hall, Consultant and Honorary Senior Lecturer in Community Child Health at St George's Hospital Medical School, London)

The Government has taken steps to improve the quality and availability of CHS. Since April 1990 GPs have been eligible for a special payment for undertaking CHS *provided* they can meet criteria set by the DHA/FHSA in respect of training and experience in child health. A working group of relevant professional bodies including the British Paediatric Association and the Royal College of General Practitioners has produced guidelines on the necessary training requirements and have organised training course. So far some 50 per cent of GPs have been accredited to undertake CHS.

As a result, parents now have a choice between the child health clinic and their GP for arranging CHS. The clinic may be more convenient or, alternatively, they may prefer the continuity offered by using their GP for the full range of the family's primary health care needs.

Performance in CHS is subject to clinical audit.

---

8. Has the recommendation in the Government's reply to the Social Services Committee's First Report of Session 1988–89 on Perinatal, Neonatal and Infant Mortality (Cm 741) that all Regions should have at least one paediatric pathologist in post now been achieved?

Department's response:

All but one Regional Health Authority (South East Thames) now have a paediatric pathologist in post. The South East Thames RHA's Appointment's Committee will interview candidates in December 1991; with the intention of making an appointment at the beginning of January 1992.

---

9. (a) Can the Department confirm that in its memorandum printed with evidence for 3 July (pages 186–7) and in answers to PQs (10 June, col 446, 21 June, col 324, 25 July, col 911) the Department showed that data provided to the Committee were based on only 55 per cent of births in England in 1989–90 and could not be used to produce tabulations for regions, or for districts. What was the coverage in 1990–91?

Department's response:

The Department can confirm that data provided to the Committee were based on 55 per cent of births in England in 1989–90. Regional analyses of estimated percentages of some key data items have now been produced where possible and are attached (Annex H). It is too early to make a precise assessment of maternity HES coverage in 1990–91, but indications are that about 70 per cent of birth episodes and 60 per cent of delivery episodes will be covered. Until the data are finalised, processed, and examined in depth, it will not be possible to comment on the quality and completeness of the data in these records.

(b) What has coverage been since April 1991? Has there been any problem in getting data from trusts?

Department's response:

It is too early to be able to assess the coverage since April 1991. Arrangements have been made for NHS Trusts to continue to submit HES data through the Regions in which they are located until April 1993 and there is no evidence of any specific problems with this arrangement. From 1993, data will be gathered through purchasers covering patients treated in both Trusts and other management units.

(c) What has the Department been doing to improve coverage and what have been the results?

Department's response:

The NHS Management Executive monitors the data provided by Regional Health Authorities and regularly meets with Regional Directors of Information to discuss the quality of the data. The difficulties surrounding the completeness of maternity data have been identified as a priority. This initiative has resulted in real improvements in most regions. Work has now been successfully completed in the area on linking maternity to other systems and an improvement will be evident when 1991–92 data are available.

---

10. What information does the Department have about the incidence of post-natal infection after episiotomies and caesarian sections?

Department's response:

Information about the incidence of post-operative infection after caesarian sections is contained in the paper by Miranda Mugford et al entitled "Reducing the Incidence of Infection after Caesarian Section: Implications of Prophylaxis with Antibiotics for Hospital Resources" (BMJ 21/10/89 page 1003 to 1006—reproduced as Annex I) (not reported). The introduction to that paper gives an estimate for England and Wales of at least 6 per cent wound infection following caesarian section with a range of 0–20 per cent.

Information about infection following episiotomy is available from: Kitzinger and Simkin "Episiotomy and the Second Stage of Labour" London National Childbirth Trust, 1990. Attached at Annex J is page 85 from the chapter by Bante and Thacker on infection following episiotomy (up to 3 per cent), together with the reference list (not reported).

---

11. Is the Department planning to commission any surveys to fill the gaps in information since 1985, the last year of the old Maternity Hospital In-Patient Enquiry?

Department's response:

The Department is concentrating on achieving accurate and up to date information as soon as possible and has no plans to commission any surveys to fill the gaps in information since 1985.

---

12. (a) What has the OPCS done to identify the causes of the problem identified in answers to PQs of 4 July (col 189–90) and 2 July (col 117), and OPCS Monitor DH3 91/1 which demonstrated a decline in completeness of birth registration data?

Department's response:

OPCS has carried out some preliminary enquiries into the reasons for missing birthweights. There are a range of reasons why these occur, and where possible immediate action has been taken. Further work to identify the nature of the difficulty in different areas has been started and is planned to take about six months.

(b) Are additional resources needed to solve the problem?

Department's response:

Identifying where and how much resource is required is part of the above task.

---

13. The Department's memorandum published with the minutes of evidence for 3 July said that early results of the infant feeding survey would be out in mid June. Are they now available?

Department's response:

We should have made clear in memorandum No. 4 on postnatal care that the reference in paragraph 6.3 was to mid June *1992*. The field work for the 1990 Infant Feeding Survey finished in May/June 1991. OPCS are in the process of analysing the results and the final results are expected in the Summer 1992.

---

14. When does the Department expect to respond formally to the submission of the British Paediatric Association on paediatric medical staffing for the 1990s?

Department's response:

The report on paediatric medical staffing for the 1990s is at present the subject of discussion within the Joint Working Party (JWP) on Medical Services for Children. An interim report of the JWP is being considered by the Chief Medical Officer and good progress towards a final conclusion is expected. The Joint Working Party consists of representatives from the BMA, the Royal Colleges and the Department.

The report is also being used to inform an early review of the specialty by the Joint Planning Advisory Committee; this is expected in mid 1992. (See also the response to question 2(b) above).

---

15. Could the Department provide a brief note on any issues arising in connection with the Nurses, Midwives and Health Visitors Bill [Lords] which it considers would be pertinent to the Committee's current inquiry?

Department's response:

The Nurses, Midwives and Health Visitors Bill, which passed Report stage in the House of Lords on 26 November 1991, provides for changes in the constitution of the United Kingdom Central Council and the four National Boards for Nursing, Midwifery and Health Visiting. In particular, the English National Board will, if the Bill receives Royal Assent, be responsible in future for approving institutions to run courses of pre- and post-registration courses in nursing, midwifery and health visiting. At present, the Board uses some of its grant from the Department, to fund course and salary costs for midwifery teacher training courses. The Department is still considering whether, in the light of "Working for Patients: Working Paper 10, Education and Training" this funding should be identified and protected nationally and administered by the Department, or by the Board on the Department's behalf.

December 1991

ANNEX A

TRENT HEALTH

Regional Specialities and Neonatal Intensive Care Services

Regional Specialities

1. Regional Specialties cover a small range of services not provided in all Districts because of the need to concentrate special expertise or equipment, and/or the relatively high cost, and which the Regional Health Authority (RHA) has considered should be planned and funded on a Regional Basis in consultation with District Health Authorities (DHAs).

2. The RHA has itself contracted for these services in 1991–92 with the provider units concerned and the service agreements are block contracts with indicative workloads and costs. The agreements cover Trent residents treated in Trent and for these patients there is no charge to Trent DHAs ie they are a free good. Patients being referred outside the Region are paid for by the District of residence.

3. Regional Specialties in the Trent Region include cardiothoracic services, neuroservices and genetic services. For genetics the RHA has let three contracts as follows:

Unit	Funded Value (£000's)	Expected Workload	
Leicester Royal Infirmary	245.6	Clinical Genetics:	1,085 visits/ attendances
		Molecular Genetics:	1,450 tests
		Clinical Cytogenetics:	902 tests
City Hospital, Nottingham	766.8	Clinical Genetics:	—
		Molecular Genetics:	1,420 tests
		Clinical Cytogenetics:	2,900 tests
Children's Hospital, Nottingham	576.7	Clinical Genetics:	—
		Molecular Genetics:	2,000 tests
		Clinical Cytogenetics:	3,934 tests

4. The take-up rates in Regional Specialties by DHAs are counted back into their resource position in determining their distance from target. The RHA plans to progressively de-designate most, if not all, the Regional Specialties and devolve the purchasing to Districts. Four of the smaller specialties were devolved this year and two of the larger specialties, end stage renal failure and plastic surgery/burns services, are to be devolved from 1 April 1992, with most of the remaining specialties from 1 April 1993.

Neonatal Intensive Care

5. Whilst this specialty has received special targeted funding from the RHA, DHAs handle the contract negotiations for their residents with the designated centres within a Regional framework. The RHA specifically reviewed the contracting arrangements at the start of 1991–92 to satisfy itself that the services had been safely secured during the course of 1991–92. In year one, contracts for neonatal intensive care were part of block contracts with DHAs covering a range of services. Neonatal intensive care services are not identified separately within the contracts and are generally either included under maternity or paediatric services. In a few cases the specialty of neonatology has been identified but this includes both special care and intensive care and does not differentiate between the two. For 1991–92, the majority of units have based their contracts on average costs but work is in hand in many Units to distinguish more clearly between intensive care and special care during the 1992–93 round of contract negotiations.

6. A major research project funded and undertaken in Trent has demonstrated that many babies are admitted inappropriately to neonatal cots and purchasers have been asked to review admission criteria with the providers.

7. With the exception of the Jessop Hospital in Sheffield where the tariff for ECRs shows cost per day charges for both high dependency and intensive care, neonatology charges are quoted on a cost per case basis. These cost per case costs vary widely, with the specialised units in Nottingham and Leicester charging prices more than four times higher than other units in the Region. Derby City Hospital's charges for paediatrics (including neonatal care) are quoted on the basis of DRGs. A substantial amount of work is currently in hand to refine and develop these costs.

November 1991

ANNEX C

TABLE A

QUALIFIED MIDWIVES (EXCLUDING AGENCY)

ENGLAND AT 30 SEPTEMBER

Year	Whole-time equivalents	Per cent change 1981–90
1981	16,040	
1982	16,530	
1983	17,110	
1984	17,640	
1985	18,260	
1986	18,670	
1987	19,130	
1988	19,090	
1989	19,110	
1990	19,860	23.9%

Source: Department of Health (SM13C) Annual Census of NHS Non-Medical Manpower.

Notes: (1) Figures independently rounded to the nearest 10 (ten) whole-time equivalents. Percentage calculated on unrounded figures.

ANNEX E

JOINT PLANNING ADVISORY COMMITTEE
(as at July 1991)

Chairman

Professor Peter Bevan CBE, FRCS

Members

Representatives of the Professions (11)

Chairman of JCC (or representative)	Mr A P J Ross
Chairman of CMC	Dr G Hall
Chairman of Registrar and Junior Grades Sub Committee of CMC	Dr J Cundy
Chairman of a Regional Manpower Committee	Dr J Edelman
Representatives of the Central Consultants and Specialists Committee	Mr J R A Chawner Mr J N Johnson
Representatives of the Hospital Junior Staff Committee	Dr A Carney Dr P Miller
Representatives of the Conference of Royal Colleges	Sir Terence English Professor Dame Margaret Turner-Warwick
Representative of the Welsh JCC	Dr D Daly

Representatives of academic and research interests (6)

Representatives of the Committee of Vice-Chancellors and Principals	Professor P H Fentem Professor F Harris Professor K Saunders
Representatives of the Federation of Association of Clinical Professors	Professor J Swales
Representative of the MRC	Dr D Smith
Representative of the Association of Medical Research Charities	Professor D A Shaw

Representative of dental interests (1)

Chairman of dental sub-committee of CMC	Mr J Williams

Representatives of the NHS (4)

Postgraduate Dean	Dr E Shore (North West Thames)
Regional Medical Officer	Dr S Horsley (North Western RHA)
Regional Consultant in Public Health Medicine	Dr S A M Jones (North West Thames)
District General Manager	Mr H Shaw (E Birmingham HA)

Observers (4)

(who will be expected to contribute)

Department of Health	Dr A J Isaacs
Scottish Home and Health Department	Dr D Sinclair
Welsh Office	Dr D Owen
Department of Health and Social Services, Northern Ireland	Dr D Acton

ANNEX F

GP UNITS TO HOSPITAL TRANSFER RATES

REFERENCES

1. Taylor G W et al. How Safe is General Practitioner Obstetrics? The Lancet, 13 December 1980, pp. 1287-1289.

2. Cavenagh A J M et al. Contribution of isolated general practitioner maternity units. British Medical Journal Vol. 288. 12 May 1984, pp. 1438-1440.

3. Young G. Are isolated maternity units run by general practitioners dangerous? British Medical Journal Vol. 294. 21 March 1987, pp. 744-746.

4. Garrett T et al. Outcome of women booked into an isolated general practice maternity unit over eight years. Journal of the Royal College of General Practitioners, November 1987, pp. 488-490.

5. Reynolds J L et al. General practitioner obstetrics: does risk prediction work? Journal of the Royal College of General Practitioners, July 1988, pp. 307-310.

6. March G N, Channing D M. Audit of 26 years of obstetrics in general practice. British Medical Journal Vol. 298. 11 April 1989, pp. 1077-1080.

7. Prentice A, Walton S M. Outcome of pregnancies referred to a general practitioner maternity unit in a district hospital. British Medical Journal Vol. 299. 28 October 1989, pp. 1090-1092.

8. Sangala V et al. Perinatal mortality rates in isolated general practitioner maternity units. British Medical Journal Vol. 301. 1 September 1990, pp. 418-420.

HOME TO HOSPITAL TRANSFER RATES

REFERENCES

1. Barron S L et al. Home and hospital confinement in Newcastle upon Tyne 1960-69. British Journal of Obstetrics and Gynaecology 1977; 84: 401-11.

2. Van Alten D et al. Midwifery in the Netherlands. The Wormerveer study; selection, mode of delivery, perinatal mortality and infant morbidity. British Journal of Obstetrics and Gynaecology, June 1989, Vol. 96. pp. 656-662.

ANNEX G

EXAMPLES OF THE WORK OF MATERNITY LIAISON COMMITTEES

1. Kettering DHA
   - (a) improvements in the quantity, quality and time of availability of food in the maternity unit;
   - (b) improvements to visiting policy;
   - (c) improvements to guidance on feeding new born babies.

2. King's Lynn and Wisbech
   - (a) pilot scheme for community antenatal bookings (Oct 1991).

3. Cambridge Health Authority
   - (a) MLSC played a significant part in setting up Rosie Maternity Hospital.

4. East Suffolk
   - (a) introduction of patient held maternity records (also Macclesfield HA, Crewe HA, Wirral HA, Lewisham and Southwark);
   - (b) extension of ultra-sound service to all expectant mothers;
   - (c) improvement in the management of stillbirths.

5. Rochdale Health Authority
   - (a) improvements in quality flowing from a patient satisfaction survey initiative;
   - (b) an increase in epidural service;

(c) a review of patient information service including more information and in several ethnic languages;

(d) success in improving facilities for bereaved mothers/parents (also Wirral HA);

(e) helping to introduce team midwifery.

6. Yorkshire Health Authority

(a) MSLC has led work to review balance of primary and secondary care in pregnancy and childbirth—has led to direct reviews of services and changes.

7. Leeds Health Authority

(a) Together with the CHC, the MLSC have produced a user friendly description of available services.

8. Macclesfield Health Authority

(a) A policy of GP deliveries has been developed.

9. South Sefton Health Authority

(a) Support for the breast feeding initiative (also Crewe);

(b) care of pre-term infants in the community.

10. Warrington

(a) Each mother is allocated a midwife who is responsible for her care throughout their shift;

(b) more peripheral clinics have been established.

11. Greenwich

(a) the needs of the ethnic child bearing population has been given focus through updating available literature, appointing client/patient advocates who complement the user representatives at MSLC meetings and advertising for an Asian speaker for this client group.

12. North West Thames RHA

(a) MSLCs have helped in encouraging team midwifery in many units (eg St Mary's), in obstetric day care units (Edgware).

ANNEX H

MATERNITY HOSPITAL EPISODE STATISTICS 1989–90—ENGLAND

Introduction

1. The following tables show a regional breakdown of estimated percentages relating to maternity delivery episodes recorded in the Hospital Episode Statistics (HES) system.

Background

2. Up to 1985, data relating to maternity items were collected via the Hospital In Patient Enquiry (HIPE). HIPE was based on a 10 per cent sample of all episodes and was therefore subject to statistical error especially where estimated numbers were small.

3. Following the recommendations of the Korner Committee, HIPE was replaced by HES in 1987–88. HES is designed to collect data from all hospital episodes. The system consists of the collection of data from the hospital unit where the episode takes place and recording them on the Patient Administration System (PAS). The data are then made available to Districts and Regions to enable them to be used for local management purposes, before being submitted to the centre.

4. Given the additional burden of data collection on the NHS it was decided that to ease the burden, the "Maternity Enhancement" (i.e. data relating to delivery and birth episodes), should not be collected until the 1988–89 financial year. This collection of data was eventually postponed until the third (i.e. September) quarter of that year. This resulted in a shortfall of data for 1988–89. The first full year of collection of maternity data under HES was therefore 1989–90. The 1989–90 data are however, not complete, and are based on about 55 per cent of the expected number of delivery episodes. The NHS Management Executive monitors the data provided by Regional Health Authorities and regularly meets with Regional Directors of Information to discuss the quality of the data. The difficulties surrounding the completeness of maternity data have been identified as a priority. This initiative has resulted in real improvements in most regions. Work has now been successfully completed in the area of linking maternity to other systems and an improvement will be evident when 1991–92 data are available.

Data Quality

5. The deficiency of data includes incomplete data within Districts and Regions as well as data missing from whole Districts. Within the incomplete data there is evidence of mis-recording of data items.

6. The poor quality and incompleteness of the data make it difficult and often impossible to formulate useful statistical information either at national or regional/district level. It is not meaningful to produce actual numbers of data items and therefore estimated percentages are the best that can be achieved. As the system is still in its infancy, there are no historical data against which to perform validation checks except for the last year of HIPE data in 1985.

Tables

7. The attached tables show regional breakdowns of estimated percentages of some key data items relating to delivery episodes. All figures are rounded to the nearest whole number e.g. where 0 per cent is shown, this means less than 0.5 per cent. Where, because of poor data quality, it is not possible to produce reasonable estimates, this is signified by the symbol "—". Where this occurs for the regional data within any category, it casts doubt on that region's data for other categories.

8. Table 1 shows estimated percentages relating to Place of Delivery. These estimates differ from OPCS birth registration data in that those data show 2 per cent of maternities being other than in a NHS hospital. It is thought that under-recording of home births within HES is the reason.

9. Table 2 shows estimated percentages relating to Method of Delivery.

10. Table 3 shows estimated percentages relating to Method of Onset of Labour.

11. Table 4 shows estimated percentages relating to Person Conducting Delivery.

12. Table 5 shows the mean and median Duration of Post-natal Stay.

Conclusion

13. These are the region breakdowns which it has been possible to produce to date. Work is continuing to investigate the feasibility of producing further regional breakdowns relating to Gestation and Birthweight. It has not been possible to produce regional breakdowns relating to Anaesthetic Administered.

14. The estimates in these tables should, for the reasons stated above, be treated with caution.

15. Improvements are being sought in the quality and completeness of data for future years.

These tables were produced by Department of Health, Statistics and Management Information, Branch SMI 2B, October 1991.

TABLE 1

HOSPITAL EPISODE STATISTICS (MATERNITY) 1989-90 ENGLAND

Estimated Percentages: PLACE OF DELIVERY

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang.*	*N.W. T*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*
ALL PLACES	100%	100%	100%	100%	100%	100%	—	100%	100%	—	100%	100%	100%	100%	100%
In a consultant ward	64%	68%	93%	29%	95%	12%	—	63%	66%	—	61%	20%	76%	86%	95%
In a GP ward	5%	2%	4%	3%	4%	0%	—	0%	1%	—	10%	7%	9%	1%	2%
Consultant/GP ward	31%	30%	2%	67%	1%	87%	—	36%	33%	—	29%	72%	15%	13%	2%
Other than NHS hospital[1]	0%	0%	0%	1%	0%	1%	—	1%	0%	—	0%	1%	0%	1%	1%

[1] This Line is an underestimate of the true position—See Notes.

TABLE 2

HOSPITAL EPISODE STATISTICS (MATERNITY) 1989-90 ENGLAND

Estimated Percentages: METHOD OF DELIVERY

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang.*	*N.W. T*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*
ALL METHODS	100%	100%	100%	100%	100%	100%	100%	100%	100%	—	100%	—	100%	100%	100%
Spontaneous	77%	80%	77%	76%	75%	76%	78%	76%	75%	—	75%	—	78%	74%	78%
Instrumental	9%	8%	8%	11%	11%	11%	8%	10%	11%	—	13%	—	9%	9%	9%
Caesarean	12%	11%	14%	11%	12%	12%	12%	12%	12%	—	11%	—	11%	14%	12%
Other and Unspecified	1%	1%	1%	1%	1%	2%	2%	1%	2%	—	1%	—	2%	2%	1%

[Continued

TABLE 3

HOSPITAL EPISODE STATISTICS (MATERNITY) 1989-90 ENGLAND

Estimated Percentages: METHOD OF ONSET OF LABOUR

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang.*	*N.W. T*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*
ALL METHODS	100%	100%	100%	100%	100%	100%	100%	100%	100%	—	100%	100%	100%	100%	100%
Spontaneous onset	74%	72%	71%	77%	77%	77%	77%	73%	79%	—	73%	79%	74%	75%	71%
Elective Caesarean	5%	5%	6%	4%	6%	4%	5%	6%	6%	—	5%	4%	5%	6%	5%
Surgically induced	4%	8%	4%	3%	4%	4%	4%	3%	3%	—	7%	4%	5%	3%	7%
Oxytocic drugs	8%	9%	9%	6%	9%	3%	9%	11%	6%	—	7%	9%	10%	7%	9%
Combination	6%	5%	8%	8%	4%	5%	5%	8%	6%	—	5%	4%	6%	7%	8%
Not Known	3%	2%	1%	1%	0%	7%	0%	0%	0%	—	3%	0%	0%	2%	1%

TABLE 4

HOSPITAL EPISODE STATISTICS (MATERNITY) 1989-90 ENGLAND

Estimated Percentages: PERSON CONDUCTING DELIVERY

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang.*	*N.W. T*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mids*	*Mersey*	*N. West*
ALL DELIVERIES	100%	100%	—	—	100%	100%	100%	100%	100%	—	100%	100%	100%	100%	100%
Hospital doctor	24%	21%	—	—	26%	23%	25%	25%	27%	—	26%	17%	23%	27%	24%
General practitioner	0%	1%	—	—	0%	0%	0%	0%	0%	—	1%	1%	0%	0%	0%
Midwife	74%	76%	—	—	73%	75%	74%	74%	70%	—	71%	80%	76%	71%	71%
Other	2%	0%	—	—	1%	2%	1%	2%	2%	—	1%	2%	1%	1%	5%
Not known	2%	2%	—	—	0%	0%	0%	0%	0%	—	0%	0%	0%	0%	0%

[Continued

TABLE 5

HOSPITAL EPISODE STATISTICS (MATERNITY) 1989-90 ENGLAND

DURATION OF POSTNATAL STAY (DAYS)

RHAs	*England*	*N'thern*	*Y'shire*	*Trent*	*E. Ang.*	*N.W. T*	*N.E. T*	*S.E. T*	*S.W. T*	*Wessex*	*Oxford*	*S. West*	*W. Mid*	*Mersey*	*N. West*
MEAN	4	4	3	3	2	3	2	3	3	—	3	3	3	4	4
MEDIAN	3	3	3	3	2	3	2	2	2	—	2	3	3	3	4

WEDNESDAY 13 NOVEMBER 1991

Members present:

Mr Nicholas Winterton, in the Chair

Mr Tom Clarke	Sir David Price
Mr James Couchman	Rev Martin Smyth
Mr David Hinchliffe	Mr Roger Sims
Alice Mahon	Audrey Wise

Memoranda submitted by the Royal College of Obstetricians and Gynaecologists

POSTNATAL CARE

1. Current Practice of Postnatal Care

1i *Introduction*

The puerperium is considered to last for about six weeks. Postnatal care takes place for most women initially in hospital and following discharge, in the community. While for the vast majority of women the postnatal period presents no difficulties, for some, major problems do arise and there are a number of important issues.

1ii *Hospital Care*

(a) *Team Approach*

In theory the team approach adopted by obstetricians and midwives—led by consultants—during the antenatal and intrapartum period continues postnatally. In practice inpatient postnatal care is largely left to the midwives and the most junior medical staff, with middle grade and consultant obstetricians becoming involved only if medical problems arise. While it is probably quite appropriate for the routine medical input to cease after delivery, this gives rise to two problems. Firstly consultants tend to have little if any input into the establishment of standard hospital policies for postnatal care so that in certain areas—such as contraception and infant feeding—there is a tendency for management and advice to women to be inconsistent if not conflicting.

Secondly some women, expecting the medical input to continue after delivery, may feel short-changed if they do not see "their obstetrician" once the baby is born. Complaints that "no-one came near me after the baby was born" are heard not uncommonly.

Recommendations

Consultant obstetricians should be involved in establishing consistent policies for all aspects of postnatal care and ensuring that the policies are adhered to. All hospital staff should be aware of policies for postnatal care and information about policies should be available to patients, who should know what care to expect.

(b) *Discharge Policies*

With improvements in antenatal and intrapartum care and general health and wellbeing of the community, the time spent in hospital following delivery has reduced and most hospitals have abandoned fixed durations of stay after childbirth.

By and large the duration of inpatient care is dictated by the mode of delivery, parity of the mother, health of the neonate and demands on bed occupancy. Increasingly the tendency is towards early discharge both as a result of pressure from some consumer groups and from managers who see short stays as being economical. With the closure of small maternity hospitals and rationalisation of maternity services it may become difficult for mothers who need or wish to remain in hospital longer, for social rather than medical reasons to do so. This particularly applies to single mothers, women who need more time to become confident with handling their baby, babies with feeding difficulties and so on.

Recommendations

Discharge policies should be flexible and should meet the social needs of mothers as well as the medical needs of the postnatal period.

The policy of early discharge into the community should be scientifically evaluated. Its effect on the successful establishment of breastfeeding and on the recognition of postnatal depression may be detrimental.

1iii *Community Care*

Community care is shared by the general practitioner, the community midwives and health visitors. Midwives rule No. 27 states that "the postnatal period means a period of not less than 10 and not more than 28 days after the end of labour during which the continued attendance of a midwife on the mother and baby is required" (1). This has been interpreted by the providers as a daily visit to all postnatal mothers and babies until at least the tenth postnatal day. In practice many mothers who are seen to be coping well are not visited every day while mothers with problems may continue to see the midwife regularly until the twenty-eighth day following delivery. Health visitors are notified of the delivery and visit on or around the tenth day and thereafter according to the perceived needs of the family.

General practitioners receive item of service payments for five visits to be made during the first fifteen days after delivery and for undertaking a postnatal examination—usually done in the surgery—at around six weeks after delivery. Most GPs do not make five home visits within the first two weeks and it is doubtful whether this is a sensible arrangement since most mothers have few problems and are already seeing the midwife. It is likely though that with the increasing tendency of GPs to run their practices as business concerns that all five "visits" will increasingly be made and claimed for. Conversely in some parts of the country there now seems to be a fixed upper limit on the number of visits a health visitor may make during the baby's first year of life. The standard of care delivered in the community varies. One study in N. Hertfordshire reported that 50 per cent of patients were dissatisfied with their postnatal care (2). In a study undertaken in S.E. Scotland (3) only 40 per cent of GPs in seventy-seven training practices noted delivery dates in practice diaries—the majority relied on being informed of the delivery by the patient, her husband or by the hospital. Only a handful of GPs visited the mother in hospital and 30 per cent did not visit after discharge—relying on midwives visits or the mother coming to the surgery. While over 90 per cent of the GPs felt that there was a team approach to postnatal care in the community this belief was not supported by the other members of the team—the midwives, health visitors and practice nurses. If a mother is discharged from hospital before 48 hours after delivery the GP is obliged to make an early home visit. Most of these early discharges are arranged during the antenatal period but if not there can be problems with informing the GP of the mother's departure from hospital. There appears to be no standardised procedure of informing the GP when a mother and baby have been discharged.

Recommendations

An integrated team approach between midwife, health visitor, GP and hospital with an excellent standard of communication between all parties is essential to maintain a high standard of postnatal care. Standard, effective policies for informing a practice of a mother's discharge must be established and the local GPs and their teams should be aware of the hospital's policies for postnatal care so that patient management may be consistent.

2. Specific Issues/Problem Areas

2i *Infant Feeding*

The most recent national data on infant feeding comes from the OPCS survey last undertaken in 1985 (4). Between 50 per cent and 60 per cent of women in the United Kingdom choose to breastfeed their baby but the great majority give up in the early post partum weeks, by six weeks only 40 per cent of women are still breastfeeding. Howie et al 1990 (5) demonstrated that there is a significant reduction in the incidence of gastrointestinal disease in children during the first year of life if they are partially breastfed for more than 13 weeks after delivery. There is now mounting evidence to suggest that even in developed countries breastfeeding really does improve infant health. Efforts are being made to encourage breastfeeding. The DHSS in collaboration with the voluntary organisations—particularly the National Childbirth Trust (NCT)—have mounted a countrywide breastfeeding initiative but it is low key and tends to preach to the converted. There is also a move to curtail the advertising of artificial baby milks and to force manufacturers to inform women buying these formula feeds that "breast is best".

Breastfeeding is not easy and its successful establishment depends on good instruction during the early postnatal days, commitment on the part of the mother and support from the rest of the family, particularly the husband.

Infant feeding is not often discussed in depth antenatally except at specially arranged classes which a minority of mothers attend. After delivery instruction and assistance is left to the midwives—most of whom have never had children. Mothers usually see a large number of different midwives during their stay in hospital and advice is often inconsistent. Moreover many mothers are discharged home before lactation is established. No provision is made for mothers having difficulties and very few hospitals offer breastfeeding problem clinics. Once home more advice—often conflicting—comes from a different set of midwives and a health visitor as well as from a host of friends and relatives. Small wonder that most women give up. Mothers most likely to establish successful breastfeeding and to maintain it for more than thirteen weeks are those who use

the lay organisations such as the NCT through which women have access 24 hours a day to a single breastfeeding counsellor who has herself breastfed and who gives a consistent message.

Recommendations

Hospitals should strive for a consistent approach towards instruction in and assistance with infant feeding. Most women have decided well before delivery, even before pregnancy, how they wish to feed their baby. it is unrealistic to believe that the incidence of breast-feeding can be dramatically increased by intervention during the post partum period. Attention should be focused on discussing antenatally relevant and real problems such as feeding, crying and getting the baby to sleep and on supporting women who are keen to breast-feed. Mothers who do not wish to breast-feed or who are unable to do so should not be made to feel guilty or inadequate. Consideration should be given to the wider use of breast-feeding counsellors from lay organisations in hospitals since midwives have insufficient time to handle women struggling with infant feeding.

2ii *Contraception*

Flessig (5) reported recently that 31 per cent of pregnancies ending in childbirth in England and Wales were the result of unintended conceptions. Particularly likely to have been unplanned are pregnancies occurring at short intervals (6). For a couple preoccupied with a new baby decisions about contraception are frequently postponed. Decisions about infant feeding are relevant to contraceptive choice and a change from breast to bottle may render the chosen method less appropriate or even less effective. Again a large number of professionals may give advice, none of them with a particular expertise in family planning, and usually too little time is spent discussing past experience. General practitioners are good at remembering to discuss contraception at the post-natal visit (2) "possibly encouraged by the early opportunity to claim an item of service fee" but in over 85 per cent of cases they advise the pill.

Recommendations

Doctors with an interest and expertise in contraception should be involved in establishing a consistent hospital policy with regard to post partum contraception and policies should be made known to the community teams. Discussion about contraception should not be left to ill-informed junior medical and nursing staff. In large maternity hospitals a doctor or nurse trained in family planning should be available to visit post-natal wards daily to discuss contraception.

2iii *Perinatal Bereavement*

Attitudes to perinatal bereavement have changed profoundly over the past 25 years (8). Despite this, stillbirth and neonatal death is often handled extremely badly in hospital. Staff are often ill-informed of the legal requirements and local arrangements for registration of the birth; disposal of the body or remains; funeral or burial; post mortems; the availability within the hospital of immediate support from the hospital chaplain. Support from the post-natal team in the community is often better but relies on good communication between members of the team. Recently the RCOG has distributed to all maternity units a copy of the Stillbirth and Neonatal Death Society's publication "Miscarriage, stillbirth and neonatal death; guidelines for professionals" London: SANDS 1991.

Recommendations

Hospitals should have clear and consistent guidelines about the management of perinatal bereavement easily available to all staff. The use of checklistst for management such as that available in the RCOG working party report on the management of pernatal deaths should be encouraged. Written information about statutory requirements and local arrangements should be available to all bereaved parents. Where possible accommodation in single rooms with opportunities for the partner to stay should be made available together with a time for parents to be alone for as long as they wish with the dead baby. Post-natal checks should be undertaken by the obstetrician at a time when all post mortem, infection screen reports etc. can be guaranteed to be available.

A clear and consistent policy must be made within the community and in the event of a stillbirth or neonatal death, communication between all members of the team is of paramount importance. Information about voluntary support organisations such as the Stillbirth and Neonatal Death Society should be made available in all practices.

2iv *Post-natal depression*

Depending on the exact definition used (and excluding puerperal psychosis) severe post-natal depression occurs in between 15 per cent and 40 per cent of mothers. The main failing of the medical services lies in identifying post-natal depression but it is difficult to do so as mothers often try to hide it.

Recommendations

Ante-natal education can be preventive and a climate should be established both ante-natally and post-natally in which the realities of parenting and emotional feelings may be discussed. Time should be set aside on post-natal wards to allow women to discuss their emotional response to childbirth. Sensitive midwives in hospital may be able to detect early difficulties between mother and baby and in this case liaison with the community team is essential. Consideration should be given to evaluating screening every new mother for post-natal depression using a 10 point screening questionnaire developed in Edinburgh (8) and administered preferably at around three months post partum. Health visitors may be useful in the detection of and counselling for post-natal depression but would require specific training.

2v *Help for unsupported/at risk mothers*

Single mothers, particularly the very young and mothers with unsupportive or frequently absent partners are likely to be at risk of developing post-natal depression and their babies are at risk of abuse. Too often these mothers are left isolated once the immediate post-natal period is over. The onus of these mothers and babies falls on the community team, who are often unable to arrange (or are ignorant of) practical help such as home helps, income support etc.

Recommendations

The medical services within the community should be better informed about social support systems and access to these systems should be facilitated.

3. Conclusions

Post-natal care is the cinderella of obstetrics—few if any obstetricians develop any special interest or expertise in the area. Many hospitals lack a well defined policy concerning the various aspects of post-natal care–particularly infant feeding, contraception, management of post-natal depression—such policies should be established and made known to GPs and their teams so that care can be consistent. Closure of small hospitals and rationalisation of maternity care into large units creates pressure on staff and on beds and may lead to premature discharge for some mothers with particular needs. A better organised team approach is needed in the community.

An integrated well organised team approach to post-natal care with the recognition of potential problems antenatally offers a cost-effective way of producing better parenting and improved infant health. An investment in the social as well as the medical aspects of post-natal care offers a cheap way of improving the health of society.

4. References

1. Scottish Home & Health Department. Maternity Services Integration.

2. Cranfield F. M. Survey of postnatal care. 1983.
J. Royal Society of Medicine 76:41–44.

3. Fair J. and Horsfall H. Training practice post-natal care in South East Scotland. 1991.
Scottish Medicine 10:5; 6–8.

4. Martin J. White A. Infant Feeding 1985. OPCS Social Security Divsion. HMSO London.

5. Howie P. W, Stewart-Forsyth J, Ogston S.E. et al. 1990. Protective effects of breastfeeding against infection in infants in a Scottish City. British Medical Journal 300 : 11–6.

6. Flessing A. Unintended pregnancies and the use of contraception. 1991. British Medical Journal 302 : 147.

7. Cartwright A. Unintended pregnancies that lead to babies. 1988. Soc. Sci. Med. 27 : 249–54.

8. Bourne S. Lewis E. 1991. Perinatal Bereavement – a milestone and some new dangers. British Medical Journal 302 : 1167–68.

9. Edinburgh Post-natal Depression Scale. 1984. Cox, Trotter and Sagovsky.

NEONATAL CARE

Introduction

The developments in obstetric and neonatal care during the recent past have brought about outstanding improvements in perinatal mortality and morbidity, particularly for low birthweight infants. Data from a recent review of published mortality and morbidity rates show this improvement (Figs 1-3) (Verloove-Vanhorick & Verwey 1987).

This has been brought about by the recognition that a continuum of care is required for the baby prior to, during and after birth. Effective neonatal care starts with high quality obstetric care. There is extensive research which shows that the prerequisite for the immediate and long term health of babies is that babies must be born in "good condition" ie without trauma or hypoxia/acidosis. It is imperative, therefore, that the unborn child has appropriate and effective care during labour, whatever the setting.

Primary Care

Since midwives and general practitioners may deliver babies in isolated situations they must be able to recognise signs of fetal hypoxia, respond quickly and appropriately to these signs and be able to resuscitate the baby effectively. Because these professionals have infrequent exposure to these events there is a place for certification and regular recertification of their competency in these skills.

Secondary Care

Most babies in the United Kingdom are born in consultant obstetric units in district general and teaching hospitals and all babies should have access to paediatric medical care during the neonatal period. The needs of newborn babies at this time are often unforeseen, require immediate attention and intensive treatment. Neonatal services must, therefore, be available on site, 24 hours a day and be appropriately staffed. The intensive and tiring nature of neonatal medical care needs to be recognised and the staffing of many units remains insufficient and requires improvement.

Tertiary Care

Following a controlled trial of intensive and routine care in Melbourne between 1966 and 1969 (Kitchen et al 1978; 1979) which showed a distinct improvement in survival of very low birthweight infants in the intensive care group, intensive neonatal care has evolved into one of the most remarkable successes of modern medicine. Successful systems of neonatal intensive care incorporate regionalisation or subregionalisation of perinatal services, with referral, often in utero, to a central intensive care unit. These units have high levels of committed staff with specialised skills and high quality, expensive equipment. It is important that (a) the anticipated increased autonomy of Trust hospitals and district general hospitals does not compromise the co-ordinated regional approach to care of these infants and (b) it is recognised that intensive care units are expensive and need and deserve significant financial support.

Long-Term Follow-Up

Although many more low birthweight babies now survive, many, particularly if of very low birthweight, survive with neurological and other handicaps and disabilities. A recent review of populations studies of very low birthweight infants by the Scottish Paediatric and Obstetric Research Unit, (1989), shows that within the United Kingdom 20–30 per cent of those infants have neurological, visual, hearing and developmental disabilities (Table 1). There is little evidence from the world literature that intensive neonatal care has been associated with a reduction in these disabilities. There is an urgent need to understand by long term audit and research the causes of these disabilities so that techniques and strategies can be revised to reduce their prevalence. This type of research requires long-term follow-up of these babies into childhood, which requires patience on the part of the researchers and expenses on the part of funding organisations. It is important that such funding is available so that the prevalence of handicap and disability can be reduced in our society.

References

1. Kitchen, W. H., Ryan, M. M., Rickards, A., Gaudry, E., Brenton, A. M., Billson, F. A., Fortune, D. W., Keir, E. H., Lundahl-Hegedus, E. E. A longitudinal study of very low birthweight infants. I: Study design and mortality rates. Dev Med Child Neurol., 1978; 20:605-618.

2. Kitchen, W. H., Rickards, A., Ryan, M. M., McDougall, A. B., Billsen, F. A., Keir, E. H., Naylor, F. D. A longitudinal study of very low birthweight infants. II: Results of controlled trial of intensive care and incidence of handicaps. Dev Med Child Neurol. 1979; 21:582–589.

3. McIlwaine, G. M., Mutch, L., Pritchard, C., Fletcher, D. V. (1989). The Scottish Low Birthweight Study. Report to the Scottish Home and Health Department.

4. Verloove-Vanhorick, S. P. and Verwey, R. A. (1987) Project on preterm and small for gestational age infants in the Netherlands 1983. Pub. J. H. Pasman, B. V.'s Gravenhage.

TABLE 1

Morbidity rates from population based studies of very low birthweight infants (below or equal to 1500g) from McIlwaine *et al*, 1989.

				No. (%) Survivors Assessed			
Site	*Years of Study*	*B.W. Group*	*No. (%) survivors seen*	*Neurol. Imp.*	*Visual def.*	*Hearing def.*	*MR Sev. dev. delay*
Mansfield	1963–71	<1501g	131/137 (95.6)	17(13.0)	14(10.7)	3 (2.3)	11 (8.4)
Hamilton, Ontario	1973–78	<1501g	166/179 (92.7)	30(18.1)	16 (9.6)	N/A	9 (5.4)
Wolverhampton	1975–79	<1501g	67/ 68 (98.5)	6 (8.9)	6 (8.9)	4 (6.0)	27 + 6
Mersey	1979–81	<1501g	322/353 (91.2)	25 (7.8)	11 (3.4)	3 (0.9)	14 (4.3)
Newfoundland	1980–81	<1500g	79/ 82 (96.3)	7 (8.9)	6 (7.6)	0	7 (8.8)
Netherlands*	1983	<1500g	751/770 (97.5)	73 (9.7)	82(10.9)	24 (3.2)	48 (6.4)
Northern Reg**	1983	<1500g	202/202 (100.0)	15 (7.4)	29(14.4)	13 (6.4)	13 (6.4)
Scotland	1984	<1500g	307/373 (82.3)	33(10.7)	12 (3.9)	9 (2.9)	4 (1.3)

Neurol. impairment = any motor deficit of central origin.

Visual deficit = any abnormality of vision incl. squint.

Hearing deficit = any reported hearing loss.

MR/severe development delay. MR = IQ <70.

Severe development delay = too young for psychometric testing but severly delayed DQ <70: Netherlands definition <90 or more than 3 months delay.

* Van Zeeben van de Aa. MD Thesis (1989).

** Acknowledgements and thanks to these authors for re-analysis of their data for chiidren <1500g at birth.

Figure 1

In-hospital mortality ● and total adverse outcome ○ (percentage of liveborn infants) in all studies on infants with birthweight ⩽1500g (from Verloove-Vanhorick & Verwey, 1987).

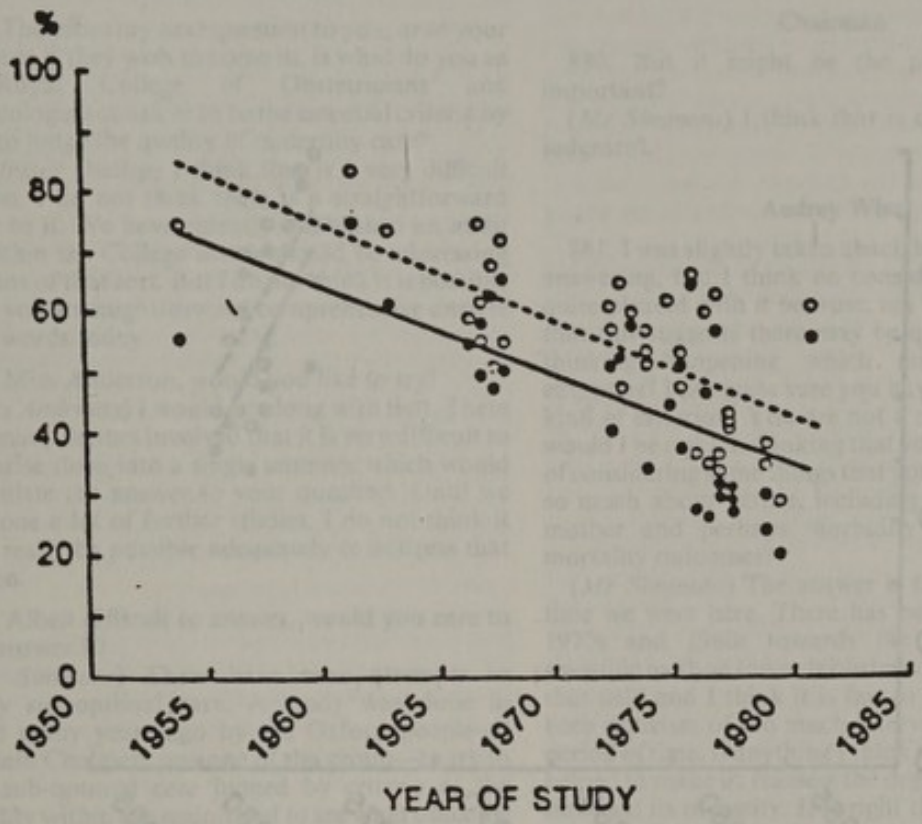


Figure 2

In-hospital mortality ● and total adverse outcome ○ (percentage of liveborn infants) in all studies on infants with birthweight ⩽1000g (from Verloove-Vanhorick & Verwey, 1987).

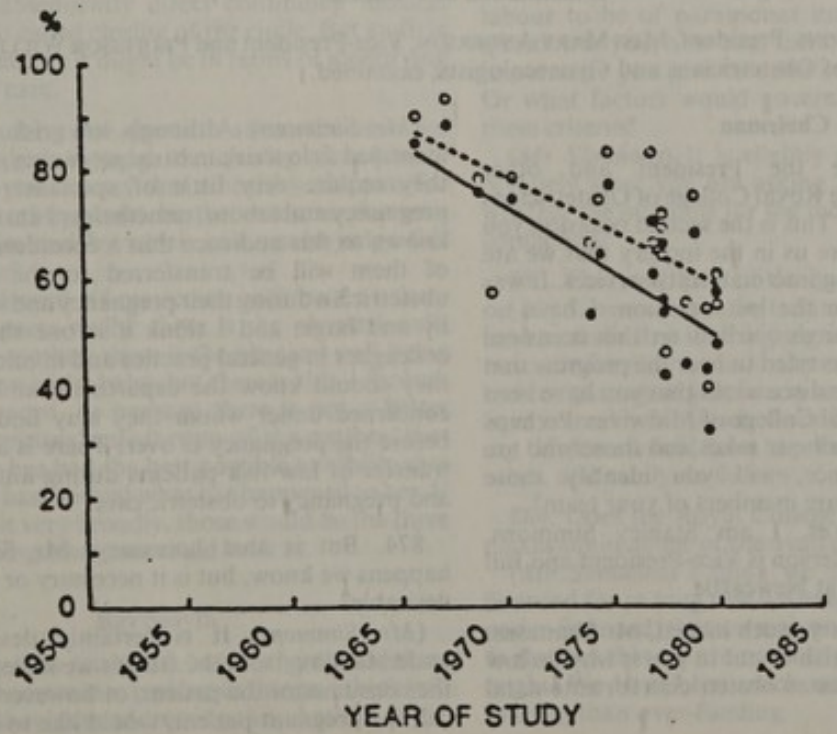
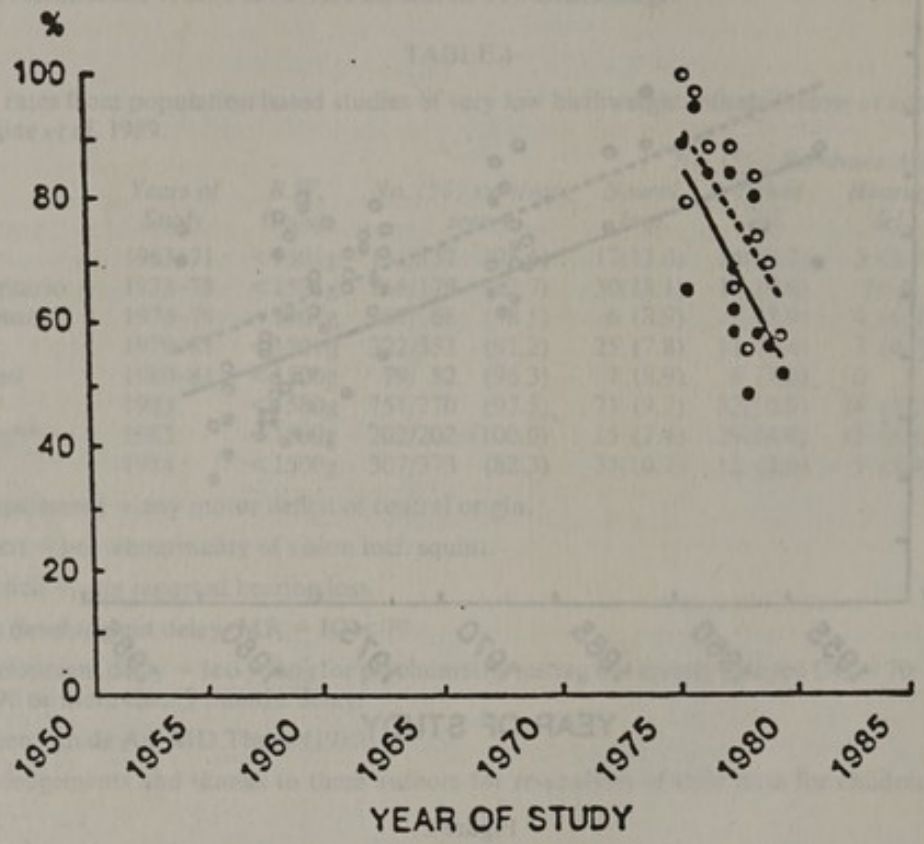


Figure 3

In-hospital mortality ● and total adverse outcome ○ (percentage of liveborn infants) in all studies on infants with birthweight ⩽800g (from Verloove-Vanhorick & Verwey, 1987).



Examination of Witnesses

MR STANLEY C SIMMONS, President, MISS MARY ANDERSON, Vice-President and PROFESSOR WILLIAM DUNLOP, Royal College of Obstetricians and Gynaecologists, examined.

Chairman

872. I welcome the President and other representatives of the Royal College of Obstetricians and Gynaecologists. This is the second occasion you will have come before us in the inquiry that we are currently undertaking into maternity services. It was a spirited session on the last occasion. I have no doubt that it will be as spirited on this occasion. Obviously we are interested to hear the progress that you have made in the discussions that you have been having with the Royal College of Midwives. Perhaps before we begin for all our sakes and those who are also in the audience, will you identify those representatives who are members of your team?

(*Mr Simmons*) Yes, I am Stanley Simmons, President. Mary Anderson is Vice-President and Bill Dunlop is Professor at Newcastle.

873. Thank you very much indeed, Mr Simmons. The first question I wish to put to you is why do low risk women need to see an obstetrician for ante-natal care?

(*Mr Simmons*) Although low risk women are identified as low risk in early pregnancy, by and large they require very little of specialist care during pregnancy and labour, nonetheless I am sure it is well known to this audience that a considerable number of them will be transferred to the care of an obstetrician during their pregnancy and it is our view, by and large, and I think it is one shared by my colleagues in general practice and in midwifery, that they should know the department and the people concerned under whom they may find themselves before the pregnancy is over. There is a substantial transfer of low risk patients during ante-natal care and pregnancy to obstetric care.

874. But is that necessary, Mr Simmons? It happens we know, but is it necessary or is it, in fact, desirable?

(*Mr Simmons*) It is certainly desirable. Our understanding from the studies we have done is that the consumer or the patient, or however one likes to call the pregnant patient, would like to be aware of

[**Chairman** *Cont*]
and familiar of surroundings in which she may find herself. That is desirable. It is wholly desirable that the patient should be aware of hospital surroundings and the environment in which she may find herself later on. Yes, that is wholly desirable.

875. Therefore my next question to you, or to your colleagues if they wish to come in, is what do you as the Royal College of Obstetricians and Gynaecologists consider to be the essential criteria by which to judge the quality of maternity care?

(*Professor Dunlop*) I think that is a very difficult question. I do not think there is a straightforward answer to it. We have recently established an audit unit within the College which should be addressing questions of that sort. But I do not think it is possible to give you a straightforward comprehensive answer in two words today.

876. Miss Anderson, would you like to try?

(*Miss Anderson*) I would go along with that. There are so many factors involved that it is very difficult to summarise them into a single sentence which would encapsulate the answer to your question. Until we have done a lot of further studies, I do not think it would really be possible adequately to address that question.

877. Albeit difficult to answer, would you care to try to answer it?

(*Mr Simmons*) There have been attempts to identify sub-optimal care. A study was done in Oxford many years ago by the Oxford people—I think Iain Chalmers was one of the group—to try to relate sub-optimal care judged by criteria of the normality within the region and to see what outcome and effect there was in those cases. I think it will be much easier when we can audit more precisely and when we audit more precisely standards of care which we are currently doing in the college. Part of the benefits of change is that we are even more aware of audit now than we were before. It is our hope that if we identify sub-optimal care it will be the way in which we subsequently direct continuing medical education, so called closing of the circle. But audit is not as adequate as it might be in terms of identifying sub-optimal care.

878. In putting the question about the essential criteria by which to judge the quality of maternity care, would you not say that a healthy outcome for baby and mother would be the outcome that you would require and by which you would judge this whole matter?

(*Miss Anderson*) If I may come back on that, there are three aspects really: there is the physical well-being of the mother; there is the physical well-being and perfection of the baby, but there is also—for lack of a better word, or perhaps there is not a better word—the spiritual satisfaction of the mother, that she feels she has had the best possible available care and that she has enjoyed what has happened to her. If you look at it very broadly, those would be the three groups of things that one could look at.

Rev Smyth

879. I may have misheard, but when you said there was an audit committee looking at things, I think you said that it should be addressing this. Are they?

(*Professor Dunlop*) As far as I know they are.

(*Mr Simmons*) Yes, that is right, they are. I think you are quite right that outcome is one criterion for addressing quality of care, but it is not the only one.

Chairman

880. But it might be the perhaps the most important?

(*Mr Simmons*) I think that is quite a reasonable judgment.

Audrey Wise

881. I was slightly taken aback by your modesty in answering, but I think on consideration that I am quite pleased with it because, am I right in thinking that this suggests there may be quite a lot of fresh thinking happening which might change the emphasis? I am quite sure you have worked to some kind of criterion. You are not a new profession, so would I be right in thinking that you are in the course of considering some things that you have not thought so much about before, including the feeling of the mother and perhaps morbidity rather than just mortality outcomes?

(*Mr Simmons*) The answer is the one I gave last time we were here. There has been a swing in the 1970s and 1980s towards the application of a scientific method towards obstetrics which was late in that field and I think it is fair to say that there has been criticism of too much intervention during that period of time. If anything I think this Committee has helped to make us reassess the degree of intervention now and its necessity. It is right that we are looking very carefully. I would suggest that we are much more conscious of the need to do that than we were before. I think that is a fair comment.

Chairman

882. Mr Simmons, you state in your submission that you consider the safety of mother and baby in labour to be of paramount importance. I put the question to you, how does this statement relate to the importance you give to other criteria you mention? Or what factors would govern how you prioritise these criteria?

(*Mr Simmons*) It is slightly difficult to interpret precisely what you are asking. Are you asking me whether the outcome for the mother or the baby are conflicting?

883. That is all part of the question indeed.

(*Mr Simmons*) It is fortunately very rare that we have to make that kind of judgment. By and large the outcome for mother and baby are not contradictory, but complementary. It is very rare these days that we have to make that kind of conflicting decision. I do not think we would have to prioritise one against the other, and rarely do so now.

884. Does the Royal College ensure that the care makes optimal use of the available resource?

(*Mr Simmons*) I think we have been so under-financed for so long that we have always felt we were under-financed, that we may not have given thought to the fact that we are not using the resources as we might. We have been much more aware of lack of funding than over-funding.

[**Chairman** *Cont*]

885. Earlier in response to Mrs Audrey Wise you indicated that the 1960s and 1970s had been the decades of a great deal of sophisticated technological equipment involved in obstetrics and that you had come in for some criticism. Most of that equipment is quite expensive not only to purchase but to use and that perhaps that was not necessary. So are you necessarily making optimal use of available resources? That does not mean necessarily that you are under-resourced. It might mean that you are not using the resources properly. You paid tribute—and I am very grateful to you—to the work of this Committee in concentrating your minds on things that perhaps were not necessary.

(*Mr Simmons*) All I was trying to indicate is that I think we are much more aware of the need to be selective, but let me answer your question, if you are talking about monitoring. If you have to monitor part of your community in the hospital you need a monitor, whether it is half the community or three quarters of the community. The need for the equipment that necessarily has to be available. I am talking about selectivity and I think we are perhaps more aware that there are disadvantages than perhaps we have given sufficient understanding to. That does not in any sense deny the need to have the availability of such equipment. I do not think we have been in any sense guilty of under-utilisation or over-utilisation of resources. I think the reverse is true. I think the achievements we have shown over the last few years are remarkable, despite under-funding. So I am not at all aware of any reason that we may not have used resources appropriately.

Chairman: I am sure that my colleagues will be pressing these matters.

Mr Clarke

886. Can I ask a few questions on the subject of domino delivery? Everybody seems to be agreed that domino delivery is a good thing, but why then is it not more generally available? What are the arguments against it? Is there still the problem of lack of sufficient midwives? Finally, could present resources be allocated more efficiently to enable the availability of domino deliveries to be increased?

(*Miss Anderson*) If I may I will start the answer to your question. Domino delivery in theory is a highly desirable arrangement. But it is expensive. It is expensive particularly in midwives. The requirements for the number of midwives is increased if one is to run a successful domino scheme. Interestingly enough I have experience of a domino scheme and although theoretically it is a highly desirable thing and one about which I am very enthusiastic about and very supportive of it. But not every mother wants it. Strangely and perhaps understandably, the mother who has children is quite glad of a little longer time in hospital to rest, recover and feel ready to go home to the rest of the family. I would say about domino that perhaps it has not been as successful. I think you asked why it had not been as successful. Perhaps my colleagues can give you other thoughts, but part of the answer may be that it has not been as demanded perhaps as one might expect. I think personally that it is a very good idea indeed, but not so easy to run and not as wished for as one would expect.

Chairman

887. Can I just put a supplementary to Tom Clarke's question? Can you tell us, Miss Anderson, where shall we find the evidence that domino deliveries are more expensive than hospital births?

(*Miss Anderson*) I do not know the answer to that.

888. So how did you then come out with the statement that it was more expensive?

(*Miss Anderson*) Because I am talking locally. I am talking anecdotally and we find it quite expensive to run. We did not have the midwives to implement it.

889. One further question, again on your response to Mr Clarke, you said that mothers who have given birth should be allowed to lie in for a little bit longer. From the Chair I am delighted to hear that because in most hospitals, even under the normal hospital birth situation, they are not allowed to lie in. They are put out within 24 or 36 hours and if they want to stay in they have to fight to do so.

(*Miss Anderson*) I did not say they should, but many of them want to stay in. I did not say they should. I did not actually commit myself on that. I understood their desire to stay in a little bit longer for a rest, but here again we are talking, I am afraid, in terms of resources because where there is a shortage of beds which there is in many places, the ability to let post natal mothers stay with us for any length of time is greatly diminished. Again I can talk with authority as far as my own scene is concerned.

Chairman: If you can let us have any of that anecdotal evidence in writing, we would be most grateful.

Alice Mahon

890. Is there consultant resistance to domino delivery? Has the Royal College surveyed its members to ascertain their opinions on domino delivery?

(*Mr Simmons*) No, I do not think there is any resistance to domino delivery. At least it would surprise me to learn that there was from my colleagues. I think you will remember last time we were here Miss Mellows made the same comment as Miss Anderson that in their district it was expensive. We are talking about anecdotal evidence. We have had the same in East Berkshire. We had a visit from the Community Health Council on the subject of the domino scheme. This was the report from the Berkshire Community Health Council, not by us. There was no chance, although they supported, of having a domino scheme at Heatherwood at the moment as it is expensive to operate and requires twice the amount of community midwives. That was the report that came. That is our experience, but I do not know of any resistance from our discipline. I would support entirely what Miss Anderson says about quite a large number of women who want to stay in not only more than a few hours, but more than 24 hours, and perhaps that is a reflection of the age of first children now. The average of first birth now is round about 30 and the size of the family is now fewer than two and a large number of women are single parents. So in and out quickly and looking after yourself in those circumstances clearly is much more of a problem than it might be where people are going home to a family with other children. I am sure that

[**Alice Mahon** *Cont*]
is right. We have done some studies, but I do not think we would subject them to statistical criteria. But we do have some evidence that there are quite a large number of women who want to stay in hospital longer than a few hours.

Mr Clarke

891. I wonder if it is known that Caroline Flint says that there are 34,000 practising midwives and about 650,000 births per year. Cannot one midwife per 18 births provide sufficient cover?

(*Mr Simmons*) It is something you would have to ask my colleague Margaret Brain to answer. I do not know. We are told from our own studies that there is a significant shortage of midwives. There is a shortage of entries and there is a shortage of midwives around the districts. But they are more able to answer that question than I am. We are also told that it is expensive operate and requires an increasing number. I cannot tell you if that is accurate information, but it is the information that we are aware of. If it is not true, it is certainly what we are told by the districts.

Audrey Wise

892. I can quite see that women may make different choices. In fact, one of the things which concerns me is that they do not get the opportunity to make a choice, either about place of birth or about, if it is hospital, how long they stay in. I think that is a pity. I would like to explore with you a little bit more the domino scheme, because I am rather puzzled. We have not been able to get any costing information out of the Department of Health. They do not appear to have any information about relative costs in any way, shape or form. I am puzzled because surely the work load is the same. Assuming that a mother is going to have the support of a midwife during the labour, then is it not a matter of where that midwife is rather than how many midwives there are? Unless, of course, as happened to my daughter in law, the midwife who was supposed to be attending her said, "I am terribly sorry. I have to leave you now because I am delivering someone else". You can do that in hospital, but you cannot do that quite so easily with the domino. Is that why it might be more expensive?

(*Miss Anderson*) I have always found puzzling the ratios and the criteria for the numbers of midwives or the numbers of babies per midwife, so I cannot give you a detailed reply to your question because I find it difficult to understand. You have reduced it to its simplest terms and it would seem, on the face of it, to be a straightforward answer. But this is what we are told. I shall certainly do my best to get some facts and figures.

Sir David Price

893. Can we move on to research/audit? I know you have in the College a medical audit unit. Particularly in the context of what we have been discussing up to now, I understand that one of those projects concerns the identification of low risk in obstetrics and that you have been doing this in conjunction with the Royal College of Midwives. I wonder if you could tell us a bit more about the work.

(*Mr Simmons*) The Audit Unit put in a grant application for looking at low risk criteria in obstetrics nearly two years ago. That was to establish a group of representatives from the three Colleges and essentially to look at the criteria for defining low risk and then to audit whether that was appropriate and then to look at outcomes. But that study has not been taken up, I believe. They have a degree of autonomy at the Audit Unit, but they define broadly their own priorities and there are, as you would guess at this time, a number of studies that they have been asked to look at—endometrial resection, I could name many others—defining other criteria in the discipline. That so far has not been done, but it is on their agenda. I could not tell you precisely where it is at this time, but it has been on their agenda since they were formed. Essentially it is to define the criteria for low risk.

894. But in those matters which have been brought before us in this inquiry and which we have been discussing so far, it strikes one as a layman looking in that this question of low or high risk is a pretty critical factor. It would seem to us that this should be a fairly high priority. Let us put it straight to you. Is it lack of resources on your part? If we could extract something more out of the department now that they are having a much more proactive research programme and not just simply relying on the MRC, would you welcome that?

(*Mr Simmons*) You are, of course, quite right. It is a higher priority than perhaps they had adjudged two years ago. Again it could be that this Committee has drawn attention to that. But there are and have been some more recent studies about movement from low risk care into more specialist care. There is one just about to be published from Leicester which I think has bearing on the question you have asked. I think it is particularly important to draw attention to the Leicester study which was a prospective study, having defined low risk by the criteria we already know. Then it was randomised to care under the midwife and care in the department. They set up within their own department, part of the department which they call appropriately their "Home-from-Home", which is a rather nice title I think. The patients in that part of the hospital are looked after entirely under midwife care—antenatally, admission, discharge. The data are about to be published, I think in the British Medical Journal, and I have had permission to allude to it here. During the pregnancy 25 per cent of those put in the midwifery home-from-home section were transferred and during labour another 25 per cent, so they transferred during pregnancy and labour 50 per cent of those already identified as low risk. The transfer is very easy. It is not from home, miles away, but it is just down the corridor, so that may increase the transfer rate or it may not. The fact is that they transferred, even in those cases selected by criteria which were determined by midwives and obstetricians, they transferred overall 50 per cent.

What I think is most interesting is that the transferred patient had the same perinatal loss as those who remained within the midwifery department. That is quite at odds and quite contrary to transfer from domiciliary confinement where a great deal of evidence shows a higher perinatal

[Sir David Price *Cont*]
mortality in transferred patients. What that says to me is that provided they have easy access to emergency facilities the risks, once defined to low risk patients, being in an autonomous part of the hospital devoted to midwives is no greater than being already in the hospital. In other words I think it gives support to the view that patients can be admitted under midwife care, but it also supports the view that it safeguards the high risk of transfer. I think that is a very important paper and it is likely to be published any time. There are others going on. There is Aberdeen and Reading and other experiments of this sort which brings me back to the acknowledgement that in our discipline changes are occurring and it is a dynamic process which is taking place now. I am sorry to have gone on rather long.

895. That takes us on to asking you what is your college collectively or your personal view about what loosely may be called the Dutch system, and in particular the midwife-only care of low risk women? We keep getting back to this definition of low risk women, do we not? It seems unavoidable in these discussions.

(*Mr Simmons*) I shall ask Professor Dunlop to answer that in a moment, but if I may give an initial answer. I am sure you know as well as I do that there is a whole spectrum from those who are arguing for home confinement to those like us who argue that hospital confinement is the appropriate way. The spectrum is complete. There are views right across that spectrum. I think we would have to say that our view is that it is in the best interests of the patient to be delivered where facilities for emergency and care either of mother or baby are available, if we have no clash of interests over midwives attending to, looking after and being responsible for considerable section of the obstetric population. But we are not enthusiastic about the Dutch system which is totally isolated in Europe. There are a lot of data becoming available now which open the system to criticism. There is a lot of intraprofessional discussion about its—propriety is probably not the correct word—about it being the correct route down which to go. There is really no other European country that is following that line. I think we would have to say that it is not our view that it is the right route at this point in time, in the light of available knowledge and scientific method. As to midwives taking charge of patients who fall within what they appropriately feel are their criteria, we have no criticism of that.

Chairman

896. But what about consumer satisfaction, Mr Simmons? This was not mentioned as one of your College's criteria for good care. How would you respond to that because this is particularly relevant when maternal choice is mentioned with regard to the place of birth? Do you not think the consumer should have a choice and that her satisfaction is really very important?

(*Mr Simmons*) I do absolutely. I think the consumer should have what I would call an informed choice.

897. By that informed choice do you mean doing what you say they should do? Or doing what they would like to do?

(*Mr Simmons*) That is not my interpretation. I do not think any of us would think that is right. Of course the consumer must have a choice, but there are constraints on choice for all of us and we are all consumers: financial, manpower and so forth. But where it is within scope to acknowledge and to agree to the choice that patients want we have no argument. My understanding—and I have to say that studies have been done and there are studies that we would like to see done—would include the choice of hospital and would include the choice of access to specialist care. Having said that, there will be a small group of patients—whatever you tell them the risk is, whatever you believe it to be, however small, however large—who insist and, rightly or wrongly, wish to have their babies at home. There are enormous benefits. One can understand the pleasure of giving birth at home. Both Miss Anderson and I have done in our time—40 years in obstetrics—quite a lot of community obstetrics. When I was a resident it was part of our job to deliver patients in Paddington at home. So we have seen the advantages and disadvantages. One of the advantages in the right setting is the pleasure of giving birth at home. It has considerable anxieties and disadvantages and I do not want to dwell on them too long. But whatever we say, however great or small the risk, there will be patients who insist on having their babies at home or rightly prefer to accept the risk. I acknowledge that they should be looked after in the best possible way we can provide and with the greatest support that we can give. But I have to tell you that we are desperately short of staff in our discipline. The size of that additional work load would be a considerable problem, or could be.

Chairman: I am going to ask Mrs Wise to ask a question before we move on to the Reverend Martin Smyth, but I should inform our witnesses that because of certain domestic Conservative Parliamentary matters downstairs at five o'clock I intend to suspend this sitting for approximately five minutes in two minutes time.

Audrey Wise

898. I cannot help feeling, Mr Simmons, that in your own mind you are identifying those women who choose home confinement as rather an awkward squad and perhaps inclined to ride roughshod over evidence. I should like to put three points to you. In your previous evidence in writing you said in paragraph 9.1 that "there is no conclusive evidence that hospital delivery is safer than home". You then went on to say that there is no evidence that it is more risky, "that the risk ... is increased from iatrogenic causes such as obstetric intervention". So you had a neutral view in paragraph 9.1. In paragraph 9.2.3 you said "delivery in hospital is the only really safe option". So in your own evidence you were showing a certain amount of contradiction. You will be familiar with *Effective care in pregnancy and childbirth* as produced by the National Perinatal Epidemiology Unit and you will be familiar with the fact that their evaluation—which is very highly academically regarded—of all the research which has been done leads them to include "insisting on universal institutional confinement" in the list of forms of care which should be abandoned in the light of the

[**Audrey Wise** *Cont*]
available evidence. Now, where do you stand? Do you say that they are simply wrong?

Chairman: The questioning was with Mrs Wise and Mr Simmons was about to give considerable lengthy thought to the questions posed by Mrs Audrey Wise.

(*Mr Simmons*) You do not want to repeat your questions, do you, Mrs Wise?

Audrey Wise

899. I am willing to do so. But I thought you knew it.

(*Mr Simmons*) You asked me first of all about the National Perinatal Mortality Unit in Oxford. We were one of the constituent members who were responsible for its formation, so we entirely acknowledge the work it does and the basis for looking in future at care. So we do not expect to criticise it. But I would draw attention to chapter one which says that different objectives of care during pregnancy and childbirth will always remain a matter for individual judgment. They are unlikely to be influenced by the kind of evidence reviewed in the chapters that follow. They are saying that these are guide-lines and that they are not enshrined in stone. That is borne out by the fact that they are constantly updating and this is a dynamic subject. I do not think we shall be held in chains by what is at the end of the chapter. That is the first thing I would say.

Then you asked me whether we say that every single delivery should be in hospital. We say that we think delivery should be where the best possible facilities are available in the patient's interests, where we believe that all the emergencies that may occur and do occur—we have just described transfer—in childbirth have all the facilities available to all the patients. We are not saying that every single patient must be delivered in hospital, but it would be our advice that they should be where those facilities are available. You would know, as my colleagues in the other Colleges know, that there is a safe motherhood initiative around the world to try to reduce maternal death where such facilities are not available. It would be irresponsible to suggest that there is room for complacency. I believe you have read the maternity mortality survey. It starts by saying in its conclusions that there can be no room for complacency. Because we have produced a high quality of care there is no reason to think that risks still do not exists. You know they do.

900. It sounds to me as though you are still saying delivery in hospital is the only really safe option, despite the lack of evidence identified by the National Perinatal Epidemiology Unit?

(*Mr Simmons*) There is no lack of evidence for the need for emergency cover. This occurs wherever the patient is put. Emergencies occur. There were 180 in two years in Staffordshire and there were 180 flying squad calls of which half were bleeding. There is no argument about that. We also know the transfer perinatal mortality in four or five studies, many studies, show a very high perinatal mortality for transferred patients as far as the baby is concerned. That is not argument. All I am saying is that I think all patients are entitled to that option. If they understand those risks and if they still decide to accept them and be delivered at home, we will do all we can to take care of those patients and provide the emergency cover. We do just that. In my own region we will have a flying squad and it still goes out and we still do our best to cover that. I have brought with me the forms we give to patients who wish to be delivered at home and the maps of the house produced. But there are risks. It is no good denying them.

Chairman

901. Mr Simmons we could go on with this particular issue for some time and we are rather pressed for time, as you know. Perhaps to help Mrs Wise and the Committee could you perhaps advise the Committee of the studies that you keep quoting? You have said that there are four, five, several studies that indicate what you have just said to Mrs Wise. If you could let us have details of those studies we should be very grateful and it would help us a lot.

(*Mr Simmons*) We are happy to do that.

Rev Smyth

902. In your earlier evidence on antenatal care in the section on low risk mothers, your memorandum states: "Midwives should continue to have links with the hospital and, if possible, be able to provide intrapartum as well as antenatal and postpartum care for the women in the community". Would you like to elaborate on what that actually means and how could such care be organised?

(*Mr Simmons*) Can you tell me what is difficult to understand? That seems to me to be fairly straightforward, that they should have care antenatally and intrapartum—

903. In the community? With the emphasis at the moment on hospital as the place of safety, for example. How do we then keep the midwives moving between hospital and the community?

(*Mr Simmons*) It is antenatal care in the community.

904. Yes, but it is the three?

(*Mr Simmons*) I am sorry, I do not see a problem, but all we are saying—and there are many examples of community antenatal systems and there are examples of domino care—is that there should be a continuity of care in which the midwife is involved throughout. If the wording is not clear then I apologise, but I do not see any problem. Are you saying that we have said they should deliver patients at home as an ideal? That is not what it is intended to say.

905. No, we are trying to explore just what is the basic thinking in the College in so far as we understand that while we are talking about low risk at the moment, some 70 per cent of deliveries, even within hospital are by midwives. When you go on in your subsequent paper on intrapartum care and dealing with home delivery the College states: "... labour remains a potentially dangerous time and delivery in hospital is the only really safe option". How does that square with the previous quotation?

(*Mr Simmons*) I am sorry. I do not see any difficulty. There are risks. The risks I acknowledge and we understand there is a spectrum of argument about the safe place, but it is our view that the safe

[**Rev Smyth** *Cont*]
place for delivery is where facilities exist for dealing with emergencies. That is our view.

Chairman

906. So what you are saying, Mr President, is that all babies should be born in hospital?

(*Mr Simmons*) We are saying that—

907. Are you not? In fact, you seem to have equivocated, because to Mrs Wise's questions you seemed to reply that if a woman wants to have the baby at home she can have it at home as long as she knows all the risks, but in the quotation which the Reverend Martin Smith has referred to yet again you have come back to what I perceive to be the guidelines of the Royal College and that is that every single baby should be born in hospital because there is a risk with every baby and therefore every baby should be born in hospital?

(*Mr Simmons*) At this point when we are dealing with semantics I need the Professor, so you will understand why I ask Professor Dunlop to respond.

(*Professor Dunlop*) I do not see a real conflict. I think what is being said is that we accept that some babies are delivered in the community. That would not be our own priority. We would not consider that that is the safest thing to do, but in that it does occur we would want to ensure that midwives have clear links so that if problems arise, and they do arise in 25 to 50 per cent of these cases. In almost all studies that have looked at this, it is stated that there should be the ability for patients to be transferred quickly into hospital where safe care is available.

Rev Smyth

908. But if we can follow it through a little further, am I right in thinking, or am I completely in another direction from you, when I suggest that the Royal College's position is not just simply that they should be delivered in hospital, but they should be delivered in hospitals with highly skilled provision, because even in the concept of transfer they go wrong. We know that there is movement afoot that there should be 2,500 to 3,000 deliveries in a hospital to be recognised with all the facilities that are needed today in the perception of the Royal College and others for delivery. I am probing that because I understand you are also having consultations with the Royal College of GPs and the Midwives. I am wondering, in the concept of consultation, is the Royal College moving towards them or away from them, or are you reinforcing the general impression now that GPs give to mothers coming along that hospital is the only place and we are not prepared even to give you the cover unless you go there?

(*Miss Anderson*) Perhaps I can answer this. It would seem to us clear that we feel that the safest place is where the facilities are. The finest of facilities will be in the biggest units. Fairly good facilities will be in much smaller units, but those facilities will be better, we believe, than no facilities at home, other than a flying squad and support of that kind. I would say that in our thinking we have moved away from the thought that "You must have your baby in hospital" concept of some 10 or 15 years ago. I would say very strongly that we recognise that women's choice must be accepted and invited. I would take issue when we were accused of not making any comment about this. We comment in the opening section of our antenatal care document that modern antenatal care aims to provide the maximum choice for the mother. We do try to move towards that. All we are saying is that we believe that all facilities should be available, but in full discussion with mothers. If they still make the choice then we will want to take part in the proper care of those mothers.

909. Are you saying that in the light of your understanding of the situation that the informed choice of mothers has just led to one per cent of home deliveries? This seems rather low from the other information and evidence that we are picking up. That is why we are probing. When we speak of "informed choice" a mother, or perhaps more particularly a father, may not want to have too much responsibility at home and might also be conditioned into making sure his wife is in hospital out of the road.

Mr Hinchliffe: That was a sexist question!

910. As a mere mortal I acknowledge that we are different sexes. It is the conditioning that is going on and that is what I am trying to probe, whether in the sense from the top of the Royal College the conditioning is going through to our medical students and others so that the woman may not have a truly informed choice because she has been told, "If you do not do what I am saying, you will be held responsible for anything that happens to your baby".

(*Mr Simmons*) I do not think that is a fair analysis. As I explained at the beginning, there is a whole spectrum of opinion about the place of delivery. The arguments have been back and forth for years. It is our view in the present state of knowledge that if we are to safeguard patients against the risks of pregnancy and labour which exist, the best place on that count is in hospital. It is true that there are disadvantages to hospital. We acknowledge that the environment is often shabby. We are often understaffed. Not enough money has been spent on improving the environment and a great deal could be done to improve the environment in the way that we feel patients would be more at home, home from home. But that does not alter the fact that on balance we think the safest place for babies to be born is where such facilities exist. The evidence I have mentioned already. That does not in our view mean that we have the right to insist. But inevitably, if we think that is the right place, there will be some bias. It would be quite difficult not to have bias in giving advice. It would not, in my view, be responsible to tell a patient that it is absolutely safe to have your baby at home, that there is no risk if you choose that option. I think that would be irresponsible. There must be some bias if we are on that side of the spectrum. Would it be wrong not to advise patients in that respect?

Audrey Wise

911. It is not absolutely safe to cross the road.

(*Mr Simmons*) Of course it is not. But the patient must make the decision. On the other hand you would not run across the M4 if there was a bridge to go over.

Chairman: Oh, I do not know!

Mr Couchman

912. I would not necessarily disagree with your preferred option, that of hospital confinement. What I have been worried about over a number of years is that by withdrawing recognition for training purposes, the Royal College has been responsible for the closure of a number of small units countrywide, whether they be GP units or whether they be small isolated maternity units. Do you regret that over the years, or do you really believe that all confinements should be within the large modern units? In terms of home from home some of those small units much more resemble home than do perhaps the large district general hospitals.

(*Mr Simmons*) My response to that is that, as I have tried to point out, there are the safety element and there is the environment—

Chairman

913. Mr Simmons, we do not want to go over the same argument again. Can you give a direct answer to Mr Couchman's question? Does the Royal College regret the closure of cottage and other hospitals?

(*Mr Simmons*) No. It is not a subject we have discussed in our council, but I do not think we regret the closure of small units.

Chairman: Thank you very much.

Mr Couchman

914. It is a subject your council must have discussed over the years because it has been the withdrawal of training recognition which has been the catalyst for closure?

(*Mr Simmons*) No, if the institution does not fulfil the criteria for training then recognition might be withdrawn. That is our role. That is our responsibility to see that criteria for training are fulfilled. If they do not fulfil criteria, then it is withdrawn. We would not regret that. We would rather see the institution raise its standards to fulfil the criteria.

(*Professor Dunlop*) The purpose of withdrawing recognition is not in order to close the unit. It is because we need to safeguard the training of our juniors. Our primary purpose would not have anything to do really with the provision of services within the unit.

915. But you will have known in withdrawing training recognition that it is impossible for many of those units to be brought up economically—

(*Professor Dunlop*) In fact that is not always the case. It is possible to withdraw recognition and it is possible for posts to be filled by trained staff who do not require further training and for alterations to be made so that training facilities can be improved and recognition has been granted again to hospitals from which it has been withdrawn in the past.

916. I should be very interested to know what the figures are for recognition being reintroduced.

(*Professor Dunlop*) I am sure we can find it.

Chairman

917. If you have any evidence we would be very pleased to receive it. But you suggest, Mr Simmons, that women should be told the risks of having a baby at home. You would accept, I think, that there are also risks in having a baby in hospital, albeit perhaps rather different risks. Are women told of these risks when they book in for a hospital birth?

(*Mr Simmons*) What risks are you talking about?

918. Infection.

(*Mr Simmons*) Let me say this. Professor Dunlop wants to speak, but when you talk to patients about risk we always have to judge the benefits of informing patients of the drama of risk in any situation against the benefit of seeing that the patient is fully informed. That is a common medical problem.

919. I asked you a question whether or not you actually explained the risks of having a baby in hospital?

(*Mr Simmons*) No, we do not specifically.

920. Why do you not? If you explain the risks of not having a baby in hospital, why do you not also explain the risks of having a baby in hospital?

(*Mr Simmons*) Because—do you want to answer that?

(*Professor Dunlop*) We would be interested to know what these risks actually are.

921. Mrs Wise and I answered with one voice, a higher risk of infection.

(*Professor Dunlop*) What is the evidence? I know there was evidence a century ago, but what is the current evidence?

922. There is evidence of a higher risk of infection of those who have a baby in hospital and those who have a baby at home.

(*Mr Simmons*) On a normal childbirth?

Audrey Wise

923. For example, the National Childbirth Trust did a survey which showed a high rate of infection of episiotomies and showed a deplorable state of cleanliness in hospitals. This was confirmed for me by my said daughter in law who had a baby 12 weeks ago, took her own cleaning materials into hospital and was glad that she did so because she needed to use them.

(*Mr Simmons*) That is awful.

Audrey Wise: And common.

Chairman

924. And increased incidence of unnecessary intervention.

(*Mr Simmons*) I think it is awful and if it exists I hope you will make representations to see that it is changed. That is awful. May I ask you the question? When a patient comes to see us, do you think it is right that before she has any procedure we sit here down with a list of risks of that procedure as a form of counselling? We have to do what we judge to be right in the patient's best interests. That is what the College is there for, in the public interest. The way in which we present the case, I hope we do it in the way which is in the patients' best interests. I do not think we sit down with a list of risks for any procedure. We try to give a balanced judgment and help them make a decision. It is true that we would have a biased view because we try to give them the view which gives them the safest outcome. Of course we are not going to say,

[**Chairman** *Cont*]
"If you have this, that and the other, you will become infected. If you have to have an operation you are likely to get peritonitis". That would not be a proper way to approach a patient. We are not dealing with procedures, we are dealing with whole people, frightened people, anxious people.

925. They may be frightened sometimes when they come in front of you. They may not be frightened when they find out that they are pregnant. Professor Dunlop asked me a question. I say surely that increased intervention in a normal physiological process is something which happens in hospital and which certainly could cause increased incidence of infection. Would you not agree, Professor Dunlop?

(*Professor Dunlop*) It is a secondary phenomenon, but I was talking about normal confinements. I am not aware of any clear evidence that there is an increased infection associated with normal confinements.

926. As Mrs Wise has said, we have had quite a lot of evidence given to this Committee.

(*Professor Dunlop*) I would really have to see that evidence before answering.

927. That is fair enough. Miss Anderson, you wanted to come in a little earlier. I have forgotten the question now.

(*Miss Anderson*) It was going back over ground again. I have been the chairman of the hospital recognition committee in the College. I should like to say that I am not aware of this impression that we have been given of wholesale closure of small units. We do our very best to maintain recognition of training in smaller units because they can make up in quality what they lack in quantity. Where the training is obviously inappropriate for lack of work and lack of facilities they may have that recognition withdrawn for their training. But then I would have said again—-

928. But you are aware surely, Miss Anderson, that some consultants have in the past been reluctant to come out from their district general hospital to cottage and peripheral hospitals because it has been inconvenient for them to do so. Therefore fewer patients have gone to the cottage hospitals, therefore the criteria for meeting training criteria have disappeared and therefore the training is taken away. Would you not agree that that is the case?

(*Miss Anderson*) I am aware that that happens, but I could not name more than perhaps on the fingers of one hand where it exists. Up and down the country consultants do go out and cover antenatal clinics, gynaecological clinics and so on in small peripheral units.

Chairman: I think we have made some progress on that. Alice Mahon and David Hinchliffe have a number of important questions still to ask.

Alice Mahon

929. The Royal College's memorandum on antenatal care says that a domiciliary visit to the mother by the midwife is advantageous, but that the booking visit is not the most suitable occasion. Can you tell us why not and what is the booking visit for? Do doctors need to be consulted during the booking visit, and, if so, which doctors, the GPs or the obstetricians?

(*Professor Dunlop*) I personally would not take a very strong line on this. I think it is important that women are seen at a relatively early stage in pregnancy by an obstetrician. It need not necessarily in my view be the booking visit, but it could be. It is just that there is a need for a screening for a large number of potential problems and may of these can increasingly be diagnosed at a very early stage in pregnancy and intervention can then follow from that early diagnosis. If the opportunity to be adequately screened was not available at the beginning of pregnancy, then the opportunity to deal with some of these early problems may be lost.

930. So you think the obstetrician should be consulted, because the Royal College of General Practitioners lays stress on the advantage of having the GP being consulted because he or she has all the patient's previous medical notes?

(*Professor Dunlop*) My own view is perhaps rather personal, but this is an area of obstetric practice that is changing dramatically month by month. We are increasingly able to make diagnoses which were previously almost unheard of. It is such a growing area that I feel at the moment that many people in general practice and in the periphery may not have that information immediately available. That is not a criticism. It is simply that things change rapidly and that there must be access to the most up-to-date information possible.

Mr Hinchliffe

931. Can I move on to the question of teamwork? The Committee took interesting evidence in Amsterdam from professionals over there and some of us recall with interest discussions we had with midwives there. All the Colleges agree on the importance of teams of doctors and midwives working together, but seem to disagree on who actually should lead the team. What would be wrong about midwives being the team leaders?

(*Mr Simmons*) I think if midwives have the background and are prepared to accept the responsibility and the training to fulfil that responsibility, there would be nothing wrong.

932. Can you expand on what you mean by training? You imply that additional training would be needed over and above the existing training.

(*Mr Simmons*) I think you have to understand that a consultant obstetrician, by and large, before he is appointed has had perhaps 15 years in medicine, perhaps 10 years in the discipline and then has another 25 or 30 years. I would have thought that that imposes upon us the responsibility and the leadership that goes with it. That is one we have accepted and I think it is expected of us. But if you tell me that there are other disciplines that accept that responsibility and can fulfil and discharge that, there would be nothing wrong.

933. If we were talking about a disease, we could accept that as an answer. But you have said yourself—we have had this from every witness and I am sure we all agree—that this is a normal physiological process, a natural process. If we were to

[Mr Hinchliffe *Cont*]
move away from the medical model would not leadership by midwives be totally appropriate?

(*Mr Simmons*) I accept that in retrospect pregnancy and labour are a normal physiological process. If I could refer you to the confidential inquiry—

934. It is the first time you have said that today.

(*Mr Simmons*) Pregnancy is a physiological process. It is not without its inherent risks. In retrospect it is a physiological process, but it carries risk. Some 500,000 women every die in pregnancy and you may say—

Audrey Wise

935. Worldwide.

(*Mr Simmons*) Yes, worldwide, but you may say that is underdeveloped countries, but in this country the situation was precisely like that when this College was formed.

936. Quite a long time ago.

(*Mr Simmons*) That is the position. It is a normal physiological process when the outcome is a happy one for everybody, but it has inherent risk. That is all I would say about it. That training that the obstetrician undergoes is to safeguard patients against that risk. That is our responsibility. Of course anybody who fulfils that need could lead the team, certainly.

Mr Hinchliffe

937. Can you advise us about the progress of the discussions that have been ongoing among the three Colleges about maternity care? What point have you reached so far and what sticking points have you come across in these discussions?

(*Mr Simmons*) As far as our College is concerned, there are two meetings. There are the meetings between the Presidents, which is going on and has been going on for a little while. I think we have reached the point where very shortly we shall produce a consensus view about maternity care. It is very near to publication. There is also another team meeting general practitioners looking at training which Mary Anderson has been chairing and which is also very near to publishing its results. I hope that answers your question.

Chairman

938. Before Sir David Price finishes with the last question, can you tell the Committee, Mr Simmons, what the RCOG has done to smooth the path towards the consensus that needs to be reached between the general practitioners, the RCOG and the Royal College of Midwives?

(*Mr Simmons*) I have said this to you last time I was here. I think all three Colleges and all those involved in the care of pregnant women, maternity care, have a responsibility to work together. I have repeated this to my colleagues many times. I think the worst thing we can do in an attempt, albeit unintended, to alter the various status of the various disciplines is to undermine confidence in the team either for the individual or for the public, that would be disastrous and highly irresponsible. When you ask me what we have done, I have put forward that philosophy and I will continue to do so. Our responsibility is to the public.

939. But you are not saying that you have done anything specific in order to reach the consensus that we hope to view when we read the paper that you have indicated to us is shortly to be published?

(*Mr Simmons*) I have done many things specifically.

940. Will you be specific, then, and tell us what you have done?

(*Mr Simmons*) I cannot be specific. You will have the document very soon and you can read it for yourself.

941. I am asking you here in this Committee. Will you be specific?

(*Mr Simmons*) I am not quite sure what is the specific you want. Are you asking me whether we have agreed to one form of delivery against another? No, on the issues which we agree upon we have published data. On those we have published opinion. On those where we have differences of opinion or where we have a different emphasis we are also prepared to acknowledge. We shall not agree on every issue concerned with maternity care, but that is not something that prevents us from publishing a document in which the broad issues are agreed upon. When you say "specific" I am not sure what you mean, except to identify the importance of such a team publication.

Chairman: It looks as if we shall have to wait for that document.

Sir David Price

942. I can give you an example in evidence that we received from the Royal College of General Practitioners. They were critical about the training that doctors receive in obstetrics, both at undergraduate level and immediately post qualification. They suggested that possibly you had some responsibility for this. I do not know how you would react to another College obviously. But do you accept that you have a responsibility and that it may be due to your attitude that there is a decline in the number of younger GPs doing maternity work? Or is it all these other factors that we have spent a long time discussing? It means that the GP has followed the thrust of—

(*Mr Simmons*) I understand precisely what they are saying. I do not think there is very good evidence that that is the case, but it is sufficient for them to make the point for us to look at it very carefully. Mary Anderson will explain to you how we are doing that. I do not think there is very good evidence for what my friend Colin Waine said to support his contention.

(*Miss Anderson*) This is one thing that the College has been doing by initiating and working out the discussions which inevitably back up the final outcome of such a document on training, for example. These discussions have been quite wide ranging, not just in defining educational needs for GPs, but in the differences that the GP has felt from our own approach to training and the eventual outcome of general practice obstetrics. It has been enormously useful and we have reached a very friendly and well-considered consensus of opinion on

[**Sir David Price** *Cont*]
this. I think you will find that when this document, which is, I hope, about to be accepted by the councils of both Colleges, I think you will find that we have highlighted where our deficiencies have been. Of course it would be wrong to claim that we have done it all right. We have highlighted those deficiencies and we have tried to tackle them and to acknowledge the enormous place that the general practitioner has in the general care of the pregnant woman.

Chairman

943. What about the midwife?

(*Miss Anderson*) We have also touched on midwives in our document and have highlighted one particular area in which we would like them to be part of the educational team concerned with the general practitioner and the trainee doctors.

Sir David Price

944. There are two aspects to this. There is the basic initial training and there is the other, which concerns us all today with the speed of advance, and that is what might be called in-service training. I wonder, particularly about the developments that Professor Dunlop was touching on, whether you organised, and in what depth, updating the training of GPs and some of your own College members?

(*Professor Dunlop*) I think those are very important points indeed. We are in the process of reassessing our training for the diploma examination which is what most general practitioners take. A working party to meet early next year has been set up to try to look again at our educational objectives and to ensure that we train general practitioners in what they wish. I think it is important for the Committee to remember a point that I made last time. Obstetrics is only one aspect of what general practitioners learn during training in obstetrics and gynaecology and increasingly there is a need for gynaecological skills. There is a movement within general practitioners who feel that their obstetric skills and particularly their intrapartum skills are therefore suffering because the training has changed. It seems to me that at the moment the diploma examination is a very popular examination. We had our diploma examination last week. There were 845 candidates who applied for that examination. It is certainly a popular examination and it seems to me that it is likely that it fulfils some of the needs of general practice, but we are not complacent and we shall certainly look again at what is required.

945. I wonder, without detaining you now, whether it would be possible to let us have a very short note on the in-service training of GPs?

(*Professor Dunlop*) We can certainly let you have the regulations for the diploma examination. There is no problem about that at all.

946. I think you would agree, would you not, that one of the major problems with considerable resource implications for looking ahead in health care is how we keep everyone up to date?

(*Professor Dunlop*) The working party will have general practitioner representation but will not be reporting to council until the middle of next year. That may be too late for your purposes.

Chairman

947. But will you accept that there is considerable evidence from trainees that their training has not been adequate or appropriate in many areas?

(*Professor Dunlop*) I know of a survey which has been carried out in Bristol which addressed that point and I heard of the data presented. I must say I found myself in considerable disagreement with some of its conclusions.

948. Thank you very much. As I thought at the beginning, this has been another lively session. You have provoked us. I suspect that we have provoked you. Thank you for your patience in allowing a break in the middle which was longer than I had hoped, but I am most grateful to you and your colleagues, Mr Simmons, for coming to give us evidence this afternoon. Thank you very much.

(*Mr Simmons*) I would just like to say that sometimes the form of the questioning suggests that there is a major schism within hospitals throughout the country between midwives and obstetricians. I would like to say that it is certainly not my experience that that is the case. By and large I think the relationship between the two disciplines in hospitals throughout the country has been and continues to be extremely good. I think it would be quite wrong to give an impression that we are day in day out working together and fighting for some possession of a poor patient. The association is extremely good and I think it has been an example over many years to many other disciplines.

Chairman: Thank you for that concluding comment, Mr Simmons. Perhaps you will now allow the midwives to come forward. I apologise for them for keeping them waiting.

Supplementary Memorandum submitted by the Royal College of Obstetricians and Gynaecologists

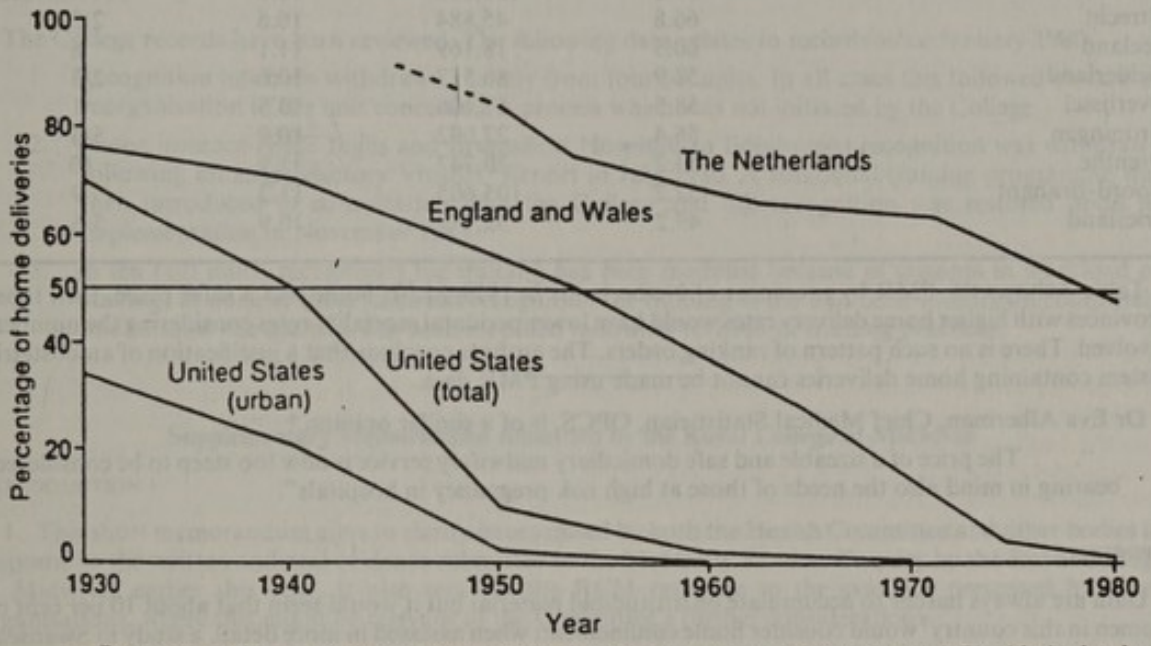
APPENDIX 1

THE CURRENT POSITION OF HOME DELIVERIES

BACKGROUND

In 1989 there were 682,979 births in England and Wales of which 6,941 were in the home,[1] an average of 19 a day in the whole country or one every ten days in each Health District. About half these cases are unbooked and so would only be attended by emergency care. Hence, less than 0.5 per cent of all deliveries are booked and accomplished at home.

Rates of birth outside the hospital have been declining steadily since 1930. There has been no sudden change because of any pressure form any particular group of consumers or professionals (see Figure 1); each year the numbers continue down (see Table 1).



—Percentage of home deliveries in the United States, England and Wales, and The Netherlands, 1930-80

	Deliveries at Home	
	n	*per cent of all deliveries*
1964	252,114	28.6
1972	60,473	8.3
1980	8,131	1.2
1989	6,941	1.0

TABLE 1: Numbers of home deliveries and the percentage of total deliveries (1964–1989)[2]

Statistical Justification

How may we give soundly based advice about where women should deliver? Perinatal mortality rates (PMR) are now very low in England and Wales and the numbers of women delivering at home are so few that statistically one is not comparing like with like. Further, the women who have home deliveries are obviously from a group who have been selected to exclude those with high risk factors such as relative age, problems in past deliveries or raised blood pressure in pregnancy.

The last statistically sound examination of home births in the United Kingdom was for the year 1979.[3] Here the women who delivered at home had a much lower PMR than those who were hospital delivered but as the authors point out, those who delivered in hospital included many who originally had booked a home birth but had to be transferred in pregnancy or were in labour. This last group has a very high PNMR, four times that of the hospital booked group.[4] Thus, although trends stand out, the data in the United Kingdom are too inexact to offer help in the individual case but the only country left with a statistically large enough sample for home deliveries is Holland.

13 November 1991] *[Continued*

Province	*per cent Hospital Deliveries*	*No. of Births*	*PNMR/ 1000*	*Ranking Order*
Noord-Holland	75.7	106,591	11.0	7
Limburg	70.7	48,874	12.1	11
Zuid-Holland	67.6	155,630	10.8	4
Utrecht	66.8	45,884	10.6	2/3
Zeeland	60.3	18,169	11.1	8
Gelderland	58.9	86,537	10.6	2/3
Overijssel	58.5	57,106	10.5	1
Groningen	56.4	27,092	10.9	5/6
Drenthe	53.2	20,747	11.9	10
Noord-Brabant	52.2	105,605	11.2	9
Friesland	49.2	32,772	10.9	5/6

Table 2 shows the PMR by provinces of Netherlands in 1979–82.[5] If home was a safer place, then those provinces with higher home delivery rates would have lower perinatal mortality rates considering the numbers involved. There is no such pattern of ranking orders. The authors conclude that a justification of an obstetric system containing home deliveries cannot be made using PMR data.

Dr Eva Alberman, Chief Medical Statistician, OPCS, is of a similar opinion.[6]

". . . The price of a sizeable and safe domiciliary midwifery service is now too steep to be considered, bearing in mind also the needs of those at high risk pregnancy in hospitals".

Opinions

Data are always harder to accumulate on attitudinal material but it would seem that about 10 per cent of women in this country[7] would consider home confinement; when assessed in more detail, a study in Swansea[8] of those who would give birth at home (eight per cent of the study women) show that although wanting home delivery, most of them chose to be delivered in hospital for they were given confidence by the equipment and skilled staff available even if it was not used.

An Inexpensive Solution

Much of what a woman dislikes in hospital delivery involves the length of postnatal stay and the regimentation she receives from the staff. The second could be improved by more friendly attitudes of doctors and midwives and this is already happening; the former can be reduced greatly by the better use of *Birthrooms* in District General Hospitals. Here, women at lower risk who have been looked after in the antenatal period by their own midwives come in labour with their own midwife to the birthroom. This is close to, but set apart from the main labour ward. Other family members can be there and the baby is delivered. If all goes well the family and midwife return home within hours of childbirth. If the midwife is worried she can summon aid and necessary equipment from the nearby labour ward. Such Birthrooms have been tested in randomised controlled trials[9] where the women will require less analgesia and ran into very few difficulties in labour. The use of the Birthroom has now spread to many other hospitals in the country and deserves encouragement. This is an inexpensive way of satisfying women's needs while ensuring that they are near to professional help and specialised equipment should the need arise.

References

1. Office of Population Census and Surveys. VITAL STATISTICS 1989. HMSO London Series F M I No 18 (1990).

2. Macfarlane A., and Mugford M. BIRTH COUNTS. HMSO, London (1984).

3. Campbell R., Davis I. M., MacFarland A., Berol V. HOME BIRTHS IN ENGLAND AND WALES 1979. Brit Med J *289*, 721-724 (1984).

4. Chamberlain R., Chamberlain G., Howell B., and Clareaux A. BRITISH BIRTHS 1990. Heineman Medical Publishing (1975).

5. Treffers P. E., and Larne R. REGIONAL PERINATAL MORTALITY AND REGIONAL HOSPITALISATION OF DELIVERY IN THE NETHERLANDS. Brit J Obs Gynec *93*, 690-693 (1986).

6. Alberman E. THE PLACE OF BIRTH. Brit J Obs Gynec *93*, 657-658 (1986).

7. Caplan N., and Madeley R. HOME DELIVERY IN NOTTINGHAM 1980-81. In Public Health *99*, 307-313 (1985).

8. Shepherdson B. HOME OR HOSPITAL BIRTH. Health visitor *56*, 405-406 (1983).

9. Chapman M., Jones M., Spring J., de Swiet M., Chamberlain G. USE OF A BIRTHROOM. Brit J Obs Gyn. *93*, 111-116 (1986).

APPENDIX II

QUESTION 916

The College records have been reviewed. The following data relates to records since January 1980:

1. Recognition has been withdrawn entirely from four (4) units. In all cases this followed closure or reorganisation of the unit concerned, a process which was not initiated by the College.
2. In one instance (Elsie Inglis and Bruntsfield Hospitals in Edinburgh) recognition was withdrawn following an unsatisfactory Visitors' Report in July 1980. A rotational training programme was then introduced in consultation with the College and full recognition was restored upon its implementation in November 1983.
3. In ten (10) units, recognition for training has been modified because of changes in workload or staffing. In none of these cases has recognition for training in the unit been withdrawn completely and in some the decision has been modified following revision of training practices.

Supplementary Memorandum submitted by the Royal College of Midwives

INTRODUCTION

1. This short memorandum aims to clarify issues raised by both the Health Committee and other bodies in response to the written and oral evidence submitted to the Maternity Services Enquiry by the Royal College of Midwives earlier this year. It also sets out the RCM response to the evidence presented by other organisations, where this might be relevant to the Committee's further considerations.

THE MIDWIFERY PROFESSION AND CHANGE

2. The RCM recognises that the proposals contained in its written evidence of May this year for a midwifery led maternity service providing continuity of care to defined caseloads of women within a specific geographical area may be regarded as idealistic. It might also be suggested that they are unrealistic in relation to the structures in which the majority of midwives currently work. Firstly it should be stressed that the profession views the proposals as radical rather than revolutionary. Prior to the move to 100 per cent DGH delivery in the early 1970s the majority of midwives were operating in a community-based structure undertaking the full range of midwifery tasks for the women in their care.

3. Secondly, the midwifery profession collectively has demonstrably not lost skills in the intervening period. Both the concept of midwifery and its practical attributes have been sustained and developed by a continuing emphasis on improved midwifery education. Indeed, although NHS policies and structures have made it difficult to practice what is understood by midwifery, the profession in the United Kingdom has maintained its high reputation internationally. For example, in setting up action programmes to promote its Safe Motherhood Initiative the World Health Organisation identified as key workers those who could work with women in their own communities to provide primary maternity care and health promotion including family planning. The skills they envisaged were based on the British midwife who represents the role model for this key worker. As a result the RCM has been invited to contribute to a number of initiatives overseas to improve training and practice. It has been involved in three main areas: helping to establish appropriate education for midwives aimed at saving life and improving outcomes, contributing to developing research to improve practice and advising on the legislation required to enable and control the practice of midwifery.

4. Some problems may well be posed for individuals within the profession by change, although the profession already possesses credible mechanisms to deal with these (see paras 6, 7 and 8 below). However, far greater problems will arise for the profession as a whole if change does not come about because of the existing disparities between education and skills and the opportunities to put these into practice. In 1990 the College commissioned the Institute of Manpower Studies to survey midwives with a view to establishing the critical issues to be addressed if qualified midwives were to be retained in the NHS. The results of this study made clear the importance midwives gave to the full use of their skills and to "professionally rewarding client patient contact".

5. In all organisational change there are individuals who will need help in adapting to altered circumstances. For midwives this is likely to centre on reactivating skills which have not been called upon in their current jobs. These could be anything from updating knowledge of labour ward practice to the practical provision of breast-feeding support. The needs are likely to be quite specific to the individual practitioner, but there already exist mechanisms to both identify and meet their needs.

THE ROLE OF THE SUPERVISOR OF MIDWIVES

6. The statutory role of the Supervisor of Midwives is outlined in the Annex to the College's written evidence of May 1991 entitled "The Role of the Midwife", which describes the legal status and accountability of the profession. For individual midwifery practitioners a source of support and leadership should be available from the local Supervisor of Midwives. Supervisors should be readily available to midwives; they should know local circumstances and have sufficient knowledge and experience to command the respect of their peers and represent their views where professional practice is an issue. Some health authorities have failed to understand the nature of the Supervisor's role and they have not appointed supervisors appropriately; they may well benefit from further guidance on this topic. However, in general the role of the supervisor is a major pillar in maintaining existing high standards of midwifery and will be of considerable significance in any changed structure.

7. An example in practical terms is that one of the tasks falling within the Supervisor's responsibilities is to monitor the clinical practice of each midwife in her area at least annually and to maintain appropriate records. It would be feasible, therefore, to identify the particular training needs of individuals through the supervisor's review and to set out a tailor-made programme to meet those needs.

CONTINUING EDUCATION AND REFRESHER COURSES

8. Midwives have a professional responsibility to keep up to date on all aspects of midwifery practice. Such continuing education enhances individual practice and service provision. A key component is the statutory obligation to undertake periodic refresher courses. (There are no equivalent courses for nurses or health visitors). Implementation of the UKCC's Post-Registration Education and Practice Project (PREPP) will add to these responsibilities. There are several ways in which this system could be built on to implement change. One idea would be to add onto the current refresher course components designed to enhance particular skills so that over the transition period individuals could choose a course specific to their needs. Alternatively, individuals could be encouraged to seek training which would be accepted as an alternative to a refresher course and put them in compliance with their statutory obligations. Both of these measures would require pump-priming resources. However, the refresher course requirement would enable transitional training needs to be met in a cost-effective manner.

9. In recent years the RCM has given a high priority to developing a range of post-qualification courses to further improve the options for continuing professional education. These include a Postgraduate Diploma in Professional Studies, Midwifery, and the first Masters in Midwifery Programme in Europe in collaboration with the University of Surrey. The College has also sought to encourage open and distance learning initiatives. It is a member of the Steering Group for the development of a Diploma in Professional Studies-Midwifery, by distance learning, in conjunction with South Bank Polytechnic and it has been involved in the development of a return to practice programme by distance learning. Clearly these developments could be built on to provide for additional training needs.

10. A major current issue for midwifery and one which will be critical to the future quality of midwifery care is to ensure that midwifery education remains founded on clinical practice with a recognition that it is a skill-based profession. To do this midwives need to retain control of midwifery education and it might well be necessary to strengthen the mechanisms at both statutory and institutional level to ensure that midwives can direct their education and practice as intended in the Nurses, Midwives and Health Visitors Act 1979.

11. Within the NHS structure there are two existing routes through which change could be facilitated. The first is the Heads of Midwifery who are likely to have an important role in implementing service developments. At present, management structures in some health authorities do not enable the Head of Midwifery to contribute as fully as is desirable and improved recognition of those who represent the profession is required. Only midwives can speak for midwifery and it is essential now and could be increasingly so in the future, that where maternity provision is being considered a midwife with the appropriate experience and standing is able to participate fully at the level where decisions are made. The second route to change could be the Maternity Service Liaison Committees. It was recommended by the Maternity Services Advisory Committee in 1983 that all health authorities should have such a forum to discuss, review and establish acceptable policies for all those providing maternity care. Despite the passage of time some health authorities still do not possess a fully functional Liaison Committee. It would be hoped that general managers would appreciate that such bodies can provide a prime source of advice when arrangements for maternity care are being considered. They should ensure that there is equal representation from professional groups and consumers and that an adequate secretariat is provided.

THE ROLE OF THE GENERAL PRACTITIONER

12. In oral evidence to the Committee in June the RCM expressed concern about the duplication of care in the community by both the midwife and the GP. It was suggested that the GP's item of payment for maternity services in which care was broken down into three components (ante-natal, intra-partum and post-natal care) systemised the fragmentation of care. The College is aware that at that point its comments were

considered controversial. It was therefore pleased to receive and comment on the General Medical Services Committee document, "Building Your Own Future—An agenda for General Practice". In its response the RCM reiterated its policy that women should have access to a full range of maternity services including direct referral to a midwife—within the context of the GP continuing to take prime responsibility for broader family care. The RCM strongly supported the GMSC concern to see a system of remuneration which wholly reflects the work GP's undertake and their wider responsibilities and commitment to their patients. However, the College expressed the view that item-for-service payments did not lend themselves to "whole service provision" and proposed that a weighted capitation fee based on the number of women of childbearing age on a practice list would be more appropriate. This would take account of the GPs' responsibility for the provision of a very wide range of services to this group and would also allow for the development of more varied, appropriate and effective patterns of care.

13. The RCM and the RCGP have agreed recently to set up a Joint Working Party to examine the delivery of maternity care in the community. The working party will produce recommendations in four major areas:

13.1 the formulation of a programme to guarantee high quality care from confirmation of pregnancy to the post-natal examination.

13.2 the definition of the contributions of the general practitioner and the midwife to the delivery of maternity care to avoid unnecessary duplication of services.

13.3 the maintenance of continuity of care for women through pregnancy, childbirth and the infancy of their child.

13.4 the examination of ways in which women can be kept informed about the process to ensure their choices about maternity care are heard and acted upon.

The Working Group will report direct to the ruling Councils of both Colleges in early 1992.

The Maternity Services Advisory Committee—Maternity Care in Action

14. The RCM was concerned to note the heavy dependence of the Department of Health written and oral evidence on the three documents produced by MSAC. These aimed to review the then current practice to raise standards of care and present a source of advice and an achievable action plan for health professionals and managers. Since their publication in 1983 the documents have proved to be valuable but there have been subsequent clinical developments, social changes and alterations to the structure of the NHS which should now be taken into account. The RCM does not believe that Maternity Care in Action currently represents the best advice of midwives nor the best advice to midwives and it considers that it would be timely to draw together new national guidelines for the provision of maternity care.

15. There are three particular areas which the College believes are not addressed by Maternity Care in Action and which should be incorporated into new guidance:

15.1 *The need for a woman-based service offering adequate choice and continuity of cover.* Maternity Care in Action was largely concerned about humanising a pre-existing system; it was not consumer-centred. The Advisory Committee did not possess the evidence currently available on the importance of continuity of care and carer.

15.2 *Modern approaches to clinical practice*—The available evidence, drawn together in "Effective Care in Pregnancy and Childbirth", including information on the appropriate use of technology such as electronic fetal monitoring and oxytocic drugs.

15.3 *Methods of Promoting Change*—In line with the Health Charter it would now be appropriate to establish clear targets for health authorities for particular aspects of maternity care, eg waiting time in ante-natal clinics, intervention rates and the introduction of named midwives and continuity of carer schemes.

Research Priorities

16. The RCM considers that one of the causative factors leading to the present emphasis on abnormalities of pregnancy and childbirth has been the disproportionate volume of resources devoted to this aspect of care. Midwives recognise the right of "high-risk" women to have the opportunity to safely deliver a healthy child. However, the effectiveness of care given to the majority of "normal" women with a resulting decrease in levels of clinical morbidity could also be improved by means of good quality research and the application of the results of research to practice. The RCM contributes to the Steering Group for the midwifery research data base (MIRIAD) centred at the National Perinatal Epidemiology Unit, Oxford. This has significantly raised awareness among midwives of the application of research to practice and generated an increase in practice-based research. The College also runs courses for research midwives and the "Research and Midwifery" conference. Despite such activity midwifery research is relatively underdeveloped compared to medical research a major constraint being the lack of secure sources of funding to enable large-scale projects to be undertaken. The RCM administers funds on behalf of various trusts and commercial sponsors, but such funding is generally for a very limited period and rarely in excess of £5,000. As midwifery (and also nursing

research) develops, the number of high quality project proposals is increasing. This is beginning to give rise to a very unequal situation whereby a medical research proposal of similar quality and validity to a midwifery proposal is far more likely to attract funding. The RCM considers that the stage has been reached where it is necessary to consider the feasibility of establishing a free-standing body with earmarked resources along the lines of the Medical Research Council to support suitable midwifery and nursing research.

November 1991

REFERENCES

Enkin M Keirse, Marc JNC, and Chalmers Iain (1989) *Effective Care in Pregnancy and Childbirth*. Oxford University Press.

General Medical Services Committee (1991) *Building Your Own Future—An Agenda for General Practice*. BMA Print and Design Unit.

Maternity Services Advisory Committee (1982, 1984 and 1985) *Maternity Care in Action*. HMSO.

Examination of Witnesses

MISS MARGARET BRAIN OBE, President, MISS RUTH M ASHTON, General Secretary, MISS BEVERLEY BRYANS, Director of Professional Affairs, MISS ANNE RIDER, Maternity Services Manager/Director of Nursing Services, University College Hospital and MS LESLEY PAGE, Director of Midwifery Services, John Radcliffe Hospital, Oxford, Royal College of Midwives, examined.

Chairman

949. Miss Margaret Brain, as President of the Royal College of Midwives, can I welcome you most warmly to the Committee this afternoon to give evidence for a second time in this inquiry we are carrying out into maternity services. I publicly apologise to you for keeping you waiting so long. You know part of the reason and also naturally we were rather engrossed with the Royal College of Obstetricians and Gynaecologists, seeking to solicit additional information from them. We are now giving you an opportunity to bat. Will you, first, for the benefit of all, introduce your team to us?

(*Miss Brain*) Thank you very much, Mr Winterton. We are delighted to be back. I have the same team with me that batted before. They are Anne Rider, who is the Maternity Services Manager and Director of Midwifery at the Obstetric Hospital at UCH in London and is also a supervisor of midwives; then Beverley Bryans, the Director of Professional Affairs at the Royal College of Midwives. We have Ruth Ashton, the General Secretary of the Royal College of Midwives and Lesley Page, Director of Midwifery at the John Radcliffe Maternity Services in Oxford and also a supervisor of midwives.

950. Thank you very much indeed. We obviously hope to get through the questions that we have down for this afternoon, to wind up on evidence that we took at the earlier session. I lead off by asking you the first question, a very general one. What do you consider to be the essential criteria by which to judge the quality of maternity care? What factors would influence how these are prioritised by the Royal College of Midwives?

(*Miss Brain*) There are many criteria which can be used to judge the quality of care and probably the easy ones are the hard statistics relating to maternal mortality rates, perinatal mortality rates. Other statistics, such as the types of deliveries within hospitals, can also be used to look at the type of service you are providing. But pregnancy must be recognised as a life event and therefore there are other criteria which need to be looked at. I will therefore ask Lesley Page to comment on the more women-centred or the softer statistics and soft criteria which can be used and which must be used.

(*Ms Page*) I think it is important when we are looking at a yardstick for measuring quality in the maternity services that we recognise that we are caring for a woman who is having a baby. We are talking about basing our indicators of value on the value which is important to that human life event. We are looking at things like developing confidence in parenting, happiness at the outcome of having a baby, the mother using the feeding method of her choice, as well as looking at the health of the mother and baby. A lot of these are consistent with value for money and one of the things that we need to focus on more in the maternity services are the social interventions and the effect that they have. We need to have some social indicators of quality. When one asks a mother if she has had good quality care it is very obvious to her whether she has had good quality care or not. It is not a difficult question to answer.

One of the things that is particularly important is looking at the sensitivity with which the mother has been treated. When dealing with difficult complaints, as I do often in the maternity services, one finds that for the women who have been treated insensitively we cannot really resolve their complaints. We have to recognise that those women are affected to the very core of their being. We often talk to old women who remember difficulties that they had when they were having their children. It is not always the bad physical outcomes, but the sensitivity with which a woman has been treated. It is particularly important that she has control over her own body and the birth of her own child and the partner and the family of that baby have to have control too. They are the kinds of things that we need to look at as well as the hard physical outcomes when we are looking at quality in the maternity services.

951. There are one or two questions from me before I hand over questioning to my colleagues. Miss Brain, in the oral evidence that your College gave to the Committee in June you described the

[Chairman *Cont*]
under use of the midwives in the country as—and I quote the words that were used—"a scandalous waste of money". What have you done as the Royal College to persuade the Department of Health to quantify this waste of money? What assessment have you made of the resources which could be released by the reorganisation of maternity services? Where would you apply these resources? What amendments or concessions have you got from the GPs and the Royal College of Obstetricians and Gynaecologists?

(*Miss Brain*) Lesley!

(*Ms Page*) I have this feeling that this is an area where angels fear to tread, but I will get into the area.

952. You and I are in it together.

(*Ms Page*) I have to link this with your question to the RCOG previously. We keep on hearing the misconception that domino systems, for example, are too expensive. But nobody can ever quantify or give evidence that they are too expensive. What we have to be looking at are systems in which we do not superimpose one system on top of another. We actually have to look at fundamental reorganisation of the whole system. So, for example, if you put a domino scheme on top of a traditional system it becomes more expensive. It is easy to see how the misconceptions arise. The midwives who do domino deliveries are community midwives and highly paid. They have leased cars. They have travel expenses. So, on the face of it, it seems expensive. On the other hand, we have traditional systems which are inflexible to the peaks and troughs of the work load, so we need midwives where the mothers are when the mothers need them. That is very simple. I have done some local work on costings with our unit accountant. It is a very difficult area to quantify. I have looked simply at the midwifery cost per case when we use the traditional system, and team midwifery, which is community based and hospital based. In fact, if we use the proper skill mix with community based team midwifery, it is as cheap as the traditional system, if not cheaper. We also have to be able to add in there the reduced intervention rate, which often follows with those systems. So I think it is an area on which there needs to be much national work and we need to look at remodelling whole systems and looking at a new organisation, not at imposing a different organisation on top of a traditional one.

953. The RCOG in their evidence just now—you were present and you heard it—indicated that there was a shortage of midwives. Is there a shortage of midwives?

(*Ms Page*) We work in systems where midwives feel constantly frustrated and stressed—

954. No, that was not my question. Is there a shortage of midwives?

(*Miss Ashton*) Yes.

955. Or is it that they are not properly organised at the moment because of the primarily hospital based service?

(*Miss Ashton*) Can I elaborate on that "yes", because I was not going to say "no"? I do not believe that we can say that there is not a shortage of midwives. That is why I said "yes". However, I think there are certain issues that one has to look at in relation to the use to which midwives are put. There is no doubt at all that if you look at the way the maternity service and particularly midwifery is organised and begin to analyse and use the processes which can analyse the way that midwives provide the care, those places that have done that have been able to utilise the midwives better, but at the same time, with fair confidence, many of them have identified that there are shortfalls in the numbers of midwives that they require. It may not be such a shortfall as they might have anticipated while they used the different system, but nevertheless they have identified shortfalls. The difficulty is—and this is where I think the pressure is—that if you look at the establishment, those numbers that are allowed, you might find the vacancies are all filled. But if you look at the number required to provide a service then you will discover that there were not enough midwives working in some places. Therefore there is a shortage of midwives working within the NHS to provide the type of care that we are talking about.

Audrey Wise

956. Following directly on that, is there what would be called a wastage of midwives? Is there a drift away by qualified midwives? If there is, can you identify any reasons for that and any ways of preventing it?

(*Miss Ashton*) We did a survey last year through the IMS. One of the questions related to the likelihood of people moving out of midwifery within the next five years. One of the things that came out very loud and clear was that what midwives wanted was to be able to exercise their professional expertise to be able to utilise their skills. The survey indicated to us that midwives are frustrated with that and that they felt that they would come out of the NHS, out of maternity care within a short period of time. That is the indication we get of people's likelihood of leaving. We are certainly beginning to get anecdotal evidence now and I think that within the next year we shall be able to discover the extent to which this is happening, that midwives are moving out of midwifery. We were talking the other day with some people from the north of England and one of the things that seems to be happening is that midwives are going to work in practices. So they are practice nurses, no longer exercising their midwifery skills. One of the reasons for that—we are not here to talk about pay and conditions—is the pay they receive as practice nurses as opposed to the pay they might get working within the hospital or community system in the NHS. The other thing is their frustration at not being able to do what they believe they are there to do; that is to practice midwifery in the way that they should be, free to be a midwife and practice midwifery. I am sorry we cannot give it to you now, but I am sure over the next year we have to follow up this increasing anecdotal evidence of midwives moving out of midwifery into other areas of care, because the opportunity is now much more available to them and the general practice issue has suddenly provided that opportunity for people to move out.

Sir David Price

957. How far do your members feel that they must act independently? How far do they feel themselves, initially at least, to be members of the primary health care team and therefore working very closely with the GPs and the health visitors? Or do they prefer to be independent?

(*Miss Ashton*) If the primary health care team is an organisational concept, then they are not part of that organisational concept. Midwives are working in the main in this country in the context of an integrated community/hospital service. That is where the team is which covers community and hospital. Most midwives working in the community setting will liaise and co-operate and work with their colleagues who are in a primary care team where that primary care team is interfacing with the work that they do, for instance the health visitor. At the moment very few midwives are structurally within what is defined as the primary health care team.

958. So they would not particularly wish to work from the premises of a group practice?

(*Miss Brain*) They may be working in these practices, yes. They may be working in those premises, but they are not actually a part of the primary health care team. They will be part of the total midwifery service for the district.

959. Let us take this in the context of hoping to get the primary health team closer to the hospital at one end and out into social care at the other. I think you will agree that more and more, as one takes a holistic view of these things, one is talking about health care the spectrum, rather than trying to separate out exactly which part of the individual's problems or need for care is strictly health and what is strictly other but important matters. Let us take the example with the pregnant mother of her diet. In our earlier report we took a good deal of interest in that.

(*Miss Ashton*) At the moment—and this is something we have advocated—midwifery and midwives cover community and hospital. For a long time we have said that it is inappropriate to separate midwives off from that group and that team and take them out and put them into a community team. There are all sorts of reasons why the integrated service for midwifery is appropriate. That is the one side. The second side is that we believe that midwives obviously must and do—in the organisation of the care which is provided in the community to mothers—work with the team of people who will provide whatever sort of advice and services are needed. That may be the dietician. Midwives should know and understand the dietary needs of the mother and should be able to help, but the midwife will liaise with and work with the dietician. Our College has taken the stand and will continue to take the stand that the seamlessness where maternity is concerned must be between community and hospital and that the seam must be between the midwife in the community and the other community people and that has to be bridged by liaison. What we do not want is for the seamlessness to be in the community between community midwives and other community staff so that they then have to try to establish the seamlessness between their colleagues who are working across the district. That is, hospital and community should be one, and then midwives should liaise with their colleagues outside that to make sure that the mother gets the sort of care she requires. That is the stand that the College has taken.

960. So you would expect the majority of midwives to be working out from the hospital base? Physically that would be the way to do it, would it?

(*Miss Rider*) I think that varies from geographical area to geographical area. If it is a big area there may be teams of community midwives working within community institutions, like GP practices or health centres. Where I work the midwives work from within the hospital and go out. They work in 12 or 13 different health premises. It will vary, but their allegiance and their control is from within the hospital. That is what happened in 1974 with the integration of the maternity services. Having worked before 1974 the advantages are superb, because whoever deals with the woman, community midwife or the hospital, they are working to the same policies, practices and understanding of how the system works. This means that the woman does not notice the difference, whether she is being cared for within the community or the hospital because the philosophy of approach is exactly the same.

961. Following that, how common is it nowadays for a midwife to alternate, still based within the same general area, between hospital and community? In my part of the world in Wessex I have found it quite common for a midwife to do six months in the hospital and then six months anywhere out in the community. I know that it produces great problems over regrading. Is that a kind of model that you think will become increasingly common?

(*Miss Bryans*) In fact, increasingly there are rotational schemes of midwives working between the hospital and the community for the very reason, it has been said, to keep the seamlessness of the service. A midwife also is trained and able to deal with all aspects of care, antenatal, intrapartum and post partum care. Supervisors of midwives in recent years plus managers have very much been encouraging the fact that the midwife utilises all her skills and works across the gamut of hospital and community. We really very much welcome this. If the emphasis is woman-based care rather than institutional then you are following it right across the span.

Chairman

962. Can you just clarify one point? This came up during the evidence that came before us during the evidence given to us from the RCOG. Do midwives carry resuscitation equipment when attending home births?

(*Miss Bryans*) Yes.

(*Miss Rider*) For the mother and the baby.

963. Another question, going back to some of your written evidence which you have given to the Committee, is it right that you support capitation fees for GPs caring for women of reproductive age? Can I ask your College whether you think this will enable more GPs to provide maternity care?

(*Miss Ashton*) I have no idea whether it will allow more GPs to provide maternity care. The issue in relation to the capitation as opposed to the item-for-item payment is that where there is the item-for-item

[**Chairman** *Cont*]
payment, the GPs are paid for specific activities of care, in other words antenatal care or post natal care. They are paid according to the fact that they have given an aspect of care. Maternity care is not to do with aspects of care. Maternity care is to do with the care of the woman from the beginning of her pregnancy until she has had her baby and until she and the baby are satisfactory post natally. If we had a capitation arrangement—and we have discussed this with the GPs—there would not be the same pressure on GPs to get their hands in there to make sure that they get the payment. We believe that their payment should be made for the type of contribution which they should make to women during their pregnancy and that then the actual care of the woman should be determined according to the professionals that should be involved. In that sense the mother would not be experiencing anything like a fragmented service. It becomes fragmented, if somebody has to get their hands on to get their money.

964. What reaction have you had to that proposal?

(*Miss Ashton*) The interesting thing is that the RCGP really supported what we were saying. We were quite surprised at this and asked why it was not possible therefore for the whole issue to be taken forward. Their answer was, "We do not negotiate terms and conditions," and that perhaps we could talk to the GMSC. That was their response.

965. The Royal College of Midwives?

(*Miss Ashton*) The RCGP suggested that we could talk to the GMSC. In fact I have a meeting with the GMSC at the beginning of January and this will be one of the subjects we shall talk about. It is a service, it is not a one-off hands on thing. That is really the point we were trying to make when we were talking about the need for general practitioners to be given a per capita, somehow determined by the number of child bearing people within their population. In that sense they would get the money. They would provide the service that they need to provide for the women and the affinity that they need to for the women, but the women will not get this fragmented approach, "I must get my hands on in order to get my money".

966. But have you any evidence to back up that proposal that you have put forward or is it just the grass root feeling of midwives that that sort of change in remuneration for GPs would provide a new focus of maternity care which would not only benefit the mother, but would enhance the image and role of the midwife?

(*Miss Ashton*) We have quite a lot of anecdotal evidence that that would make a considerable amount of difference. The people who are in the service know the difficulties that exist because general practitioners have to get their hands on in order to get their payment.

967. If you do have any anecdotal evidence and you feel it would be helpful to let us have it by way of a short note—the Clerk will probably criticise me for asking for further paperwork—but I think it would be very helpful to our Report.

Audrey Wise

968. I should like to ask two disconnected questions, just to make sure I get the second one in. The first is that the Committee and the people from whom we have been taking evidence have been stressing the importance of continuity of care. Can you tell us what effect the rather reduced working week compared to days gone by has on the ability of midwives to supply continuity of care? For example, will they be expected to have a long period on call? If they are, will they be willing to? If not, are there other ways which are efficient and which still provide continuity in organising the service?

(*Miss Brain*) In the good old days of the 1940s and 1950s, community midwives or district midwives as they were called then did work in partnerships and in groups. Although looking back on it many of us feel that they took the sole case and were on 24 hours a day, seven days a week, etc, they did work in groups, perhaps only in groups of two or groups of three. In order to accommodate the reduction in the working week, groups of midwives have to work together and therefore the woman would have to get to know more than one midwife. It would be unrealistic to pretend that one midwife per woman could be obtained for everybody throughout the United Kingdom. There would have to be groups of midwives, although there could always be a prime midwife for a particular woman.

(*Ms Page*) What is happening in practice is that we are being very flexible about the hours and we have fixed experimental schemes, team midwifery and even domino care in community teams. Although we recognise that there is a 37 hour week, we are flexible about it over several months. The midwives are willing and wanting to do this. They are wanting more professional practice rather than employment status so they will take their time back. They do not think that they have to work only 37 hours in this week, but will work it out often over a number of months. It is important to them that they get the professional satisfaction from doing that.

969. So you mean that if they are in the middle of dealing with a delivery they would prefer not to say, "I am sorry. I have finished now. Off I go." But they would prefer to see it through, provided they received adequate recompense in the way of time off in lieu?

(*Ms Page*) It is important too that the management changes, because these teams take a lot of responsibility for controlling their own work. If there are a lot of deliveries due they will have more people on duty, but they will take the time back when there are not many women delivering. There are always peaks and troughs in the service in the number of people delivering. They definitely would not want to walk out on the delivery of a woman.

970. I have heard it described as staffing the women, rather than staffing the wards?

(*Ms Page*) It is the midwife being with the mother when and where she is needed basically.

(*Miss Brain*) Midwives follow mothers, in the same way that money follows patients.

971. I hope rather better. Does the culture of the NHS normally allow for this flexibility or do you have instances where a midwife is delivering and is told to go rather against her will so that you have a

[**Audrey Wise** *Cont*]
change of shift anyway? Do you think that that is inevitable?

(*Ms Page*) No, it is not inevitable. I would say that we have two cultures operating at the moment and we are moving very quickly to the new culture. In the recent olden days, not the good old olden days, we had a situation where midwives were expected to work certain hours, where they were controlled, where there was a hierarchy. We are now moving to a situation where we recognise that we are professional practitioners and we will often make the choice. We are not stuck with rigid regimes, meal breaks and so on. The midwife has to take that responsibility and make that choice herself, and do so in partnership with the woman.

972. Do you think that midwives in general, or sufficient of them, are willing to move to that second culture?

(*Ms Page*) The younger midwives are longing to do it, and a lot of the older ones too. I think there are still some midwives who probably need to change in their thinking on it, but it is moving fairly fast.

973. My second disconnected question relates to breast feeding. It has been put to me by a recent mother that she was with two other mothers, all delivered about the same time. The other two were bottle feeding and she was breast feeding. They were in the same little unit and the pressure of being with two bottle feeding mothers was enormous because the kind of questions that were routinely asked, "How much has the baby taken?" and all that kind of thing seemed to be geared to bottle feeding. She felt that she could not give the kind of answer that seemed to be expected of her. She felt it was very discouraging. She felt that breast feeding mothers should be kept together to compare notes and work out their own problems and bottle feeding mothers should be kept together. Have you come across this problem before?

(*Miss Rider*) Yes, I think there is a problem sometimes, but I think there is a movement now within the education of midwives in preparation for breast feeding, that it is not like it was ten years ago when we were imparting information. We are actually trying to build the woman's confidence and having discussions with her about the problems that she will encounter. The resistance from husband, friends, partner, general public etc, so that she is facing up to these issues and makes a good informed choice and feels confident about facing up to all of these things when she actually commences breast feeding. The education of the mother to breast feeding has been looked upon in a much more holistic way, where as it is true to say it was quite didactic in the past.

974. I take that point and I welcome the comment, but the point which was specifically being made to me was not that it was pressures from society, but pressures from the hospital itself and the way expectation seemed to be geared—not intentionally probably. But because bottle feeding can seem to be more straightforward—you have this quantity of milk and will the baby take it or will the baby not—breast feeding seems to involve more subtle changes, more subtle needs and problems. The hospital did not seem to be geared to that. In fact it was put to me that any longer in hospital and she would have given up breast feeding.

(*Miss Rider*) One of the very good reasons when there is proper domestic support that the woman receives midwifery support at home and does not have to be in an institution, because as managers we have all tried very hard to make the post natal wards less like an institution, but we cannot get away from the fact that women watch each other and they do see midwives—who, by and large, are usually uniformed in a hospital—and the doctors in their white coats as the experts. That diminishes their own sense of confidence in themselves because they are seeing these experts around them and other people perhaps having bad experiences at that time. They do not see them three or four days later when they might be having good experiences.

Mr Hinchliffe

975. I have two very quick questions. You laid great emphasis on the need for improved continuing education for midwives. If additional resources are made available, would this be the best use of such scarce resources?

(*Miss Ashton*) If there is more money available for continuing education that is an excellent use of resources. Any education is an investment in the standards that you hope will appear subsequently. Money spent on education is always value for money. If the nature of your question is whether that value would be equivalent to the value of using that money elsewhere—-

976. That is the point. It is an either/or situation. If you had scarce resources would you direct it towards the education?

(*Miss Ashton*) It would depend on what else was to be given up. I think it is vitally important that the right amount of resource for education is made available for midwifery and for midwives. As I have said that is an investment in the quality of care that midwives provide. No profession finishes at the point at which the person has finished the first part of education and training. It has to go on. What we have been talking about today and what we talked about last time is that there is a tremendous amount of change taking place and we certainly hope that the Committee will be able to make some further recommendations about the types of change which must be seen within the maternity services. If change is to be brought about, the only way it can be brought about successfully, even if one has highly qualified people, is to invest some money in the change process. There must be money going into education and continuing education anyway. If we want to bring about change money is needed as an investment to produce change in the best possible way.

977. To continue with the education theme, in your evidence you state that it would now be appropriate to review the content and format of medical training in obstetrics? Why do you think that is the case and give us an idea of what you think the content and format of medical training in obstetrics should be?

(*Miss Ashton*) I think our concerns in relation to medical training are to do with the fact, particularly in the context of the hospital setting to date, very often the people in the learning part of obstetrics are

[Mr Hinchliffe *Cont*]
not being given the right kind of support and not being seen as learners. They are very often seen as actually having to act as if they were far more experienced than they are. As an organisation we believe and we hope that where medical training is concerned in obstetrics those people who are supposed to be there in a training capacity should be treated as trainees and should be given the right kind of support to enhance their skills and develop the competencies they need to become whatever they want to become.

978. So you are saying that they are thrown in at the deep end too soon? Is that the impression that you have?

(*Miss Ashton*) Yes, my colleague said this afternoon, what was it?

(*Ms Page*) See one, do one, teach one.

(*Miss Ashton*) I think sometimes that is what happens and certainly that is the experience. I think we are not alone in our experience. It is something that has also concerned our colleagues in the other two medical colleges. Perhaps what they are looking at in education will address that problem as well.

Mr Couchman

979. We heard from the RCOG earlier this afternoon that they could see no reason why midwives should not lead a team, but that the training consultant obstetricians have usually had tended to fit them better for these teams. I suspect one of the reasons for this is that perhaps the fear of increased litigation and that sort of thing has become more of a factor as to which of the two professions should or should not lead the team. In your view should the fear of litigation automatically lead to an increase in medical intervention in antenatal care, care during labour and birth and post natal care? If so, how can this increase in intervention be avoided?

(*Miss Brain*) It has been shown in America—one tends to think of America when one starts talking about litigation because of the problems that they have had—that where the woman knows her carer and has built up a good relationship over the months of the pregnancy there is much less litigation. In fact the organisation for midwives in that country, the American College of Nurse Midwives, have had very few of their members brought before the courts. That is one aspect of it that we would emphasise; that where the midwife gets to know the woman there is much less likelihood of litigation. You started off on the question of leading the team. I believe that at any one time—if you like to call it the leader of the team—it could be the midwife, the obstetrician or the general practitioner who will be the key worker for that woman. That person, of whichever profession, will take the lead for that woman.

980. My point was, is the leader in greatest jeopardy of litigation if things go wrong in those circumstances?

(*Miss Bryans*) No. The midwife is accountable for her own practice.

(*Miss Brain*) I do not see that it links to the litigation at all.

981. What are your views on a system of no fault compensation? Should that be available for medical accident?

(*Miss Ashton*) Our college has a policy of pressing for no fault compensation in the realm of obstetrics and midwifery. We take the view that a person having a baby who is damaged for whatever reason should not have to rely on the courts to determine whether or not they should get the sort of compensation they need. In our profession the person who acts wrongly is subject to the discipline of our statutory body and we believe that the profession should take responsibility for ensuring that professionals who do not undertake their professional work in the right way should be disciplined. We feel that it is very wrong that women whose babies are damaged for whatever reason have to wait until it is shown that somebody acted wrongly professionally before they are given the compensation.

Chairman

982. Did I understand you correctly a few moments ago? I therefore put the question to you. Are you saying that in the United States of America where the sole carer is an obstetrician the litigation is less of a problem? Were you saying that?

(*Miss Brain*) No. I referred, Mr Winterton, to the American College of Nurse Midwives which has over 4,000 nurse midwives practising in the United States of America in various states. I was talking about the litigation that those midwives have had to face.

Audrey Wise

983. Compared with American doctors?

(*Miss Brain*) Yes, that is right. One has to recognise that poor outcomes do occur in obstetrics, regardless of the very good care. That is important when one is looking at this. However good the care is there will, from time to time, be a poor outcome. The different and separate issue is the question of malpractice and how the professional organisations and statutory bodies cope with that.

Chairman

984. But in answer to this direct question—you may say it is loaded—if the midwife was given a greater role in maternity care, do you think the unsatisfactory outcomes would be more or less?

(*Miss Bryans*) Less.

(*Miss Brain*) Less.

985. So, by implication, you are saying that the midwife should be given a more important and enhanced role in maternity services?

(*Miss Brain*) Yes.

Mr Sims

986. Given that maternity services can expect their fair share of the increased resources to be allocated to the National Health Service as a whole, would you like to indicate where, within the service—education apart, which we have just discussed—you feel the priorities should lie? Would you favour, for example, more resources to home births or perhaps building up small local GP units? In particular you mentioned in one of your memoranda your feeling that the resources are skewed in maternity care by the perception of it dealing with critical rather than

[**Mr Sims** *Cont*]
normal births. Is this a shift you would like to see in resource allocation within the service?

(*Miss Rider*) The question of the allocation of resources has to be looked at in each individual district because each individual district is at a different stage and has developed different things. Obviously what we would like to see is the establishment of teams of midwives giving continuity of care for all the reasons we have given previously about greater satisfaction, less interventions and so on. In some districts additional resources for midwives may be required, but not all. I have introduced it in my own district without additional resources, so it will be give and take. Whether it is home confinements or domino deliveries, it really depends on the women within that locality. It is no good preparing for 50 per cent home confinement if that is not required.

One of the important things I feel we should consider is women's views of the service. As you probably know, the OPCS has produced a wonderful package exploring women's views, but it is very expensive to apply. We have just costed it in our district and it would cost us £50,000 properly to survey two hospitals, which is about 7,000 women. If we are to have a women-led service, in other words it is to be consumer-responsive, we have to have good surveys to establish, so those might be other areas that we might want to put resources into. But it really depends on each individual district and in each district you would get a different answer. We must not forget that we are not just talking about midwives. We are also concerned in some districts about the junior medical staff. We cannot see the way forward, even if they do shed some tasks on to the midwives. We still cannot see how some of the demands to get their right hours can be met without additional resources. I think it needs to be looked at very carefully.

(*Ms Page*) I should like to confirm what Anne Rider has said. The maternity service basically has to make the decision locally about the use of resources, but would like to confirm that it must be bottom up. There has been a disparate proportion of resources poured into high risk pregnancy. We do need money for the care of women who are having a normal healthy pregnancy. The decisions about the use of those resources have to be made jointly by the midwives and the doctors in those services and that is a very important point to make. Also those extra resources might help us to turn around systems like those which are very stressed and are experimenting with different organisations of care, but to turn round the whole system would be very difficult because we are feeling stretched at the moment. We might then be able to have more effective and efficient use of our resources like midwives.

Audrey Wise

987. Do you think that is what will happen, or do you think decisions will be made more by managers in any case, rather than either the doctors or the midwives? Has the Department of Health ever approached you, either in your capacity as a college or your individual capacities in your areas, for discussion about costings?

(*Ms Page*) There is now the most marvellous opportunity for discussion between purchaser and provider. Provided that it is set up well it will provide a very good mechanism for setting standards for the use of those resources and proper decisions about those resources. We just need to make sure about it. There is a danger and I fear what you have said, that the decisions might be made by managers who are not professionals. In reality that is sometimes happening. But if we can have legitimate support from our College about using these resources and the Department of Health, it would be helpful.

(*Miss Bryans*) I want to add that the Department of Health has just funded a one year scheme in which the College is involved looking at all the team midwifery schemes and continuity of care schemes within the country. The information coming back from that—although it is a year away before the results will come—will be very interesting to look at and possibly some information on costing, how different schemes can be implemented. You are talking about managers. We asked a large number of very senior midwifery managers recently whether, if they had the opportunity to change the direction of how the care was to take place—larger community based teams, midwife case loads, the midwife to the fore in the normal—they would be willing to work with that and facilitate it. It was a most encouraging response. Obviously they will have to look again at their budgets and relook at their care, but from that level of management there was a willingness. We believe overall that if we could address the duplication of roles and use the midwife for so much of the normal properly and look at the skill mix in its fullest context, we could end up making it very cost effective. There may be some resources needed probably to start with for the management of the change.

988. But when we discuss this we are always told, "Well, after all 70 per cent of the births are delivered by midwives anyway, so what are you talking about when you say that midwives should have an enhanced role?" What is the difference between 70 per cent of the births being delivered by midwives and the kind of things that you are advocating?

(*Miss Bryans*) It is all to do with continuity.

(*Ms Page*) What we are talking about when we say 70 per cent of babies being delivered by midwives, is often the midwife who only works in the delivery suite, who makes contact with that mother when she is in advanced labour, who does not know her as a person and who says goodbye to her after she has given birth to her baby, never to see her again. What we are talking about is midwives in a position where they can make policies for the maternity services in collaboration with their medical colleagues, and actually direct and lead those policies and the organisation of care and the use of resources.

Mr Sims

989. But you are saying that the initiative for those policies should come locally and not be imposed from the centre?

(*Ms Page*) There are two things. First, they have to come locally, but there has to be a drive at a national level and from the College level to make this kind of reorganisation and change legitimate. That will help

[**Mr Sims** *Cont*]
people like myself and Anne Rider who are trying to move forward these changes. It will give them some legitimacy.

(*Miss Bryans*) Also there is information from the National Perinatal Epidemiology Unit in Oxford which talks about continuity of care and low intervention leading to better outcomes. We might be able to increase the numbers of normal if we had a change in the type of care.

(*Ms Page*) May I add a really burning issue which has been burning away in me since the obstetricians were speaking? There was a lot of emphasis on the need for facilities for women who are giving birth. One of the most important things is a midwife present with the woman when she is in active labour. There are a lot of myths about hospital services and even the best teaching hospitals cannot always provide one to one care for a woman in active labour. When we look at the allocation of resources, we tend to look at very fancy facilities, but the most important thing is the midwife who monitors the health of the mother. Any kind of technology depends on the clinical judgment of that midwife and her interpretation of the results. It is terribly important to remember that.

Chairman

990. I have four questions that I want to put, Miss Brain. Can I suggest that I put the questions one by one and as I have put the first question, will you then allocate one member of your team to answer that question? First, the Maternity Services Advisory Committee *Maternity in Action*. There is a statement in these documents—and I refer specifically to chapter 7 on intrapartum care—"As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are readily available". As far as I know, you do not draw attention to this. Is this because you believe it is still valid and do not want that advice to be reversed?

(*Miss Bryans*) We would very much question that statement at this time on the point of view of choice. Advocating 100 per cent hospital confinement is not giving the consumer the full choice about where the baby can be born. Secondly, we question it on a real look at the evidence. In the work previously from the Oxford unit *Where to be born* by Alison Macfarlane, Marjorie Tew's work and very interesting work that is coming out of Nottingham where a very large audit has been done on midwife-led care and home confinements. The perinatal mortality rates in some cases show better outcomes and certainly no worse with home versus hospital. We have to say that we want the choice and the evidence looked at in a new way. We would not go along with that point.

991. The next question falls to you, Miss Bryans. Do you feel that if a mother has a home birth, there should be at least two midwives present: one to care for the mother and the other to care for the baby if it has, for example, breathing difficulties or problems?

(*Miss Bryans*) In some local policies it is thought it is better to have two present, perhaps a midwife and a student, so that if assistance is needed someone can go for the telephone. But is not a requisite. My colleague referred earlier to staffing problems within hospitals where there are not always two people present at the birth. We would say it is desirable, especially for a senior student, to see the normality and to be the back up, but it is not essential to have two midwives present. However, it is desirable to have an assistant.

992. It is desirable. In the latest memorandum to the Committee you mention "the baby" only once. Does this suggest that midwives are concentrating on the outcome of a pregnancy exclusively in the terms of the mother's experience and failing to give adequate attention to the risk to the baby? Are you happy that midwives are properly trained in the resuscitation of new born babies and in the recognition of illness and if not what should be done about it?

(*Miss Brain*) I think it just shows that we think of mother and baby as one family unit.

993. An excellent political answer!

(*Miss Brain*) I then move the question to someone else, having earned my gold star.

(*Ms Page*) Yes, we certainly expect all midwives to be trained in the resuscitation of the new born baby. We often use a shorthand language because when we talk about being with the mother and caring for the mother, we are also talking about looking after the mother in the context of her family and recognising the importance of a healthy baby.

(*Miss Brain*) You asked whether we were trained to look after the ill baby. The answer to your question must be yes and particularly that midwives are trained to spot the abnormalities. If the baby is not thriving normally, then they are trained to spot that and refer to appropriate medical advice.

994. My final question may put the cat among the pigeons. It might be possible to read much of your evidence, and the comments which surround it, as suggesting that the RCOG take an almost entirely obstructive attitude towards developing the profession which you represent, that of the midwife. What has the Royal College of Midwives done to smooth the negotiations between the relevant professional bodies? Do you acknowledge the justice of the RCOG's claim that the involvement of obstetricians in normal births is a central part of their professional experience? Or do you think that this is equivalent to claiming that surgeons should make a habit of regularly removing healthy limbs and organs?

(*Miss Brain*) I am not sure which is the cat and which is the pigeon, now. First I would like to say that the two Royal Colleges are not at each other's throats, or whatever phrase you actually used. Certainly at national level we work very closely together and share many of the philosophies of care. However, we have to face the reality of life, which is that out there—I nearly said "in the sticks", but you might think of the wrong place—in the field at service level there are problems in certain areas. It would be unjust if we did not face up to that. I believe that one of the roles of the two Royal Colleges at national level is to assist local people to get together and to sort out some of these very real problems.

995. You are President. You may have the last word, but do any of your colleagues wish to add to that extremely adept and constructive political comment?

[**Chairman** *Cont*]

(*Miss Bryans*) It would be much easier for midwives working out local protocols and getting agreements if there is a shift of emphasis from the centre and nationally. In some areas local protocols and the role of the midwife are taken well forward and in others it is quite difficult, so if there is a national shift it would make local negotiation much easier.

996. Giving you the last word, Miss Brain, can you say, unlike the RCOG, what you have done to smooth negotiations between the relevant professional bodies?

(*Miss Brain*) I believe that by coming together at President level the three Royal Colleges are working together to work out some of the perceived problems and working together to recognise each other's roles so that we all work together for the good of the women. As far as the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists are concerned we have a joint standing committee set up in 1988 with the aim of looking at those issues at service level which are causing problems so that they can be sorted out. I believe that the Royal Colleges have done considerable work to raise these issues and solve the problems.

997. What have you done particularly in your own role as a Fellow of the Royal College of Obstetricians and Gynaecologists? Or have I put you in an embarrassing position?

(*Miss Brain*) I have been a midwife for some 35 years and throughout that time I have worked very closely with obstetricians in this country and abroad. I have always recognised their expertise in obstetrics and I believe they have recognised my expertise in midwifery care. I am a very young Fellow. I have only been a Fellow since June and I shall continue to work closely—

998. Maybe, Miss Brain, they have compromised you!

(*Miss Brain*) Certainly not! I shall continue to work closely with the Royal College of Obstetricians in the interests of the women of this country.

999. So perhaps on behalf of the Committee I can say that we look forward to seeing a report in which the role of the midwives is properly recognised by the other Royal Colleges.

(*Miss Brain*) I am sure you will.

Chairman: To you, Miss Brain and your colleagues, and to our other witnesses today I say thank you very much for coming before us. It has been very helpful indeed.

WEDNESDAY 20 NOVEMBER 1991

Members present:

Mr Nicholas Winterton, in the Chair

Sir David Price
Audrey Wise
Rev Martin Smyth

Memorandum submitted by Professor Malcolm Levene, Head of Department of Paediatrics and Child Health, University of Leeds.

Management of Infertility and Implications for Neonatal Care

This Memorandum has been prepared from data collected by myself and Prof Philip Steer on behalf of the British Association of Perinatal Medicine. I hold a Chair of Paediatrics at the University of Leeds and have an Honorary contract with the Health Service as a Consultant Neonatologist at the Leeds General Infirmary. I am also Honorary Secretary of the British Association of Perinatal Medicine (BAPM) and was the organiser of a one year study to ascertain all the triplet and higher multiple births occuring in Britain in the calender year 1989. This project was commissioned by the BAPM, but this Memorandum is written as an individual and does not necessarily represent the views of the BAPM. The results have been submitted as a full paper to the British Medical Journal, but as it has not yet been published it is not possible to send the Committee a copy. This Memorandum summarises the important points arising from this study.

1. The remit of this project was to ascertain the significance of assisted reproduction in the increasing numbers of triplets, quadruplets etc which will be referred herein as higher multiple births. It has been noted for several years that the numbers of higher multiple births have been increasing steeply. Between the two quinquennia 1961-65 and 1981-85 there was a 13 fold increase in the number of pregnancies comprising four, five or six fetuses (1). The shortfall of facilities for neonatal intensive care in the United Kingdom (2) makes it very difficult to plan for the delivery of higher multiple births and widespread use of methods for assisted reproduction appear to be contributing to this problem.

2. All Consultant Paediatricians were circulated every month for one year (1989) with a card asking them whether they had been involved in the paediatric care of triplets or higher multiple births delivering after 22 weeks of gestation. Those giving a positive response were then asked to complete a questionnaire and were also asked to send a second and third questionnaire on to the Consultant Obstetrician responsible for the antenatal care and, if appropriate, the Gynaecologist responsible for the treatment of infertility.

3. We were informed of 143 sets of triplets, 12 quadruplets and one quintuplet set (482 babies delivered). Of the 156 pregnancies, 47 (31 per cent) were spontaneous, 52 (34 per cent) had ovarian stimulation (usually with clomiphene and/or gonadotrophins), 37 (24 per cent) had in-vitro fertilization (IVF) and 17 (11 per cent) were treated by Gamete Intra-fallopian Transfer (GIFT). All 13 pregnancies delivering quads and quins followed assisted reproduction.

4. The majority of triplets and higher multiple births occurring after assisted reproduction were treated in District General Hospitals by Gynaecologists not specialising in infertility. Ultrasound monitoring of follicular development (assessment of the number of eggs produced by the drug stimulation) was used in less than half the cases where ovarian induction was undertaken by means of drugs alone. In some cases very high doses of stimulating drugs were used.

5. In five cases where we were told of the number of ova replaced during the IVF treatment four ova were inserted, but in 15 cases the Gynaecologist would not tell us of the number of ova inserted. This study was undertaken before the Human Embryology and Assisted Reproduction Bill was enacted and hopefully this will not happen in the future.

6. The GIFT technique requires relatively low technology and I believe will become more widely used. In 10 of the 17 cases where the Gynaecologist told us of the number of ova (eggs) inserted, four or more were replaced. This led to seven sets of triplets and three sets of quadruplets.

7. The Medical Research Council (3) has recently reported that 80 per cent of all GIFT and IVF pregnancies in Britain occurred after treatment in just three centres; all of which operated outside of the National Health Service. Those babies who require intensive care and who have been conceived by treatment in private institutions apparently all received care in cots funded by the NHS.

8. One recent study (4) found that only 53 per cent of women undergoing assisted reproduction undertood that multiple birth was a possibility. It is clear that apart from the medical problems associated with multiple pregnancies there is considerable social and financial cost to the families into which these babies are born (4).

9. I urge the Committee to consider the following points with reference to the problems of increasing numbers of higher multiple births due to assisted reproduction:

i. Infertility should be managed only by Consultant Gynaecologists trained in this area and who have access to all the appropriate facilities required. The organisation of infertility treatment should be on a Regional and Sub-regional basis so that every family has access to an infertility centre close to their home town. It should be the responsibility of the Royal College of Gynaecologists to monitor the training and service.

ii. Infertility centres should be in hospitals where there are adequately provisioned Neonatal Intensive Care Units. These Units should have enough capacity in terms of cots and equipment to be able to offer intensive care facilities to three, four or more babies at one time which will avoid the need to break up siblings of the multiple group and sending them to different hospitals for care.

iii. A counselling service should be offered to all couples prior to the onset of infertility treatment to inform them of the risks of higher multiple births and all that it entails.

iv. Consideration should be given to a requirement that all private infertility centres take out some form of insurance to pay for neonatal intensive care in NHS hospitals which may be required for the infants born following these methods of treatment.

v. That GIFT be regulated under an Act of Parliament similar to (or incorporated into) the Human Embryology and Assisted Reproduction Act and that the number of ova replaced be strictly prescribed.

REFERENCES

1. Levene MI. Grand multiple pregnancies and demand for neonatal intensive care. Lancet 1986;ii:347-8.

2. Report of the Royal College of Physicians. Medical care of the newborn in England and Wales. London, 1988.

3. MRC Working Party on Children Conceived by In Vitro Fertilisation. Births in Great Britain resulting from assisted conception, 1978-87. Br Med J 1990;300:1229-33:

4. Botting BJ, Macfarlane AJ, Price FV, eds. Three, four or more. A study of triplet and higher order births. London: HMSO, 1990.

Memorandum submitted by the British Association of Perinatal Medicine

The BAPM has for 15 years represented the opinions of paediatricians, obstetricians and other nursing and allied professions involved in the care of the mother and her newborn baby. The organisation has not only provided a forum for the exchange of new ideas, but provided teaching seminars for junior staff and guidelines for practice. At present it is also engaged in setting up a national network of units willing to participate in multicentre research projects. The views expressed below are of the current President, Professor R.W.I. Cooke, Professor of Paediatric Medicine, Liverpool, the Secretary, Professor M. Levene, Professor of Child Health, Leeds, and the national executive of the BAPM.

Introduction

The results of perinatal care have improved greatly in the United Kingdom in the past decade, due to improved techniques, improved staff training and better organisation of provision of services on a national and regional basis. This improvement was, however, from a fairly poor baseline, as expectations of the general public, and even many professionals were very low. With a better understanding of what can be achieved for even very preterm infants, these expectations have grown, and the services are stretched to meet them in many areas of the country. The introduction of new techniques such as surfactant therapy substantially reduces mortality amongst the smallest infants, but will paradoxically then increase the need for intensive care for these survivors in their first weeks of life.

Structure of perinatal care

1.1 The BAPM guidelines on levels of equipment and staffing (Appendix I) need to be accepted as the norm in order to help 'purchasers' ensure that 'providers' are able to meet adequate care standards. In addition, 'purchasers' should ensure that 'provider' units at regional and sub-regional level have an annual throughput which is large enough to ensure that staff can both acquire experience and maintain long term intensive care skills. All units where babies are born must continue to be able to provide short-term intensive care facilities.

1.2 Although there is some evidence to show that providing neonatal intensive care is more expensive in smaller units, transfer of such services to larger units may not be more economic as much of the costs may be fixed rather than marginal. Small general practitioner units have a place in maternity care, provided that patients have been properly assessed for risk at booking. It is essential, however, that clear guidelines exist for

emergency transfer if needed, and that the staff are fully trained and regularly updated in infant resuscitation techniques.

1.3 It will be important to retain and develop a regional strategy for perinatal care, to ensure provision of appropriate specialist services such as genetic antenatal diagnosis and counselling, and neonatal intensive care for the extremely preterm. A regional perinatal group should also audit overall outcome and highlight deficiencies in the regional perinatal programme.

1.4 With the rapid development of the specialty, staff working in district hospitals need to be kept aware of what can be offered in terms of antenatal diagnosis and therapy, and post-natal care. A regional perinatal group should have the responsibility of publicising new developments and monitoring their uptake by district hospitals.

1.5 It is often necessary to transfer infants and their mothers before or after birth for their care, and delays often occur. The establishment of a clearly defined route of referral for each district hospital would reduce the likelihood of such delay.

1.6 A proportion of nursing shortage is related to the use of nursing staff for non-nursing tasks such as clerical and cleaning duties, and in trying to get defective equipment to work. The use of ancillary and technical staff (at lower cost) for such duties frees nursing time to be used in direct patient care.

Giving Perinatal Care

2.1 Pilot studies have recently provided data on the actual amount of nursing time that is needed to provide intensive and other care to sick newborns, and these can provide a factual basis upon which staffing numbers and skill-mix can be based. By modifying the latter it may sometimes be possible to improve care provided without substantially increasing the numbers of staff.

2.2 The suitability of the neonatal nurse practitioner for certain roles should be explored. Such roles could included management of ventilator care, intubation, dialysis etc; and the direction of research projects. Nursing objections to such a grade are largely based on the lack of nursing staff at present in many units. The grade could enhance the continuity of skills available in a unit, which at present fluctuate due to frequent staff changes, and provide a role for the experienced neonatal nurse who wishes to retain maximum patient contact rather than move into management.

2.3 There is a need to ensure that the introduction of new medical techniques and treatment occurs only after they have been carefully evaluated by adequately designed trials. This would be facilitated by the further development of the BAPM/NPEU clinical trials group. Recent successful trials on the use of surfactant, steriod therapy for chronic lung disease, and ventricular tapping for hydrocephalus have been completed. There is a danger that "glamorous" but inadequately evaluated therapies such as "ECMO" will be offered by Trust hospitals, consuming scarce resources but without significantly improving outcome.

2.4 While there is no scientific reason to limit the availability of full intensive care to infants above a specific gestational age, the results in terms of survival, outcome and economics will be poorer at the lowest extremes. A case can be made for limiting care to infants in this category to a number of major centres where, suitably funded research could determine the optimal approach to their management.

The Outcome of Perinatal Care

3.1 There remains a need for a basic but standardised form of follow-up on a national scale for all infants. Expansion of an obligatory minimum data set within the Korner system if fully and uniformly applied would go a long way to achieving this. Because of a lack of central government interest, the Korner system was unevenly implemented, and is widely discredited by clinicians. The structure still exists, and with interest and care, perhaps from regional perinatal groups, could be made to work. The BAPM is prepared to assist in advising on items which should be incorporated in such a system.

3.2 The outcome for "high-risk" infants needs to be evaluated in a more structured way in order to avoid missing hearing loss, visual and speech defects until a late stage.

3.3 For the minority of survivors who have ongoing disabilities, clear provision needs to be made within current services for the disabled. Often the "hand-over" from neonatal unit to paediatric services needs to be improved.

APPENDIX I

REPORT OF WORKING GROUP ON CATEGORIES OF BABIES REQUIRING NEONATAL CARE

There should be four levels of care; intensive care, high dependency care, special care and normal care.

Definitions of Neonatal Care

Intensive Care

Care given in an intensive care nursery which provides continuous skilled supervision by qualified and specially trained nursing and medical staff.

High Dependency Care

Care given in a special care nusery which provides continuous skilled supervision by qualified and specially trained nursing staff who can care for more babies in high dependency than intensive care. Medical Supervision is not so immediate as in intensive care.

Special Care

Care given in a special care nursery transitional care ward or postnatal ward which provides care and treatment exceeding normal routine care. Some aspects of special care can be undertaken by mothers supervised by qualified nursing staff.

Normal Care

Care given by the mother or mother substitute requiring minimal or no medical or neonatal nursing advice.

Clinical Categories of Neonatal Care

Intensive Care

Intensive care should be provided for these babies:

1. Receiving assisted ventilation (including intermittent positive airway pressure, intermittent mandatory ventilation and constant positive airway pressure and in the first 24 hours after its withdrawal).
2. Of less than 27 weeks gestation for the first 48 hours after birth.
3. With a birthweight of less than 1,000 grams for the first 48 hours after birth.
4. Who require major emergency surgery for the pre-operative period and post operatively for 48 hours.
5. On the day of death.
6. Being transported by a team including medical and nursing staff.
7. Who are receiving peritoneal dialysis.
8. Who require exchange transfusions complicated by other disease processes.
9. With severe respiratory disease in the first 48 hours of life requiring an Fi02 of > 0.6.
10. With recurrent apnoea needing frequent intervention, for example over five stimulations in 8 hours or resuscitation with IPPV two or more times in 24 hours.
11. With significant requirements for circulatory support, for example ianotropes, three or more infusions of colloid in 24 hours, or infusions of prostaglandins.

High Dependency

High dependency care should be provided for babies:

1. Requiring total parenteral nutrition.
2. Who are having convulsions.
3. Being transported by a trained skilled neonatal nurse alone.
4. With arterial line or chest drain.
5. With respiratory disease in the first 48 hours of life requiring an Fi02 of 0.4-0.6.
6. With recurrent apnoea requiring stimulation up to five times in an 8–hour period or any resuscitation with IPPV.

7. Who require an exchange transfusion alone.
8. Who are more than 48 hours post-operative and require complex nursing procedures.
9. With tracheostomy for first 2 weeks.

Special Care

Special care should be provided for babies:

1. Requiring continuous monitoring of respiration or heart rate, or by transcutaneous transducers.
2. Receiving additional oxygen.
3. With tracheostomy after first 2 weeks.
4. Being given intravenous glucose and electrolyte solutions.
5. Who are being tube fed.
6. Who have had minor surgery in the previous 24 hours.
7. Who require terminal care but not on the day of death.
8. Being barrier nursed.
9. Undergoing phototherapy.
10. Receiving special monitoring (for example, frequent glucose or bilirubin estimations).
11. Needing constant supervision (for example, babies whose mothers are drug addicts).
12. Being treated with antibiotics.

RESOURCES REQUIRED FOR NEONATAL CARE

Staffing

The BPA recommendations and the Neonatal Nurses Association guidelines for staffing levels are as follows but are subject to local conditions and are not, as yet, founded on research on dependency levels. On presentation of appropriate research these may require amending.

Nursing Staff

Trained Nurses hold RGN, RM, RSCN or EN. Qualified Nurses hold a certificate in Intensive Care of the Newborn eg English National Board Course 405, 409, 904, 904A certificate or Joint Board of Clinical Studies certificate ie 400, 401, 402.

Intensive

5.5 nurses (wte) qualified and trained per cot

High Dependency

3.5 nurses (wte) qualified and trained per cot

Special Care

1.0 nurses (wte) qualified per cot

Medical Staff

Intensive

Minimum medical staffing should consist of both an experienced paediatric registrar and senior house officer on duty and available in the intensive care area at all times with an appropriately trained consultant in charge.

High Dependency

An experienced senior house officer on duty and available in the high dependency area at all times with a more senior member of staff on call and a consultant paediatrician in charge.

Special Care

Minimum medical staff for 24 hour cover: an appropriately experienced senior house officer on duty, an experienced more senior member of staff on call, and a consultant paediatrician in charge.

Equipment

The BPA recommends the following equipment:

Intensive

The following equipment must be available for each baby:

Intensive care incubator, or unit with overhead heating (1)

Respiratory or apnoea monitor (1)

Heart rate monitor (1)

Intravascular blood pressure transducer or surface blood pressure recorder (1)

Transcutaneous PO2 monitor or intravascular oxygen transducer or saturation PO2 monitor (1)

Transcutaneous PCO2 monitor (1)

Syringe Pumps (2)

Infusion pumps (2)

Ventilator (1)

Continuous temperature monitor (1)

Phototherapy Unit (1)

Ambient oxygen monitor (1)

Facilities for frequent blood gas analysis using micromethods.

Facilities for frequent biochemical analysis including glucose, bilirubin, and electrolytes by micromethods.

Access to ultrasound equipment for visualisation of organs such as the brain.

Access to equipment for radiological examination.

Transport incubator with transport ventilator.

High Dependency

Same as Intensive Care without a ventilator

Special Care

The following equipment must be available for each baby:

Incubator or cot adequate for temperature control (1)

Ambient oxygen analyser (1)

Apnoea alarm (1)

Heart rate monitor (1)

Infusion pump (1)

Phototherapy unit (1)

Ventilator to be used for short term ventilation (1)

Access to frequent blood gas analysis using micromethods

Access to biochemical analysis (including glucose, bilirubin, and electrolytes) by micromethods.

Access to equipment for radiological examination.

Special care may take place on a postnatal ward, particularly in an area specially set aside for the purpose.

Revised *January* 1991

Memorandum submitted by the British Paediatric Association

1. INTRODUCTION

1.1 The British Paediatric Association is established to advance, for the benefit of the public, education in child health and paediatrics and to relief sickness by promoting the improvement in paediatric practice. The Association promotes paediatric research and pubishes the results of such research, it organises scientific meetings including a major annual scientific meeting, it advises Government and other professional bodies on problems of child health and works closely with the Royal Colleges of Physicians both through the Joint

Paediatric Committee of the Royal Colleges of Physicians and in its representation on the paediatric committees of the Royal Colleges of Physicians.

1.2 The BPA has a membership of virtually all consultant paediatricians within the United Kingdom. Most trainees within the specialty are members and also included in its membership are many senior doctors working in the child health services together with consultants in other specialties which treat children for example paediatric surgery or radiology.

1.3 The BPA has many standing committees and joint committees including the Standing Committee of the BPA and the Royal College of Obstetricians and Gynaecologists which is separately producing a response which the BPA supports. The BPA has very close links with the specialty groups within paediatrics including the British Association for Perinatal Medicine.

2. British Paediatric Association Detailed Comments to Inquiry

2.1 The BPA notes the terms of reference of the House of Commons Health Committee

> "To enquire into maternity services to determine the extent to which resources and professional expertise are used to achieve the most appropriate and cost effective care of pregnant women and delivery and care of newborn babies".

2.2 The response from the British Association for Perinatal Medicine is attached as Appendix B to this response and is supported and commended by the British Paediatric Association.

2.3 Background: Consultant Obstetric Units

Although some babies are born at home and in GP maternity units most babies in Britain are born in consultant obstetric units (approximately 85 per cent of which have 2,000 or more deliveries per year). (See Appendix A). The majority of the consultant obstetric units are located in district general hospitals but some are located in major regional centres where regional neonatal intensive care is carried out. All of the babies born in consultant obstetric units require paediatric medical care during the newborn period, (some very urgently and frequently unpredictably at birth in order to resuscitate—even in apparently uneventful pregnancies and labours). Some of the babies require *special* care and a small proportion of the babies require *intensive care* (see the BAPM document).

Therefore all consultant obstetric units should have paediatric medical staffing and facilities must be present in all for immediate resuscitation at birth and for short term intensive care which will be required while awaiting the transfer or collection teams when needed from the regional or subregional neonatal intensive care unit where longterm intensive care is carried out.

A proportion of babies are of course born in the hospital where regional neonatal intensive care is carried out. Some of these are babies who are resident in the district served by the consultant obstetric unit which is associated with the regional neonatal intensive care unit but is providing district services to that population. Some however will have been from high risk mothers transferred for their care from other districts because of anticipated problems with the labour or delivery or in the newborn baby (for example very premature or multiple births, babies suffering from haemolytic diseases of the newborn or where a condition requiring paediatric surgery or other intensive care therapy has been identified before birth and where a period of intensive care is expected).

2.4 Much antenatal care and some neonatal care is of course provided by general practitioners in general practitioner units and also, most importantly, following hospital delivery of patients when they are cared for in their homes. General practitioners also occasionally undertake home delivery and immediate newborn care. The BPA's comments which follow relate specifically to those services not provided by general practitioners and largely relate to hospital based services.

2.5 The care of newborn babies is provided by professional staff (medical, nursing and other professional staff) within the hospital based services.

Paediatric medical care for newborn babies is provided by consultant teams in a hospital based service supported by appropriate junior medical staff. Much neonatal care therefore is provided by paediatric medical staff as part of their multiple responsibilities that is: admissions for paediatric medicine and day care; outpatient paediatric medical practice; work in the Child Development Centre with chronically sick or disabled children; consultations in the A + E Department; and work within the community.

The hospital and communnity based child health services provide for the health needs of children other than those services which are undertaken by general practitioners. These services are:

— Acute services able to respond immediately to the needs of the acutely ill or injured child and the newborn infant

— Preventive services such as immunisation, vaccination and child health surveillance; school health services

— Services for the chronically disabled or ill child

— Services for health needs arising from disadvantage or deprivation

2.6 Hospital Based Paediatric Services

Children should receive their care in a comprehensive children's department in a District or in a Regional Centre which incorporates the following: inpatient, day patient and outpatient facilities for children and maternity and neonatal services including short term intensive care in all District Health Authorities and long term intensive neonatal care in some. This service should be available on the same hospital site as the comprehensive Children's Department.

3. Perinatal and Neonatal Care

Consultant paediatricians are, together with associated junior paediatric medical staff, responsible for:

— the provision of resuscitation services for newborn babies—a responsibility and requirement throughout the 24 hour period. Paediatric medical staff will attend deliveries of low birthweight babies and babies demonstrating foetal distress or where complicated labour or caesarean section takes place. The medical staff must be available for the unexpected requirement of a newborn baby for resuscitation and therefore need to be resident at the site of delivery.

— the examination of all newborn babies at least once and often twice after birth, including advice on infant care given to parents of healthy newborn infants.

— the detection and management of many problems which arise in otherwise healthy newborn babies (eg jaundice, infection, hypoglycaemia).

— the detection and management of congential abnormalities and serious illnesses (and where appropriate, in collaboration with the Consultant Obstetrician, for ante natal counselling and planning of delivery for disorders affecting the foetus).

— the provision of short term intensive care in all District maternity units and, in some, for long term neonatal intensive care.

— for follow up of children—sometimes over many years—who have presented with problems in the newborn period. (This may beneficially be undertaken in a community setting).

It is important to stress that a substantial acute emergency workload arises from maternity and neonatal units and labour wards even if long term intensive neonatal care is not carried out in that hospital.

4. Paediatric Medical Staffing Issues

4.1 From the above detail it will be seen that paediatric neonatal care is provided within the context of a child health service. However, in larger units, especially in the regional neonative intensive care unit, the staff will be fully committed to neonatal intensive care but also may have additional responsibilities in the form of teaching undergraduate and postgraduate students, research etc. The effectiveness of the service and the satisfactory improvement in the prognosis in terms of mortality and morbidity in newborn babies has been achieved partly by an improvement in the training and experience and numbers of paediatric staff at junior and senior level over the prior decade. However, the further developments in the care of the newborn baby have produced additional workload and the service is now maintained at a cost of excessively burdensome work falling both upon junior medical staffing (this has achieved much publicity lately) and upon the senior doctors involved in such care. The hidden personal costs of this excessive work burden should not be underestimated. The BPA is concerned about the shortfall of adequate numbers of consultant paediatricians to meet this workload and also upon the shortfall in adequacy of numbers and experience in junior medical staff who have to be resident in order to provide resuscitation and other aspects of newborn care.

4.2 The BPA is also concerned at a shortfall in sufficient numbers of training posts in paediatrics to meet the necessary expansion which will be required over the next ten to fifteen years. The present consultant numbers specialising in neonatal care in England and Wales are 63 and the future need is 125. (See recommendations in "Paediatric Medical Staffing for the 90s".) For general paediatricians providing for care at a district (or provider unit) level, the present consultant staff amount to some 570 and the future need is for 1,100-1,500.

4.3 Evidence for the excessive workload falling upon junior medical staff in paediatric units is present in "Patterns of Hospital Medical Staffing, Junior Doctors Hours", Robin Dowie, British Postgraduate Medical Federation, 1989. The advised staffing levels for the future needs of paediatrics are given in Appendix C attached which is a BPA document "Paediatric Medical Staffing for the 90s" (not reported).

5. Impact of Neonatal Care Developments on Paediatric Services

5.1 The improvement in survival of extremely low birth weight babies has produced certain consequences for paediatric services for the infants following the neonatal period.

5.2 Some infants require long term low flow oxygen therapy at home for many months. Nursing and medical supervision at primary and secondary care levels is needed.

5.3 Some infants, following successful neonatal intensive care, have a substantially increased admission rate later to paediatric wards for the treatment of respiratory infections. Often such infants require fairly high dependency care (as do other babies) on the children's wards; and nursing staff levels and appropriate monitoring equipment should be available on those wards.

5.4 Long term follow up of small babies requires repeated assessment of nutritional status, visual and hearing competence, supervision and assessment by physiotherapists, speech therapists and psychologists in Child Development teams to ensure early detection of developmental problems which occur more often in small babies than in term babies.

6. Conclusion

The last 12 to 15 years has shown a substantial and gratifying improvement in perinatal mortality and in the adverse consequences of events in the immediate newborn period. This has led also to a reduction in morbidity in survivors of neonatal intensive care. Such rapid improvements in morbidity and mortality, especially amongst the babies of low birth weight, are largely due to improvement in obstetric and perinatal management. There is however evident variability in outcomes between different units and this relates both to the socio-economic circumstances within districts but also to the organisation of perinatal services which should meet the standards detailed in the response from the British Association for Perinatal Medicine (BAPM). Every effort should be made to ensure that where babies are cared for, the services meet the required standards in terms of staffing and in equipment. This should lead to a reduction in variability of prognosis for newborn babies and for further improvements in the measures of outcome of perinatal paediatric care.

April 1991

APPENDIX A

1989

NUMBER OF MATERNITIES

REGION OF RESIDENCE	< 1000	1000-1999	2000-2999	3000-3999	4000-4999	5000 +
Northern	1	5	6	3	1	0
Yorkshire	0	4	8	1	3	1
Trent	0	1	1	4	2	4
East Anglia	0	1	2	3	1	1
NW Thames	0	0	2	7	3	1
NE Thames	0	2	1	9	3	1
SE Thames	0	1	4	8	0	1
SW Thames	0	2	8	2	2	0
Wessex	0	2	2	2	1	3
Oxford	0	0	2	2	1	3
South Western	0	1	3	2	3	2
West Midlands	0	3	7	5	4	2
Mersey	0	1	5	1	2	1
North Western	0	3	6	9	1	0
All English Regions	1	27	57	59	27	20
Wales	0	2	2	0	1	4

APPENDIX D

Standing Joint Committee of the
British Paediatric Association and the
Royal College of Obstetricians and Gynaecologists

RESPONSE TO PARLIAMENTARY SELECT COMMITTEE ENQUIRY INTO MATERNITY SERVICES—INTRAPARTUM CARE

1. The current number of intensive care cots and support staff is insufficient to support the number of babies that could reasonably benefit, particularly in the light of the recent dramatic increase in the number of higher order births, and the availability or surfactant treatment which can be expected to increase the number of normal survivors.

2. This committee is concerned about the deterioration of the standards of statistical reporting of maternity events at a national level in the United Kingdom, for example birthweight, Caesarean section. Without this information, the impact of changes in practice cannot be assessed.

3. The committee feels that labour ward staffing is still neglected and that in general the numbers and seniority of obstetric, anaesthetic and paediatric staff available is inadequate. Urgent attention needs to be paid to the quality and continuity of training of junior medical staff and the number of consultants needs to be increased.

4. As perinatal care develops, it is important that techniques and/or technologies are properly evaluated as regards their efficacy and cost effectiveness. Such evaluation requires properly designed research, including muli-centre studies. We consider that managers should be asked to allow for such research in their financial planning.

5. It is important that all professionals responsible for intrapartum care be appropriately trained in neonatal resuscitation, and that their level of skills should be tested on a regular basis.

Memorandum submitted by the Neonatal Nurses' Association

The Neonatal Nurses Association was established in 1973 to promote good standards of neonatal nursing for the benefit of the public. In furtherance of this aim, the Neonatal Nurses Association collects and disseminates on all matters affecting neonatal nursing to all members and other bodies having similar purposes whether in the United Kingdom, Eire or Overseas. Full membership is open to any nurse whose name appears on the register of the United Kingdom Central Council for Nurses, Midwives and Health Visitors or the professional register of Eire. Our membership is a growing one, we currently have 1,600 full paid-up members.

We therefore welcome the opportunity to comment to the Health Committee of the House of Commons on issues affecting the delivery of Neonatal Nursing care.

Neonatal Nursing has developed alongside the significant changes in Neonatology particularly over the past two decades in the development new technologies, increased knowledge and enhanced skills resulting in the improved management of the small vunerable infant.

The Neonatal Nurse acting as advocate for the family, and as the prime care giver is in a unique position of liasing at the interface between midwifery and paediatrics thus facilitating communication and services for the benefit of these families.

Family Centered Care

Neonatal Nurses are committed to the concept of family centered care in the management of the small newborn with special needs. Our members are convinced that only by such a family centered approach to care in a service utilising considerable technology can partnership with parents be achieved, thus maximising the family role and independence. Such an approach promotes early discharge wherever it is possible and thus enables the utilisation of resources at a higher capacity.

Nurse Staffing

Nursing establishments together with the present skill mix require a major rethink to provide for future demands upon the neonatal nursing services. Whilst most management initiatives relate to the recruitment of staff the members of the Neonatal Nurses Association believe that there is also room for a more creative approach to promote retention and prevent "Burn Out" of staff with this area of "High Tech" and associated stress.

There is an urgent need for the establishment of support team networks to ensure the effective utilisation of establishment costs.

April 1991

Supplementary Memorandum submitted by the Neonatal Nurses' Association

CONTENTS

(* Not reported)

The Neonatal Nurses Association (NNA) was established in 1978 with the aim of promoting good standards of neonatal nursing for the benefit of the public.

Introduction

We welcome the Select Committee's attention to the provision of maternity and perinatal services, and the opportunity afforded to the many interested professional and support services to comment on these services.

We recognise that during the years the NNA has been active there has been a rapid growth in scientific knowledge and technology, parallel with a rise in holistic family care. We believe that the baby and his family have the right to receive optimal care regardless of geographical area.

1. *Preconceptual Care*

We endorse the concept of health education and preconceptual care as an essential part of maternity services. Health education should commence in schools, with particular emphasis on reduction in smoking. Attention should be paid to both public and social issues in an attempt to reduce the incidence of low birth-weight infants.

2. *Antenatal Care*

Improvements in antenatal care have raised family expectations and may result in an increased public expectation of neonatology.

2.1 We endorse intra-uterine transfer consistent with maternal health to locations suitable for appropriate neonatal care.

2.2 It is important that obstetric and neonatal services liaise to provide advance planning and preparation between the family and professionals.

2.3 Parents should have readily available information and access to visit facilities provided for neonatal care.

2.4 Ultra-sound scanning facilities may frequently identify surgical anomalies in early stages of pregnancy. Parental pre-admission visits, joint management of care and communication is essential for complicated neonatal deliveries.

2.5 During the first and second trimester, broad information about less intensive neonatal care and available facilities may be of assistance in reducing some of the anxiety felt by parents should care become necessary for their infant.

3. *Delivery*

3.1 Sound communications between departments is essential for optimal timing of delivery to enable appropriate neonatal skills and resources to be available.

3.2 Where geographical location and resources permit, it is desirable that a neonatal nurse is present to assist medical staff in resuscitation in pre-term or complicated deliveries.

3.3 Midwifery skills and education in resuscitation and immediate neonatal care should be consistently updated.

3.4 Where pre-term delivery is unavoidable in locations without the necessary neonatal facilities, it is essential that skilled interim care and transfer personnel are available.

3.5 Multiple births or delivery of infants requiring immediate surgical intervention should take place in regional centres.

3.6 Planned care enabling the small healthy infant to be nursed with his mother should be instigated following delivery.

3.7 Infants born between 24 and 28 weeks gestation will invariably have intensive care facilities available. This is in direct contrast to the lack of legal recognition afforded to infants below 28 weeks gestation that are born dead. This lack of recognition of the baby as a "person" results in acute distress to parents.

4. *Postnatal Care*

Following birth we support the primary aim that the baby is not separated from his mother unnecessarily. The healthy, small baby's needs are such that his care can be managed in the post-natal area, enabling the mother to be the primary care-giver with the support of the midwife and access to the paediatrician.

4.1 We are encouraged that over the years improvement has been made in delivering this care within the postnatal area, but there is still great variability between units' policies of admission. This has a major effect on the utilisation of neonatal personnel and resources.

4.2 It is our considered opinion that healthy infants over 34 weeks gestation should be nursed with their mothers. Low-dependency special care can be delivered at the bedside, for example: phototherapy, tube feeding, minimal clinical monitoring and intravenous cannulation for antibiotic therapy.

4.3 Resources must be built in to maternity services to enable the extra support to be available for these mothers and babies.

4.4 The number of postnatal beds and skilled midwives should reflect this model of care.

4.5 This support must also be available in the community and requires that the community midwife has a similar expertise in the care of the small baby, and thorough knowledge of potential neonatal problems.

4.6 The community midwife should have direct access to the paediatrician or neonatal unit when this is required. This is particularly important after a very short stay, for example domino deliveries.

4.7 Post-registration education must be utilised to increase the skills and confidence of the midwife in this role of post-natal care.

5. *Paediatrics*

Under this heading we have chosen to consider the baby in need of specialist neonatal care, with the right to expect personal, family-centred care provided by informed, competent nurses with the necessary support services and equipment.

5.1 Neonatal nurses are members of the Working Group on Categories of Care. This is attempting to define the baby in terms of the need of intensive, high dependency, special and normal care, with appropriate nurse and medical staffing [Appendix 1].

5.2 Improvement in care available has resulted in a differing workload in units. Many of the babies are of lower birth-weight and gestation, utilising elective ventilation from birth and frequently necessitating long periods of assisted breathing.

5.3 A new population within units is the long-stay neonate with chronic lung disease. These infants are often in need of prolonged intensive facilities. The neonatal unit may not be the most suitable environment to meet the psychological and social needs of the older infant.

Unfortunately, there are few paediatric intensive care facilities available, and the normal paediatric ward does not have the essential resources.

We await the results of current research into the use of surfactant, it may be possible that this will reduce the incidence of chronic lung disease.

5.4 Multiple births arising from infertility treatment creates a sudden take up of available resources and personnel. This can result in closure to any further admissions, necessitating in trying to transfer out booked mothers and babies.

Concern is felt that the emotional, physical and financial implications may not be fully appreciated by the family.

5.5 Improvement in care parallels an increase in necessary invasive procedures. These, and the complicated equipment in use need frequent explanations to parents. Time must be made available for this.

5.6 The complexity of the unit requires units to devise information booklets to assist parents in understanding the working of the unit.

5.7 Neonatal nurses are committed to aiding parents to "focus" on their baby despite the high technology environment.

5.8 Despite the complexity and difficulties that are integral to neonatal intensive care, staff and parents establish a good rapport, often developing into friendship.

5.9 Death is a factor to be considered in neonatal units, nurses are constantly improving their approach to bereavement care:

- post-discharge bereavement counselling is essential for future emotional health
- many units have a Remembrance Book
- staff (medical and nursing) will often attend the funeral if parents were agreeable
- letters of sympathy are sent
- some units send flowers to the mother a few days after the funeral signifying that the thoughts of the unit are with them
- liaison with SANDS is offered
- some nurses who acted as primary nurse to baby and parents will maintain contact for some time after the bereavement (if parents wish this).

6. *Neonatal Nursing Resource*

"Systematic methods should be used to agree the number and deployment of staff in all health-care settings" [Target 17—Appendix 2].

6.1 *Staffing Establishment*

6.1.1 The sick newborn requires specialist nursing care of high calibre to ensure safe, optimal delivery of care.

6.1.2 The specialist nurse is the single most important person at the cot-side, providing constant vigilance, interpretation of the continuous monitoring, enabling medical attention to be sought.

6.1.3 This nurse will act as a coordinator between all disciplines involved in the care, and be available for constant support for parents.

6.1.4 We are aware that no scientific research has been undertaken to measure nurse: workload ratio (this research is currently in progress in Nottingham).

6.1.5 Various bodies have recommended nurse: workload ratios, the latest working group of the British Association of Perinatal Medicine (BAPM) & NNA are (draft document) advising whole-time equivalents (wte) [Appendix 1]:

wte 5.5: 1 Intensive care cot,

wte 3.5: 1 High-dependency cot,

wte 1.0: 1 Special-care cot.

6.1.6 The most common reason for bed closures is the shortage of specialist neonatal nurses.

6.1.7 We are aware that workload ratio, combined on occasions with medical pressure to accept admissions, can result in unacceptable nurse: baby ratios, resulting in greatly diminished levels of care, with the danger of falling below levels of safety.

6.1.8 It is important that medical and nursing colleagues together agree an acceptable workload level.

6.1.9 Many units do not give recognition to the existence of high-dependency babies as a separate classification.

6.1.10 It is not uncommon for administrators, senior nursing staff and medical staff to recognise intensive care and special care categories only. This omits the often unstable, sick baby who needs a great deal of vigilance and nursing skill, at only a slightly lower nurse-ratio than the ventilated infant.

6.1.11 Many units have a shortfall in establishment, and some do not have a recognised neonatal establishment.

Many of those with an inadequate establishment may have an inappropriate mix of skills.

6.2 *Skill Establishment*

6.2.1 Neonatal units need a large number of experienced, qualified (specialist) staff.

6.2.2 The English National Board state that a ratio of 70:30 is considered suitable [Appendix 3] in units undertaking the provision of neonatal courses.

6.2.3 Some units still utilise nursery nurses inappropriately. The sick neonate and his parents have the right to expect care to be given by skilled, qualified staff with commensurate experience.

6.2.4 Neonatal nurses have diverse background qualifications, but must have enthusiasm, motivation and a high level of specialist skills.

> "Both nurses and midwives have important contributions to make in neonatal units. The over-riding consideration is that the needs of the babies are identified and that units are staffed with professionals of appropriate skills."

7. *Recruitment and Retention*

7.1 Staff are recruited from registered nurses (RN), registered midwives (RM), registered sick children's nurses (RSCN and enrolled nurses (EN).

7.2 An important future source of recruitment will be the Child Health Branch (Project 2000).

7.3 Establishments must reflect the need for new staff to have the necessary preceptor and resources for induction and orientation [Appendix 4].

7.4 Continual updating must be provided with planned education by means of learning contracts exploiting individual potential, to maximise nurse development and improve service to the unit.

7.5 Initiatives enabling flexible schedules for neonatal education should be considered:

- part time training programmes
- open learning
- distance learning
- use of post-basic education (Welsh National Board), allowing credits to be accumulated [Appendix 5].

7.6 Initiatives considering flexible roster schedules should be utilised:

— mix and match shifts

— job sharing

— self selection rostering.

7.7 Encouraging holistic care with identified family relationships is a model of care that increases job satisfaction.

7.8 Good communication between medical and nursing staff is vital.

7.9 Encouraging staff-support groups, availability of counselling services.

7.10 Fostering the philosophy of personal entegrity and valuing both patients and staff as individuals.

7.11 Sufficient experienced staff to be available for mentorship to the many students gaining learning experience on the unit:

— 405 students (neonatal intensive care training)

— RSCN students (sick children training)

— RM students (midwifery training).

7.12 Saturation of units with students without providing resources for mentorship increases stress levels in "core" staff.

7.13 Adequate establishment to meet workload will enable staff to have planned off-duty periods. This will reduce the familiar pattern of staff needing to stay on, or return to duty to allow workload to be covered.

7.14 Many units do not have the required support staff. Often, technical, clerical and general cleaning duties must be provided by the nurses, or financed from the nursing establishment.

7.15 Establishments should clearly define the clinical component separate from support staff.

7.16 Specialist nursing roles should be encouraged for individual and unit development:

— Family care sister

— Educational/teaching sister

— Counselling sister.

This would enable support to be offered to all staff by assisting with parental care, monitoring and planning for educational needs. It would help diffuse the stresses encountered with ethical dilemmas, problems arising for caring of the long-term neonate, and the effect of the death of a baby.

These roles assist staff in lateral movement on the clinical ladder. Senior staff may need to be encourgaged to maximise their potential in these areas, relief after many years in the intensive clinical field could prevent the loss of senior experienced staff to the unit.

All of the above will foster and encourage commitment to the unit. Staff must feel valued as individuals as well as work colleagues.

8. *Education*

"All practitioners should have opportunities for continuing post-registration education appropriate to their work" [Target 30, Appendix 2].

8.1 Flexible educational opportunities would enable more staff to undertake training. This would aid recruitment and retention of staff.

8.2 Unit-based teachers should be part of the establishment.

8.3 Post-basic education should be reassessed and updated to meet the needs of the service and of the individual.

8.4 Continuing professional development needs to be assessed. This has financial and resource implications that are rarely budgeted for.

8.5 Many units are unable to even partially finance the study-leave necessary for professional education.

8.6 There is difficulty in releasing staff for study-leave when establishment is already inadequate.

8.7 Need for outreach teachers encouraging closer support/cooperation in the improvement of patient care between regional and referral units.

8.8 Without the support of unit-based teachers, heavy learner/student commitment places added stresses upon busy clinical staff.

8.9 Improved cooperation between unit-based teacher and clinical staff with the colleges of Midwifery & Nursing will improve educational facilities.

8.10 The NNA has, and continues to, actively encourage continual professional development by means of regional and national conferences, and offering research scholarships.

9. *Environment*

9.1 Many units are not purpose-built, there is a lack of flexibility in utilisation of space. Neonatal nurses are constantly attempting to reduce the impact of the technology, heat, noise and poor facilities on parents and relatives.

9.2 Constant monitoring of babies may be irreconcilable with family needs for privacy.

9.3 The geography of the unit can add to difficult working conditions, making a need for a greater number of staff.

9.4 A large number of allied professionals and families are working within a confined space, increasing discomfort in working conditions.

9.5 Some units have a lack of, or very inadequate facilities for parents and staff.

9.6 Improvements, such as dressing the babies in their own clothes, may be hampered by a lack of laundry facilities for parents and staff.

9.7 Heat, constant noise and the need for extreme vigilance is a perpetual source of stress on all staff and families.

9.8 Facilities such as a quiet room, breast-feeding room and a refreshment area are of major importance to parental care.

9.9 Where possible, parent support groups should be established, alleviating some of the many stresses experienced in neonatal intensive care.

9.10 Accommodation for parents is vital:

— allows them to be near when their baby is ill.

— allows them to give total care without undue close supervision, encouraging confidence in their ability, whilst allowing help if required.

9.11 Little consideration has been given to the needs of staff caring for babies and their parents, the NNA particularly welcomes the new project "The Neonatal Unit as a Working Environment—a study of Neonatal Nursing" being undertaken by the Department of Health, Bristol.

10. *Community Care*

10.1 Resources within the community are essential to facilitate early discharge. This frees unit resources for new admissions.

10.2 Good community care increases parental confidence in their ability to have their baby at home, and relieves some of the many anxieties felt at this time. The family sister can be invaluable in easing the transition from hospital to home.

10.3 Good communication between all community disciplines and the unit personnel is essential.

10.4 Neonatal nurses are committed to working with the many invaluable lay support/self-help groups.

10.5 Liaison with paediatric community services (where they exist) is essential to enable parents of the long-term/complicated neonate to be supported and assisted in home care (for example, infants with chronic lung disease needing home oxygen).

10.6 Community personnel need direct access to the paediatrician/neonatal unit when circumstances require.

10.7 Professional updating to increase the confidence and skills of community staff should be readily available.

11. *Costs*

"The cost of providing perinatal intensive care when measured in terms of quality adjusted life years would compare favourably with other forms of care available to adult patients".

11.1 Optimal care given throughout pregnancy and following birth is an investment in the future health of the population.

11.2 Larger units are more cost-effective, due to a constant workload, less "peaks and troughs". Resources are utilised to their maximum potential, and staff establish and maintain the necessary skills.

11.3 Often equipment is purchased by means of charitable monies from organisations (e.g. BLISS) and the local community. It is frequently difficult to obtain replacement equipment and maintenance from the Health Authority budget.

11.4 Concern is felt at the new structure of contracting services. The possibility now exists that regional centres will not be used fully.

11.5 In an attempt to save money, small units may decide to care for their own babies, without the resources and expertise essential for optimal care.

11.6 The NNA sees the admission of the sick newborn as an emergency if lives are to be saved and are concerned that if services are organised on a District basis or NHS Trust, suitable facilities may not be available.

11.7 Contracts must have standards built in, encompassing clinical outcome, morbidity, mortality and standards of nursing care to be given.

11.8 Nurse managers must have secretarial assistance and access to information technology.

11.9 Data collection facilities must be available to nurses.

11.10 Quality assurance tools and neonatal nursing audit must be devised and validated.

11.11 Time and facilities for nurse managers to utilise the above is invariably lacking.

REFERENCES

Stroud, E. (Chairman). Perinatal Intensive Care Services in Wales. Nov 1989. Welsh Office.

BIBLIOGRAPHY

DOCUMENTS

Government publications

Sheldon, W. (Chairman). Report of the Expert Group on Special Care for Babies. Reports on Public Health and Medical Subjects No. 127. London. HMSO. 1971.

Oppé, T. E. (Chairman). Report of the Working Party on the Prevention of Early Neonatal Mortality and Morbidity. London. DHSS. 1975.

Court, S. D. M. (Chairman). Fit for the Future. Report of the Committee on Child Health Services. Cmnd. 6684. Vols. I and II. London. HMSO. 1976.

House of Commons Social Services Committee (Chairman, R. Short). Perinatal and Neonatal Morbidity. Second Report 1979–80. London. HMSO. 1980.

DHSS. Reply to the Second Report from the Social Services Committee on Perinatal and Neonatal Mortality. Cmnd. 8084. London. HMSO. 1980. 11–12.

Social Services Committee (Chairman Mrs Renée Short). Third Report 1983–84. Perinatal and Neonatal Mortality: follow up. London. HMSO. 1984.

Perinatal and Neonatal Mortality: Government reply to the Third Report from the Social Services Committee, Session 1983–84. London. HMSO. 1984.

MacFarlane, Alison & Mugford, Miranda. Birth Counts: Statistics of Pregnancy and Childbirth. London. HMSO. 1984.

MacFarlane, Alison & Mugford, Miranda. Birth Counts: Statistics of Pregnancy and Childbirth (Tables). London. HMSO. 1984.

Developments in Maternity and Neonatal Services in England since 1980. Department of Health and Social Security. 12 July 1984.

Maternity Care in Action. Part III: Care of the Mother and Baby (Postnatal and Neonatal Care). A guide to good practice and a plan for action. Third Report of the Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales. [1985].

Department of Health. "Mix and Match": A Review of Nursing Skill Mix. Miss Patsy Wright-Warren, Deputy Chief Nursing Officer (Chairman). February 1986.

House of Commons. Session 1988–89. Social Services Committee. First Report. Perinatal, Neonatal and Infant Mortality. Together with the Proceedings of the Committee, Minutes of Evidence and Appendices. London. HMSO. 1988.

Perinatal, Neonatal and Infant Mortality: Government reply to the First Report from the Social Services Committee, Session 1988–89. HMSO. 1989.

Department of Health. Survey of Nurses in High Technology Care: Report of the Survey Commissioned by the NHS Management Board. London. Department of Health. January 1989.

Department of Health. Survey of Nurses in High Technology Care: An Executive Summary of the Report of the Survey Commissioned by the NHS Management Board. London. Deparment of Health. January 1989.

National Audit Office. Report by the Comptroller and Auditor General. Maternity Services. Ordered by the House of Commons to be printed 16 March 1990. London HMSO.

Publications by professional and consumer bodies

British Paediatric Association and Royal College of Obstetricians and Gynaecologists Liaison Committee. Recommendations for the improvement of infant care during the perinatal period in the United Kingdom. A discussion document. London. British Paediatric Association and Royal College of Obstetricians and Gynaecologists. 1977.

British Paediatric Association and Royal College of Obstetricians and Gynaecologists Liaison Committee. Recommendations for the improvement of infant care during the perinatal period in the United Kingdom. London. British Paediatric Association and Royal College of Obstetricians and Gynaecologists. 1978.

British Paediatric Association and Royal College of Obstetricians and Gynaecologists. Midwife and Nurse Staffing and Training for Speical Care and Intensive Care of the Newborn. A consultive document prepared by the Standing Joint Committee of the BPA/RCOG in June 1981, circulated for discussion in February 1982, and amended in October 1982.

Baby Life Support Systems. A Survey of Neonatal Care in the United Kingdom. London. BLISS. 1985.

The Spastics Society. Neonatal Intensive Care: A Dilemma of Resources and Needs. London. The Spastics Society. 1984.

Royal College of Physicians of London. Medical Care of the Newborn in England and Wales. London. Royal College of Physicians of London. 1988.

Documents produced by health authorities and units

Oxford Regional Health Authority. Special Care Baby Units: January to June 1985. Nursing Department. September 1985.

Oxford Regional Health Authority. Special Care Baby Units Study: Fifth Report-1989. Nursing Department. September 1990.

Hale, Paula. Health Services for Children: Nottingham Neonatal Services-Nursing. 17 May 1990.

Nottingham. Health Services for Children. 17 May 1990.

Trent Regional Health Authority. Framework for the Provision of Neonatal Care Services. [Undated].

Memorandum submitted by Dr Rodney Rivers

Dr. Rodney Rivers has been consultant paediatrician at St. Mary's Hospital Medical School since 1978. He has been closely involved in the provision of neonatal intensive care at St. Mary's, a designated subregional Neonatal Intensive Care Unit (NICU) in North West Thames. In his appointment as Reader in Paediatrics, he has a major interest in research in relation to neonatal care and is a contributor to the nursing, undergraduate and postgraduate teaching programmes at St. Mary's. He is currently Chairman of the Thames Regional Perinatal Group.

THE CARE OF NEWBORN BABIES

1.0 Introduction

1.1 The reasons behind the centralisation of delivery care and birth based on district maternity units, and sub-regional and regionally designated perinatal centres derive from the recognition that in a country with major urban conurbations and areas of social deprivation, there would be a better chance of improving perinatal mortality and morbidity by so doing. Improvements in perinatal outcome have been seen over the past 20 years in association with the adoption of this policy. (OPCS, App. 1.1)

1.2 That medical and nursing care of mothers and their newborn babies is important not only, as stated in the Report of the Royal College of Physicians 1988, because babies are more likely to die on the first day of life than any other, but also because the wellbeing of mothers and their babies has major implications for the future health and achievement of development potential of the child and, therefore, on the whole of that individual's future life.

1.3 Of deaths occurring in the first year of life in the 650,000 or so babies born in England and Wales each year, some 3,500 are born dead, 3,500 die within the first month (most during the first week) and 3,000 die between one and twelve months. The principal causes of death in the newborn period (first 28 days) are congenital abnormalities, preterm birth and asphyxia occurring around the time of birth. These conditions may be combined in some babies.

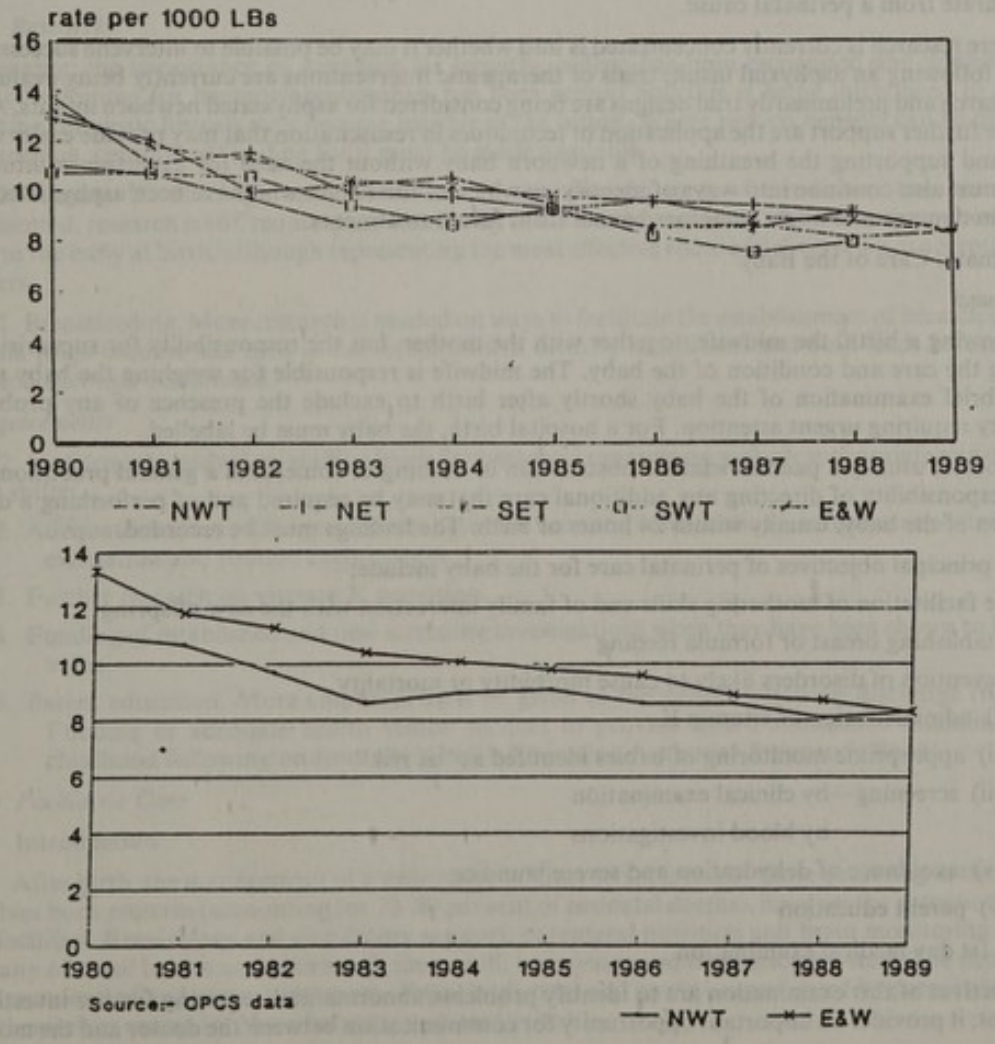
1.4 Antenatal identification of *congenital abnormalities* will reduce mortality and morbidity in three ways, (1) termination of pregnancies with lethal or severe abnormalities, (2) possible intrauterine intervention or preterm delivery with intervention, (3) a neonatal awareness of concealed abnormality with appropriate intervention and follow-up.

1.5 *Preterm birth.* The outcome for this category of babies has been the most affected by the changes in neonatal care occuring in the past 25 years. Both mortality and morbidity have been significantly reduced, but differences in outcome between babies cared for in small, district neonatal special care baby units compared with the outcome of those cared for in designated regional and sub-regional centres highlights one of the current problems arising from the inadequate provision of appropriate levels of care and, in the future, of enforcing the recommended strategies of care provision when intensive care cots are available.

1.6 *Asphyxia* remains a cause of mortality and morbidity with much research being directed against its prevention and management. Recognition and improved management of maternal conditions associated with fetal and perinatal asphyxia, the intrapartum recognition of fetal compromise and availability of neonatal resuscitation measures are all directed toward reducing the frequency of asphyxial insults and their consequences. It is possible that in the future therapeutic interventions in the newborn period will offer some hope for the surviving baby who has been asphyxiated.

APPENDIX 1.1

Thames Regions
Perinatal mortality 1980-89



2.0 *Delivery/Birth*

2.1 Birth constitutes the moment of adaptation from the intrauterine to an extrauterine existence and involves several complex and inter-related bodily and psychological changes.

2.2 Provisions at birth are dictated by the needs of mother and baby; the midwife/doctor delivering the baby must be trained to recognise the importance and signs of any failure of a baby to make these adaptations, particularly any inability to establish the breathing and circulatory changes essential for normal survival; they must appreciate antenatal conditions that put the newborn at risk and they should be able to detect certain abnormalities that might impair a baby's ability to survive intact.

2.3 Immediate resuscitation facilities must be available and access to paediatric staff trained in resuscitation is required for the baby who is identified as being at risk as well as for the baby who unexpectedly presents as a problem of adaptation. Recognition of the importance of resuscitation has led to the publication of a set of guidelines now displayed in hospital delivery rooms.

2.4 *Investigation of circumstances surrounding an adverse outcome.*

Perinatal mortality reviews are conducted by most hospitals on an annual, biannual of more frequent basis.

2.5 Research in this area has involved the holding of a confidential enquiry in cases of perinatal death at the time they occur. Although time-consuming and difficult to arrange for logistic reasons in terms of staff rotas and leave, these enquiries can provide important insights into areas where changes in policy, procedures or care might alter out-come; they can provide important sources of feedback for the parents of the child concerned. Properly conducted, these enquiries if held as a normal part of care evaluation, do not take on the undesirable "witch hunt" label with the risk that relevant information may be concealed.

2.6 *Recent Research*

Although it is general experience that in individual cases one can define how monitoring in labour led to the identification of a baby at risk of asphyxia, situations still arise where a baby unexpectedly is dead or dies at birth or alternatively is later found to be affected by a brain lesion which would not have been predicted by the perinatal course. There remains much debate as to how many of these brain lesions arise antenatally, being totally separate from a perinatal cause.

2.7 Where research is currently concentrated is into whether it may be possible to intervene successfully in the period following an asphyxial insult; trials of therapeutic interventions are currently being evaluated in animal research and preliminarily trial designs are being considered for asphyxiated newborn infants. Aspects that require further support are the application of techniques in resuscitation that may provide easier ways of initiating and supporting the breathing of a newborn baby without the need for expertise in intubation. Research must also continue into ways of identifying which of the babies who have been asphyxiated are at risk of brain damage and might therefore benefit from future treatments.

3.0 Postnatal Care of the Baby

Background

3.1 Following a birth, the midwife, together with the mother, has the responsibility for supervising and monitoring the care and condition of the baby. The midwife is responsible for weighing the baby and for making a brief examination of the baby shortly after birth to exclude the presence of any problem or abnormality requiring urgent attention. For a hospital birth, the baby must be labelled.

3.2 A doctor, usually a paediatrician or obstetrician in training or sometimes a general practitioner, will have the responsibility of directing any additional care that may be required and of performing a detailed examination of the baby, usually within 24 hours of birth. The findings must be recorded.

3.3 The principal objectives of perinatal care for the baby include:—

(a) the facilitation of mothering skills and of family interaction with the new offspring

(b) establishing breast or formula feeding

(c) prevention of disorders likely to cause morbidity or mortality

(i) administration of vitamin K

(ii) appropriate monitoring of babies identifed as "at risk"

(iii) screening—by clinical examination

—by blood investigations

(iv) avoidance of dehydration and severe jaundice

(v) parent education

3.4 The 1st day medical examination

The objectives of this examination are to identify problems/abnormalities requiring further investigation or treatment; it provides an important opportunity for communication between the doctor and the mother at

a time when many queries may be raised. In some districts, the record of the findings forms part of the child's "hand held" health record.

3.5 The 2nd medical examination

This is currently performed on most babies before discharge from hospital and is particularly important for babies where problems have been previously identified, but in most babies could probably be limited to a re-examination of the hips (BMJ 1991 *302;* 878–9).

3.6 Routine postnatal care (Hospital and at Home)

The midwife has the responsibility during the first 10 days of life of ensuring that a baby establishes feeding and that anticipated weight gain occurs. The midwife must be able to ensure that signs indicating the need for investigation or treatment are recognised, e.g. the development of severe jaundice, the signs of infection, the failure to establish an adequate food intake.

3.7 Rooming-In. A major objective of hospital-based postnatal care is that it can be carried out, whenever possible, without the baby being removed from the mother's bedside. For babies requiring additional levels of monitoring or care, this can be achieved by establishing a so-called transitional care postnatal ward where there is increased midwifery supervision or by providing a higher level of care on all the postnatal wards. Only when a baby requires special or intensive care will some separation of mother and baby become inevitable. The consequences and benefits of these developments in facilitating the formation of a close emotional attachment of a mother to her baby have resulted in less need for cots on special care baby units for babies who in the past would have been routinely admitted there for monitoring of treatment, e.g. babies born to diabetic mothers, babies born by Caesarean Section, babies requiring phototherapy treatment for jaundice. The consequence of such changes in the patterns of care provision are a need for a higher level of midwifery training and expertise on postnatal wards and an increased midwifery establishment on postnatal wards.

3.8 Discharge from hospital

It is the doctors' responsibility to ensure that the G.P. is informed of any problems relating to the baby, of any continuing therapy and of plans for future management and follow up. This communication is usually best achieved in the form of a parent held summary.

3.9 *Research*

Screening: the importance of screening for hypothyroidism has been recognised and implemented. The value of screening for haemoglobinopathies has been argued and this is being introduced to some areas. Screening for cystic fibrosis may become feasible in the future. Where proven benefits can be demonstrated for screening, centralised funding for it must be made available.

3.10 Vitamin K: although early deficiency of this vitamin in newborn babies has been frequently documented, research is still required on the efficacy of alternative modes of administration, since an injection given to the baby at birth, although representing the most effective route of delivery, is not acceptable to some mothers.

3.11 Breastfeeding. More research is needed on ways to facilitate the establishment of breastfeeding so that formula feeds become less used in the establishment of early nutritional and fluid feeds before a mother's lactation becomes established.

Requirements

3.12 1. Adequate midwifery staffing levels for postnatal supervision with an appropriate mix of experience on all shifts.

2. Adequate medical staffing to provide cover for neonatal resuscitations, subsequent postnatal problem evaluation and routine examination.
3. Further research on vitamin K provision.
4. Funding of established and new screening investigations when they have been shown to be of proven value.
5. Parent education. More emphasis must be given to the period following discharge from hospital. Funding of adequate health visitor services to provide this. Publications extending into early childhood following on from the 'Health Education Authority Pregnancy Book'.

4.0 *Paediatric Care*

4.1 Introduction

(a) After birth, the management of a wide range of disorders, especially those occurring in the 5–7 per cent of babies born preterm (accounting for 70–80 per cent of neonatal deaths), involves the provision of intensive care facilities. Respiratory and circulatory support, parenteral nutrition and brain monitoring are required by many of these babies and take much time, skill, experience and dedication by staff. The necessity for an understanding, of and supportive approach to the distress and anxiety experienced by parents and indeed by staff themselves caring for these babies is well recognised.

(b) In the past, those very low birthweight babies who survived had a high chance of being disabled by severe handicapping conditions. Whilst neonatologists in general subscribe to the view that all babies, even those at low gestations, are potentially autonomous persons and should be respected and treated as such, they recognise that there are important ethical issues that arise when caring for them. On occasion it is beneficient to refrain or desist from the provision of life support and ethical dilemmas are brought to the forefront when competing needs of patients occur against a background of ever diminishing resources. It would appear that the results of intensive care for the newborn are better by any criteria than those obtained by the provision of life support to most other groups of patients (RCP report 1988).

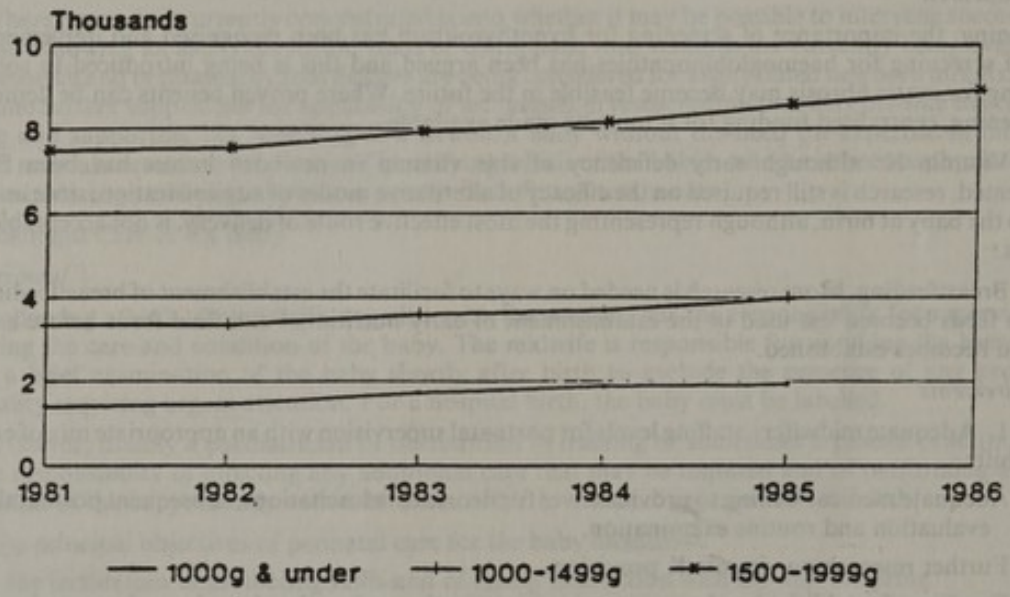
(c) Data (OPCS) indicates that the numbers of low birth weight babies are steadily increasing year by year as are the numbers of multiple pregnancies. With the improvement in results of caring for preterm babies, obstetricians have become more likely to deliver a mother before term where to delay could be deleterious for the mother, baby or both. (App. 4.1)

4.2 Categories of Babies Requiring Neonatal Care

In 1984, the British Paediatric Association and the British Association for Perinatal Paediatric (now the British Association of Perinatal Medicine) issued a memorandum identifying eight clinical categories that could legitimately be said to demand intensive rather than special care. 'Special care' was interpreted as a level of observation and treatment which exceeded the normal care that could be provided on a maternity ward. Normal care was given on a maternity ward usually by the mother, supervised by the midwife or doctor, but requiring minimal nursing or medical advice. With changing patterns of care provision (see postnatal care, 3.7) some flexibility in the interpretation of these definitions is required. In 1989, BAPM recommended the recognition of an intermediate 'high dependency' level of care (App. 4.2)

APPENDIX 4.1

Number of LBW Births
England & Wales 1981-86

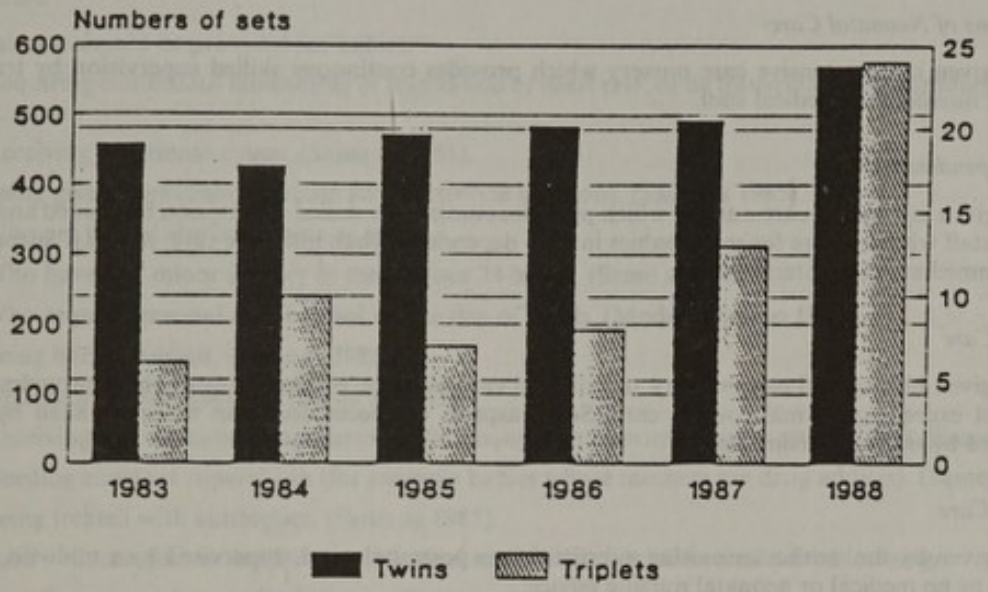


Source :-OPCS data

APPENDIX 4.1

MULTIPLE PREGNANCIES

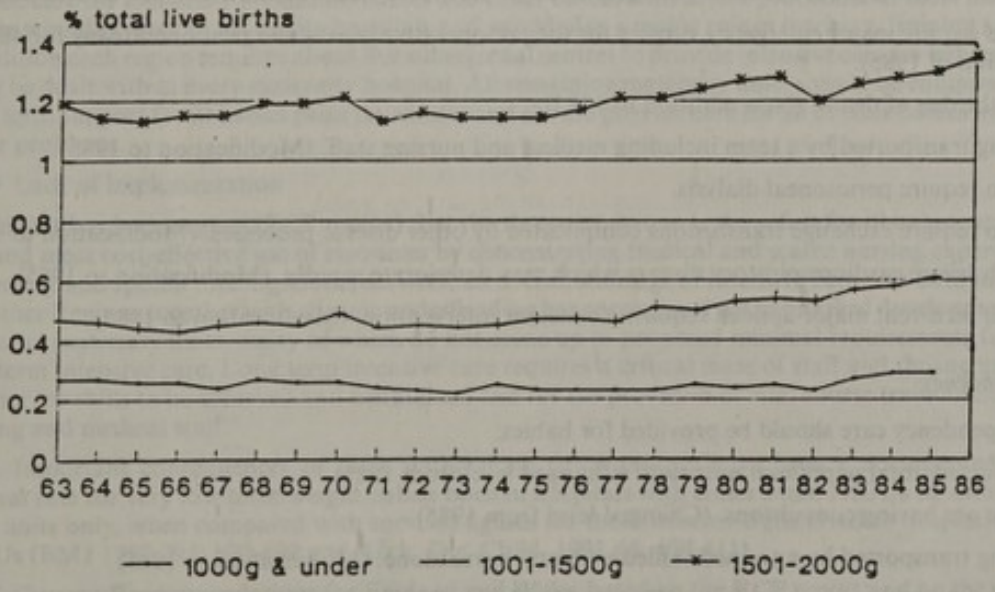
NW Thames units



APPENDIX 4.1

Incidence of low birth weight

England and Wales 1963 -86



Source:-OPCS data

APPENDIX 4.2

RECOMMENDATIONS OF WORKING GROUP (BAPM)

There should be three levels of care; intensive care, high dependency care and special care.

Definitions of Neonatal Care

Care given in an intensive care nursery which provides continuous skilled supervision by trained and qualified nursing and medical staff.

High Dependency Care

Care given in a special care nursery which provides continuous skilled supervision by trained and qualified nursing staff who can care for more babies in high dependency than intensive care. Medical Surpervision is not so immediate as in intensive care.

Special Care

Care given in a special care nursery transitional care ward or postnatal ward which provides care and treatment exceeding normal routine care. Some aspects of special care can be undertaken by mothers supervised by trained nursing staff.

Normal Care

Care given by the mother or mother substitute in a postnatal ward, supervised by a midwife, requiring minimal or no medical or neonatal nursing advice.

Clinical Categories of Neonatal Care

Intensive Care

Intensive care should be provided for these babies:

1. Receiving assisted ventilation (including intermittent positive airway pressure, intermittent mandatory ventilation and consistent positive airway pressure and in the first 24 hours after its withdrawal). (Same as 1985).
2. Of less than 27 weeks gestation for the first 48 hours after birth. (Modification of 1985).
3. With a birthweight of less than 1,000 grammes for the first 48 hours after birth. (New addition to 1985).
4. Who require major emergency surgery for the pre-operative period and post operatively for 48 hours. (Modification of 1985).
5. On the day of death. (New addition to 1985).
6. Being transported by a team including medical and nursing staff. (Modification to 1985).
7. Who require periotoneal dialysis.
8. Who require exchange transfusions complicated by other disease processes. (Modification to 1985.
9. With severe cardiorespiratory disease which may deteriorate rapidly. (Modification to 1985).
10. With recurrent major apnoea requiring constant intervention. (Modification to 1985).

High Dependency

High dependency care should be provided for babies:

1. Requiring total parenteral nutrition. (Changed level from 1985).
2. Who are having convulsions. (Changed level from 1985).
3. Being transported by a trained skilled neonatal nurse alone. (Modification to 1985).
4. With arterial line or chest drain. (Changed level from 1985).
5. With cardiorespiratory disease which is unstable but not deteriorating rapidly. (Modification to 1985).
6. With controlled recurrent apneoa requiring occasional intervention. (Modification to 1985).
7. Who require an exchange transfusion alone. (Modification to 1985).

8. Who are more than 48 hours post major surgery and are of very low birthweight or have two or more ostomies. (Addition to 1985).

9. Who are post-operative and require complex nursing procedures. (Addition to 1985).

10. With tracheostomy. (Change of level from 1985).

Special Care

Special care should be provided for babies:

1. Requiring continuous monitoring of respiration or heart rate, or by transcutaneous transducers. (Same as 1985).

2. Receiving additional oygen. (Same as 1985).

3. Being given intravenous glucose and electrolyte solutions. (Same as 1985).

4. Who are being tube fed. (Same as 1985).

5. Who have had minor surgery in the pevious 24 hours. (Same as 1985).

6. Who require terminal care but not on the day of death. (Modification to 1985).

7. Being barrier nursed. (Same as 1985).

8. Undergoing phototherapy. (Same as 1985).

9. Receiving special monitoring (for example frequent glucose or bilirubin estimations). (Same as 1985).

10. Needing constant supervision (for example babies whose mothers are drug addicts). (Same as 1985).

11. Being treated with antibiotics. (Same as 1985).

Excluded with conditions requiring radiological examination or other methods of imaging.

4.3 Past Recommendations for Intensive Care

In spite of several reports in recent years drawing attention to the need for provisions to be made for the paediatric care of newborns including the Short Report (1980) and the Report of the Royal College of Physicians 1988, extra resources have not been made available by Government and local authorities have mostly been unable to meet the funding levels required. Particularly in London, the development of neonatal services has been haphazard and based on local needs in the absence of sufficient funding for designated Regional centre based cots for intensive care provision.

4.4 A three tier regional structure for the care of high risk unborn and newborn infants in England and Wales has been widely advocated and is supported by the British Association of Perinatal Medicine. It is broadly agreed that each region needs about two major regional perinatal centres for the management of serious fetal and pregnancy-related disorders requiring specialist investigation and intervention and to provide care for extremely premature babies and other babies with severe problems. In most instances these centres would be sited in university hospitals and would play a major role in teaching, training and research. In addition each region requires about five subregional centres to provide intensive care for babies that cannot safely be dealt with in every maternity hospital. All remaining maternity units should be equipped to provide short term support for ill babies prior to transfer and should provide care for all of their babies with relatively minor problems.

4.5 Lack of implementation

Whilst it has been argued (RCP report) that the three-tier system is the safest for ill babies and makes the best and most cost-effective use of resources by concentrating medical and scarce nursing expertise, medical equipment and special investigational services, an overall shortage of intensive care cots both in the Thames and other Regions together with chronic underfunding has encouraged the haphazard development of IC cots in district maternity units, many of which do not come up to proposed minimal requirements for delivering long term intensive care. Long term intensive care requires a critical mass of staff and throughput of babies in order for skills to be achieved and maintained and for the provision of vital course training experience for nursing and medical staff.

4.6 Important consequences of these unfortunate developments have been a documented diminished survival rate for very low birth weight babies born in hospitals with either small NICUs or with special care baby units only, when compared with survival figures for those born or transferred to hospitals with larger NICUs (BMJ 1987 *295*: 690-692 and Arch. Dis. Child. 1991 *66*: 408-411).

4.7 Current Recommendations for England and Wales based on the RCP report and on the documented increasing delivery rate of very low birth weight babies requiring intensive care are:—

(a) *IC cot provision:* 1.5 intensive care cots should be provided per 1,000 live births. These should be divided between regional perinatal and subregional perinatal centres with regional neonatal surgery being ideally located within a regional centre.

(b) *Medical Staffing:* the staffing levels of regional perinatal centres should include three consultant neonatal paediatricians who have no significant responsibility for acute general paediatrics, four registrars/senior registrars (middle grade staff) with two of them full time in neonatal medicine and six senior house officers with no significant responsibilities for acute general paediatrics.

The staffing for subregional perinatal centres should include three consultants, one of whom would be a consultant neonatal paediatrician with no significant duties in acute general paediatrics, three middle grade staff, one of whom would have a full time commitment to neonatal medicine, and four senior house officers, none with any substantial commitment to acute paediatrics.

(c) *Nursing Staffing:* nursing recommendations made note of the Maternity Service Advisory Committee recommendation that a neonatal nurse should not be required to care for more than two babies receiving intensive care at a time, and recognised the important distinction between 'paper establishments' and the number of nurses available at any time due to maternity leave, sickness and study leave. Of vital significance in the staffing arrangements not apparent from 'paper establishments' is the staff mix in regard to experience and training level available on each shift.

The appropriate level of nurses per cot was recommended at 5:1 for intensive care and 1.5:1 for special care. Recently the BAPM has proposed levels of 5.5:1 for intensive care, 3.5:1 for high dependency care and 1.0:1 for special care.

4.8 Implications of Accepting Recommendations for Staffing Levels

In the RCP report, two models for the distribution of intensive care cots within regions are explored; on one, *model A*, cots were to be concentrated in regional and subregional centres whereas in the second, *model B*, allocation involved a wider distribution throughout maternity units in each region.

In Model A, based on the calculated requirement of 1.5 IC cots per 1,000 live births with the regional perinatal centres having some 15 IC cots and the subregional centres some 8-10 IC cots, it was found that virtually every maternity unit with over 3,000 deliveries per year would function as a regional or subregional centre but that units with less than 2,000 deliveries/year would not be required to carry out long term intensive care.

In Model B, each regional centre was envisaged as having some 10 rather than 15 IC cots and with subregional centres having no more than 6 IC cots each. Such an arrangement would require the existence of 119 subregional centres in England and Wales compared with 61 in Model A with 61 per cent compared with 38 per cent of the subregional centres being sited in smaller maternity units delivering 2,000-3,000 babies per year.

All maternity units with more than 2,000 deliveries per year would need IC cots and some units with less than 2,000 deliveries per year would need them also if all babies requiring IC were to be provided for in Model B. The throughput of VLBW infants in this latter category of maternity unit would obviously be very small, and would be insufficient to maintain expertise and for recognition by the ENB for setting up training courses which are so needed to expand nurse recruitment.

The staffing implications of a broad spread approach are striking with 303 middle grade medical staff required in England and Wales to provide cover in the concentrated regionally planned model compared with 666 in the model where most maternity units would be providing intensive neonatal care. The latter figure cannot conceivably be fulfilled within the remit of "Achieving a Balance". Calculations of the numbers of neonatally trained nurses is even more adverse and becomes likewise inconceivable when consideration is given to the number of 405 training course spaces available and to the predicted fall in the number of young women entering nursing for demographic reasons over the next few years.

Clearly the above calculations carry serious implications for the quality of care that could be provided for babies in small IC units where higher mortality rates and worse quality of survival is likely.

4.9 *London NICUs*

In London, the distinction between some regional and subregional centres in terms of facilities and expertise will be less apparent since several neonatal intensive care units are sited within University Paediatric Departments where active perinatal research programmes and specialised training and investigational services for neonates and children are available. Lack of funding and of the availability of appropriately trained nurses has led to chronic understaffing at both Regional and subregional NICUs in the Thames Regions.

4.10 *The White Paper*

Working Paper 2 following the White Paper "Working for Patients" states (p.22) that "the Government considers that decisions on services which are currently organised on a regional or multi district basis should be taken locally but with a presumption in favour of contract funding". Such an approach would appear to encourage competition in the market place and abolition of the regional structure for the care of ill babies with all the previously outlined serious implications of the broad spread approach. The possibility of each district maternity hospital deciding to go it alone and set up neonatal intensive care "because we could do it

cheaper" than the regional or subregional centres by utilising suboptimal establishments both numerically and in training becomes a real danger for babies. These hospitals would lack recognition for setting up their own training courses and, in association with deficiencies in special investigational facilities for the newborn, could only provide suboptimal care; although districts will be encouraged to document outcome measures, at present no authority has the power to stop a unit providing an inadequate form of intensive care no matter what the outcome data might reveal.

4.11 Limiting factors in the provision of neonatal intensive care and follow up.

4.12 *Nurse staffing*

The most important deficiency remains the lack of sufficient trained neonatal nursing staff and the underfunding which has prevented the generation of nursing establishments at the levels recommended for neonatal intensive care. The consequent stress of working conditions is an important deterrent to recruiting staff in many units.

4.13 *Equipment*

Many designated NICUs have totally inadequate funding for new equipment or for the replacement of obsolete equipment. Much equipment has to be funded from charity sources.

4.14 *Clinical Psychologists*

The importance of clinical psychology in providing staff and parent support and counselling, bereavement counselling and supervision of post discharge developmental intervention programmes is recognised but again has been dependent on haphazard research funding with few units having service funding provisions for such an individual.

4.15 *Developmental Follow Up*

Although the monitoring of outcome for high risk babies who have received intensive care is of utmost importance, the provision of trained paediatricians for this task has fallen between research and service needs with the result that funding from regional or district sources has not been forthcoming.

4.16 *When things go wrong*

Current litigation mechanisms are cumbersome and often damaging to doctor-parent relationships; rather than encouraging an openness of information, the opposite course is often adopted when accidents or errors in management occur. The frequent inability of the plaintiff to establish a certain causal effect, particularly in disorders of multi-factorial origin, results in the child often failing to benefit from the legal action. Examination of how a "no fault" form of compensation in regard to neonatal intensive care and its consequences might be applied should be undertaken.

4.17 *Research and Implications*

4.18 Surfactant Therapy

In a recent review of published trials using surfactant replacement to prevent or reduce the severity of lung disease in preterm infants, benefits have been seen in babies less than 30 weeks gestation; survivial was improved and duration of ventilatory support reduced. The improved survivial does not appear to be associated with any increase in neuro–developmental handicap.

Implication: This therapy, costing £300 per dose with babies requiring up to 3–4 doses, will become part of routine management.

4.19 Blood Transfusions

The possibility of reducing the number of transfusions given to VLBW babies by the use of the naturally occurring compound, erythropoietin, whose normal function is to stimulate blood forming tissues in the body, is under evaluation.

Implication: Erythropoietin injections might become a routine part of N.I.C. in order to reduce the potential danger of blood tranfsusion.

4.20 Nutrition

The recognition that nutritional deprivation in VLBW babies may have important implictions for subsequent neurodevelopmental outcome has received further support from studies comparing babies fed with different milks.

Improved growth and neurodevelopmental outcomes have been seen when the nutritional requirements of these babies are met (Lucas et al., Arh. Dis. Child. 1989 *64*: 1570–78).

4.21 Prevention of brain haemorrhage and of impaired brain flow.

Many NICUs have documented a reduction in the incidence of these complications in their VLBW infants in the last 20 years. (Philip et al., Pediatrics 1989 *84*: 797–801). A considerable amount of research continues to be directed towards increasing our understanding of their causes and into ways of reducing the occurrences

further. Factors which alter and destabilise brain blood flow and the study of therapeutic intervention to reduce such instability are subjects of intense research activity.

Implication: the introduction of new monitoring methods and possible therapeutic interventions.

4.22 Retinopthy of prematurity and blindness.

Multifactorial in its causation, research is still required into prevention; although oxygen levels in blood reaching the retina are important in causation, little benefit from therapies designed to reduce oxygen toxicity and to control the oxygen level in the blood have ben seen in recent years.

4.23 *General Comment*

There is no obvious source of funding for major therapeutic innovations which are proven to be of benefit by research studies. Surfactants will be the first components in this category, but erytorpoietin may be shown to be of benefit in due course. A parellel situation has been seen in renal units, unable to afford erythropoietin for patients on dialysis. (BMJ 1991 *302:* 248–249).

Some mechanism by which proven therapeutic innovations can be funded must be sought if the improved outcomes demonstrated in clinical trials are to be transmitted to the population of babies who would beneift.

4.24 Outcome measures

No formalised data of outcome measures is collected from United Kingdom neonatal units. The BAPM/RCP working group on audit of the care of VLBW infants have drawn up preliminary proposals for prospective study and this should be supported.

Until now, outcome data have come from a few individual units as part of local research projects. They have generally shown a falling mortality for VLBW infants with little change in the percentage of babies with severe handicaps in recent years.

(Stewart et al., Arch. Dis. Child. 1977 *52*: 97–104

Stewart et al., Lancet 1981 1038–1041

Marlow in perintatal Medicine, ed. Chiswick, Churchill Livingstone, p. 181 1985

Pharaoh et al., Arch. Dis. Child. 1990 *65*: 602–6)

April 1991

Examination of Witnesses

PROFESSOR RICHARD COOKE, President, and PROFESSOR MALCOLM LEVENE, Honorary Secretary, British Association of Perinatal Medicine, PROFESSOR DAVID HULL, President, British Paediatric Association, MRS WIN HUXTON, Chairperson, and MRS PAULA HALE, Neonatal Nurses Association, and DR RODNEY RIVERS, Chairman, and DR PATRICIA HAMILTON, Thames Regional Perinatal Group, examined.

Chairman

1000. Good afternoon. We welcome those that are giving evidence to us this afternoon as part of our Maternity Services Inquiry. I apologise for keeping you just a few minutes, I apologise also for postponing your arrival here, and thirdly I apologise for the limited number of members from the Committee who are here. Dare I say you have got the quality if not the quantity before you this afternoon. We are delighted you are here and I am also delighted to see an ex-Chairman of the Committee sitting again in this Committee, Mrs Renee Short. She is always very welcome when she comes. I think all of you know that we have done inquiries in the past into perinatal and neonatal mortality and there has been, we all know, a considerable reduction in perinatal mortality in recent years. Why do you think that this reduction has occurred, Professor Cooke?

(*Professor Cooke*) For several reasons: both an improvement in the health of women over the last twenty or thirty years, but also I think increasingly the appropriate application of intensive care technologies. There is a danger always of over-emphasising the role of intensive care technologies in improving health, because health is improved by lifestyle and other things, but I think that now that perinatal mortality rates have really got to quite low levels, at least on an international footing, the further improvements that have been made in recent years have been very largely due to tackling the problems of very low birth weight.

1001. So what do you think is the balance between social and medical advances in achieving this dramatic and very welcome reduction?

(*Professor Cooke*) I think you have to look at which children are now alive which a decade ago were not alive, and they are mainly the very low birth weight children. There has also been a continued but smaller reduction in term deaths although these are now at quite low levels, but the biggest change in the last decade for instance has been in the survival, in this country anyway, of very low birth weight infants and that seems to be related to the way that they are managed rather than anything else.

1002. Is there any other observation that any of our other witnesses would like to make to those opening two questions from myself?

[**Chairman** *Cont*]

(*Dr Rivers*) I think another point to make here is the reduction in the congenital malformations due to screening of antenatal women with ultra sound and offering selective terminations which has led to a reduction in the deaths that would have arisen from those congenital malformations. I think we have also seen the effects of the prevention of Rhesus disease, a disease from which there has certainly been a mortality in the past, and possibly even screening for diabetes in pregnancy has had an impact on mortality. I would certainly concur with Professor Cooke on the effects on very low birth weight infants which he has described.

1003. What about our neonatal nurses?

(*Mrs Hale*) We would think there is better collaboration between all professionals involved in the care and this is helping significantly.

(*Professor Hull*) If you want data that supports the claim that there is increased survival in babies who are born with low birth weight and that there is also an increased survival in babies with congenital abnormalities, then the statistics from the Northern Health Region are the best data to give you that information. They have come out in two booklets and the information is very secure that both those are occurring.

Rev Smyth

1004. You point to a regional study. Have you compared various regions and how far would you say termination has had a deeper impact upon perinatal mortality compared with social changes?

(*Professor Hull*) Again the data is here. The reason why I am quoting the Northern Region is that they have a population study and therefore they have the best data base on which to make the claims. I think all of us would support this in terms of having our own hospital data or indeed having our own district data that these trends are there. The same is true in Northern Ireland as elsewhere, and the overall figure has come down. But for the secure data that breaks it up into the various parts the Northern Region data is the most secure and the one that I think you can rely on, and as an example of what is going on in the rest of the country.

Sir David Price

1005. Could I ask Dr Rivers a supplementary to what you said? Would I draw the conclusion that we should as a society expect to do more screening in pregnancy and hence sorting out the possible problems later in the pregnancy and certainly at birth or post natal, and act accordingly?

(*Dr Rivers*) Yes, I think screening is absolutely crucial both in selecting mothers with potential problems and for the reasons that have already been alluded to, such as congenital malformations and disorders which can affect the foetus.

1006. Should this be available at district level or indeed we have seen it at this stage being a rather specialist activity?

(*Dr Rivers*) No, I do not think it should be a specialist activity.

1007. It should be at every district?

(*Dr Rivers*) It should be available.

1008. Or below that down almost at primary care level?

(*Dr Rivers*) I think it should be part of routine antenatal management.

1009. How far are we away from achieving that at the moment?

(*Dr Rivers*) I would not be able to answer that.

1010. But from your own experience in Thames.

(*Dr Rivers*) In Thames it probably is again very varied. I do not have information. I probably could find it. My obstetric colleagues might know.

1011. This is the relevant question for us to be asking, looking at the future success of the maternity services.

(*Dr Rivers*) I think it will be a question that certainly the obstetricians might be better able to answer than myself, but the information might well be able to be found for your Committee.

Chairman

1012. Could I take Sir David's question further? How much of what Sir David has referred to should actually be carried out and counselled about before conception and pregnancy occur?

(*Dr Rivers*) Certainly I think the information on the dangers of smoking, alcohol and other interventions should be discussed and known about before conception is even thought about. Screening then only becomes applicable of course when pregnancy has occurred.

1013. You talk about congenital malformation. Obviously if there is a history in a family, either man or woman, and they are seeking to have a family, clearly this matter could and should be discussed with them, about the risks of proceeding with a pregnancy and the way that any pregnancy might be handled.

(*Dr Rivers*) Yes. I think genetics counselling is crucial for such families where that sort of thing has been identified.

Sir David Price

1014. Professor Hull, I thought you looked as if you wanted to add something.

(*Professor Hull*) The question is about standard of surveillance for all women when they are thinking of having a baby or when they first think they have got a baby. That is a primary care function if it is done well. The problem with our surveillance procedures is actually making sure that everybody shares in that service. We are going through the same exercise for examination after birth, so that whilst it is desirable that it is a primary care function there has to be some system to ensure that everybody shares in it evenly and we do not have that system in place at the moment.

1015. Have we got any idea of the unevenness of this service because I suspect it is not so much on a regional basis but it is a much lower level?

(*Professor Hull*) You are absolutely right. It is within each general practice group, and now that there is a requirement that they report in on their register as to whether a vaccination programme has been done (they have always had that done for

[**Sir David Price** *Cont*]

rubella in pregnancy) once one starts putting other surveillance criteria into the programme, those GPs that have got registers can begin to start thinking about doing that, but those people who are not on general practitioners' registers or are reluctant to attend when requested are the ones that need to be addressed and they are the ones who have the major problems. They have a high incidence of problems and there is not a system for encouraging that at the moment.

1016. Presumably they would tend to be in the more impersonal parts of large cities?

(*Professor Hull*) Yes.

1017. When we were looking at primary health care the difference between some of the rural areas and let us say Earls Court because of the turnover of population and the number who failed to register or, having moved, did not follow up with another GP was very great.

(*Professor Hull*) Yes.

Chairman

1018. Can I address my next question to Professor Cooke and Professor Levene. In your evidence you state:

"It will be important to retain and develop a regional strategy for perinatal care". Can you summarise for us why you believe that this is so important?

(*Professor Cooke*) Perinatal care as such developed in a slightly haphazard way some years ago. During the last ten to fifteen years different regions have been able to produce regional working parties which have been able to advise each region on the appropriate distribution of perinatal services the perinatal services that should be provided and to produce a certain amount of co-operation amongst those involved in giving the service. Unfortunately people feel that if the hospitals which give the service within the region act quite independently in future then this may well threaten this somewhat embryo system that we have got in a number of regions. Some regions are much better developed than others. The Northern Region has already been referred to and the Thames regions are developing this, but other regions have virtually no such working party structure. Certainly in my own region, Mersey, I feel that over the last five to ten years we have been able to do quite a lot in developing the service and the region themselves have been very amenable to that sort of advice and help. However, the role of the region in directing money will be a lot less in the future as I see it and different forces will operate. This is likely to mean that the distribution of those resources will be less even rather than more.

1019. This actually takes me on to my next two questions because I think we are getting to the nitty-gritty of the sort of vital services that you all provide. By the way, in the questions, if I do just say "Professor Cooke" or "Professor Levene", if any other witness would like to come in with a view, for heaven's sake please do. I have to put to you the political question because if I do not Audrey Wise most certainly will. What do you think will be the effect of the NHS reforms on the sort of regional services that you have just been talking about, Professor Cooke? The Department of Health have told us that regional funding will be continuing by way of top slicing but we already have other evidence suggesting that this is not the case. What is your information about this? Do you think that regional funding should continue, and if you do, why do you think it should continue? Again perhaps that will draw in the Thames Regional Perinatal Group as well.

(*Professor Cooke*) The understanding in my own region that I have been given is that although we are not a trust hospital as yet regional funding is not likely to continue but that we will move to a system of contracting, which in fact we have largely already done, so I am surprised to hear that. I feel the problem is that when smaller district hospitals find that they are running out of resource towards the end of the year there may be a temptation to say to their own small paediatric department, "Well, you had better try and do your best". Certainly already this year the number of extra-contractual referrals which our unit has taken is far beyond what was expected, and whether these are all going to be paid for at the end of the year I do not know.

1020. What is your view, without wishing to put you in a delicate political medical situation? Do you think that regional funding should continue or do you feel we should move to what you have implied, to a contract situation?

(*Professor Cooke*) One has to admit that there have been considerable problems with funding in the past, particularly with major referral centres in that for instance, again speaking of my own experience, a quarter of all the children given intensive care do not even originate from the region, and they are actually not paid for by anybody. They are paid for by our region, and the regional top slice given to the district has been inadequate to meet the costs of regional babies and as a result the central districts, as they do in many large university towns, find that they are financing care for the region and beyond, and this has been very unsatisfactory. I think all of us have felt that something had to be done to improve that situation. Whether it is necessary to go as far as the trust hospital system I do not know. My own feeling is that it is an untried experiment at the moment.

(*Professor Levene*) My views are very similar. I think the point I would like to make is that although we have had a system whereby regional managers have subscribed to the concept of three levels of care, in my experience there has not been top slicing and funding for tertiary level neonatal units, and certainly in my own region in Yorkshire there has been no funding at all for regional neonatal intensive care costs, so the system up to the recent change has not been good. It has been very patchy through the country. Some regions have been better than others. I have worked in three different regional health authorities in my neonatal career. None of them has been anything like good. We must be very concerned about the changes which are I believe going to erode the tripartite system we have at the moment, but at the same time I do not think we should be deceived into believing that it was previously significantly better than it is now.

1021. Have you any observations to make about the impact of the reforms on your service?

[**Chairman** *Cont*]

(*Professor Levene*) The impact of the reforms on my own particular service has been positive. We have more intensive care cots because our hospital, our trust, has decided that that is an area that has to be developed because we only have half the number of neonatal intensive care cots in Yorkshire that we require. For some hospitals within the region it works well but I am quite sure that for every hospital that works well, for instance ours, there are other districts and other hospitals that do not.

1022. And your hospital is which?

(*Professor Levene*) Leeds General Infirmary. Others are suffering as a result of that because they are not having the money to develop their own services.

(*Professor Hull*) I am just a little bit troubled about the direction of the discussion. We seem to be talking about level three neonatal intensive care. If we are talking about neonatal services we are talking about the normal care of every baby that is born. We are talking about special care, high dependency care. Hospital services around the country are divided up into four groups. There are the groups where babies are born in general practitioner units which are under the care of a primary care team; they are born in small units with a thousand to three thousand deliveries where they have a special nursery but they transfer out for level three intensive care. There are also large units that do all levels of care, and mine is one. We do not transfer in or out and we have never been top-slice funded by the region because that money was allocated to units for transferring in because there is a fourth group of hospitals that were given extra money by the region for intensive care for transferring in to their unit. I think what you seem to be talking about at the moment is the capacity to transfer in from another part. My answer to the general question about trust status or non-trust status is that the provision for level three care, that is intensive care, which is expensive and rare, is very limited and in most regions there is a very sensitive awareness between the different groups to help each other out so that we look after as many babies as possible. The new system where each is going separately, not knowing whether each wants to vie for trade for not, is not helpful for the optimum use of very limited resource. We have had a regional strategy and a networking in the country for tertiary services and neonatal medicine is only one example, but it is not at all clear to us just what is going to happen in future because nobody is responsible any more for tertiary services in anything, never mind neonatal medicine.

1023. Dr Rivers, Dr Hamilton, would you care to respond to what we have heard and perhaps also to deal with the questions that I put to begin with?

(*Dr Rivers*) I think the situation in the four Thames regions is quite different within each region in terms of the way things are funded at the moment. To take South East Thames as an example, the units there are contracted by region on intensive care cot days, so they know the money is going to come, but next year I gather that money is going to be distributed to individual districts who are going to be demanded to continue the same pattern of referrals as they have at the moment, if indeed a region can demand that.

But the year after that, as I understand it, it will be for each district to decide where their babies go, so there will be no security for the level three, top level regional unit, nor the sub-regional units as designated at the moment. The situation of North East Thames is somewhat similar. There has been a major injection of money to increase the number of intensive care cots there from thirty-eight to sixty-two, but once again there is the move to devolve the regional monies to individual districts with the desire on the part of the officers of the region, I understand, to ensure that contracting can only occur with the designated regional units. I cannot imagine that hospitals that already have established intensive care at district level or the trust hospitals wishing to undertake intensive care, are going to take kindly to that idea. In North West Thames we have a completely different system which is a lead purchasing team with paediatric input who have contracted in an extra-contractual fashion for neonatal intensive care, and this is a flat rate so that every district has an extra-contractual budget with which they can refer their babies to any of the regional units and that money is secured as an extra-contractual budget, but it is a flat rate of payment so that if the level three unit (which you would expect the most severely ill or the smallest babies to go to) is faced with three months of intensive care, it gets exactly the same amount as a unit accepting babies for two or three days in intensive care.

1024. I would like to pursue that one further. Dr Hamilton, do you want to add anything to what Dr Rivers has said, because I would like to pursue the last point as it worries me immensely that it is at a flat rate which could cause considerable difficulty and problems?

(*Dr Hamilton*) I certainly reinforce that. In South West Thames the contract is held at region which does protect to a certain extent the three-tier system so that purchasers can be assured that babies are going to appropriate centres. The rate is charged at a flat rate and some babies may stay there for a month and the money is the same as for the baby who comes in and may only survive a few hours, which seems unfair both ways. I would also like to make the point that there are particular problems of London in that we have to switch babies from one region to another so quickly because we have a shortage of cots, a large number of babies and regions that are very close together whose apices concentrate around London.

1025. Where do you have the shortage of cots?

(*Dr Hamilton*) South West Thames for example has twenty-one cots in a population of 40,000 people whereas we should have nearly sixty cots if it is to be 1.5 cots per 1,000 live births, so that a lot of our babies have to go out of the regions. It makes it even more complicated if we go to another Thames region which has a different system of funding and contracting.

Sir David Price

1026. Dr Hamilton, the point you make if I have got it right is one that was common in many regional centres around the country, where first of all you have a very long delay on being paid for your referrals from outside your district, although you

[Sir David Price *Cont*]

were told ultimately you would get it. Certainly in mine—I come from Wessex—it was up to two years minimum. Secondly, the funding usually on all specialties that I know was done on an average and by definition the regional unit was taking more intensive cases and hence the average cost of their patients was bound to be more, not just in your specialty but in all specialties. That was a criticism I found very strongly made, and I find it in other regions too. I do not know if our witnesses have had that experience. It was not limited to your specialty. It was a general criticism of the system.

(*Dr Hamilton*) Yes.

Audrey Wise

1027. Thinking further of this tertiary level, it seems to me that really what you are saying is that the previous system was not adequate but needed improving in ways which strengthen strategic planning rather than moving to a competitive ethos in this particular field. Is that right?

(*Dr Rivers*) The Thames regions would support that view very strongly[1].

(*Professor Hull*) I think for something like the tertiary specialties for children, which is a limited service, what we would be keen to do is to make sure that where the service is provided it reaches a certain standard. To do that you cannot have a whole lot of units doing it and trying to do it. You must bring together the strengths and the workforces so that they can have a minimum standard level, and that means a certain amount of throughput and that means having an organised statement for a nationwide strategy. That is what you have to have if it is going to work to use the resources optimally. It does not fit in with having, as I have got in my region, one trust, one directly managed unit. We have an integrated service but we do not talk to them about it.

Chairman

1028. I want to put a rather controversial, provocative point to you really in answer to what you have just said. Is not what is happening at the present time, with some exceptions and I think Professor Cooke and Professor Levene have indicated that for some hospitals it is actually improving, what may well be described as putting the clock back twenty years to the time before regional units were in fact in the first situation set-up, ie a free-for-all to the detriment of these very small babies because you are going to be spreading the money; there is going to be a larger number of units seeking to make a bid for this sort of care and the super regional specialty units which Mrs Short and I and others advocated when we did an inquiry some years ago on this are likely to suffer? Am I right or am I wrong?

(*Professor Hull*) I think you are trying to link it in with a management arrangement. If you require a unit to be of certain size, certain standard of quality and so on so you can give directions to commissioners, and there is a perspective as to how many of those you need, with some sort of recognition that you are serving a larger population than the district health authority, then there is a possibility of solving it within the current arrangements. It takes a great deal of will and courage to put those frameworks about. It seems a pity to introduce the management arrangements until those have been agreed upon. We are now expecting nearly to rediscover the rules for setting up the arrangements but in the meantime those of us who are providing the service are going to go on doing it while the management arrangements float themselves around.

Audrey Wise

1029. It seems to me one of the things you are saying, Professor Hull, is that a co-operative attitude within the service is also part of that. I seem to pick up the idea of planning a strategic view and planning based on that, and a sort of culture of co-operation amongst the different providers. Is that right?

(*Professor Hull*) At the moment the services in Trent work because we all talk to each other and share our problems because our resource is limited to meet the size of the problem. If we start getting divisive about our interest then we are going to lose out. If you want to look at arrangements the northern region has got it structured out. Quite a lot of other neonatal services have structured themselves out. They are tentative but they are there. With the new arrangements it does not make it quite clear whether it is a disadvantage or an advantage for us to transfer babies in for example.

1030. I was interested in the British Association for Perinatal Medicine evidence which has already been referred to that you did in that same paragraph refer to the regional genetics services as well. We have taken some evidence on this and it seemed that the geneticists were very keen that there should be a certain regional provision and they felt that it could easily be squeezed out because it does not really lend itself very readily to again a competitive sort of ethos. Do you think that that is important?

(*Professor Cooke*) The genetic services are developing very rapidly. Of course with genetically determined disease most of them individually are quite rare and so the numbers of people requiring services for individual diseases are going to be very few. Wherever you have a rare disorder you need to centralise the organisation of care for that in order to build up experience and to make the thing economically viable in any sense of the word. Yes, it would be very inappropriate for everybody to have a go at being a genetics service. There simply would not be enough for all the little services to do and would fragment what funding there was.

1031. So that it might mean that the most ill babies could possibly suffer if there was not an adequate

[1] *Note by witness:* In this context, the Thames Regional Perinatal Group consider it would be helpful if some form of accreditation of units providing intensive care could be established, possibly through the mediation of BAPM under a directive from the Department. Units offering intensive care would be assessed and accredited on the basis of the quality of their care provision; each unit would be expected to meet previously agreed trained staffing levels with adequate equipment facilities and backup services for the number of intensive care cots they aim to provide. This accreditation would be a form of quality guarantee that potential purchasers could use as a basis for establishing their neonatal intensive care referral patterns.

[**Audrey Wise** *Cont*]

tertiary arrangement for them, but that at the earliest stage the people most in need of very special genetic advice might also suffer, so again it is the minority of the very ill babies and the minority of the people with genetic problems where it might get squeezed between contractors?

(*Professor Cooke*) Certainly, yes.

(*Professor Levene*) Could I just pick up on that point because I think that we must not compartmentalise it into neonatal care or genetic care. We should be talking about perinatal care and the region I think should be planning for perinatal care which includes foetal medicine, perinatal pathology, neonatology and genetics and I am sure that there are others, and I am quite sure that the region needs to have a strategic plan whereby there are relatively few numbers of perinatal centres to allow the cross-specialty of care that is necessary within the context of what we are trying to do. We cannot just think in terms of neonatal care. Genetics is important as well.

1032. It sounds as if it would be the most economic as well.

(*Professor Levene*) Certainly much more economic than every unit trying to duplicate these services.

(*Professor Hull*) I am a little unhappy about the parallels that you are making. Tertiary care as discussed by my colleagues is a relatively rare baby needing a high level of care, which needs to go to a unit that can deal with it. Genetic counselling needs to be available for everybody and that is a distributed service, and therefore, although one accepts that if you pick up a rare disease you have got to refer it to somebody who is familiar with it, genetic counselling services have got to be available to everybody where they need them, so I am not quite sure that the analogy of networking that, so that it is only available in certain special centres makes any sense at all. I think that ought to be available for everybody.

Chairman

1033. Can I ask perhaps whether our neonatal nurses would like to make any comment on what has been asked or said so far? You have a vital role to play. Are you happy with what has been said by your colleagues?

(*Mrs Hale*) The Neonatal Nurses Association feels strongly that there is a need to continue centres of excellence and to have regional centres for the care of the small, fragile and vulnerable babies, and that it requires the skill of competent and expert nurses and those nurses are unable to be dissipated across the country in the extent which they would be required if care took place outside regional centres.

Audrey Wise

1034. I was going to raise also the point you make which is relevant I think to all of you that there should be a regional perinatal group that would audit overall outcome and highlight deficiencies in the regional perinatal programme. Do you think that that is going to happen or not?

(*Professor Cooke*) I think in a number of regions it is already up and going. In other regions they have not even got started. The problem is that these sorts of things tend to happen either when there is an enthusiast around or when there is a requirement from above somewhere that this should be done.

Chairman

1035. How does it happen though, Professor Cooke, in one area where it is up and running and going well and your reply just now where you said in others it did not even exist at all? That shows an extraordinary variation in the level and quality and availability of this vital service.

(*Professor Cooke*) That is as I see it, yes.

Audrey Wise

1036. What do you think the Department of Health's role should be in this to ensure that that does not happen?

(*Professor Cooke*) People will only collect information on which you can make judgments about a service if they either themselves have a special interest in it or they are required to collect it. In fact, information collected for no particular purpose is usually fairly worthless because it is badly done. If the Department require certain figures and certain information at a certain level of detail each year, then no doubt they will get it. I hope they would make sure they did.

1037. Do you think there are such figures and information that they should require?

(*Professor Cooke*) There is a great deal, yes. They should have information about the numbers of children requiring treatment, who actually got it, what sort of delays it took for them to get it, and what standards this care is actually being given under.

Sir David Price

1038. This takes us back to a complaint we had as a Committee in the early eighties from many of your colleagues, that so many of the statistics that they are asked to provide at almost every level of the health service as you say can be of general interest but of no specific help to the individual person concerned in fulfilling their job, and one has come to the rather awful conclusion that it seems that all the new lot of statistics were designed by statisticians for the benefit of statisticians rather than for the benefit of making either clinical or management judgments.

(*Professor Cooke*) Yes.

1039. Would that be a little harsh?

(*Professor Hull*) The clinical data is unhelpful, with respect to the questions you are asking now, yes. I think Richard Cooke is being a bit harsh. There is an analysis by the Perinatal Centre on the number of units that were making reviews of their services in perinatal mortality meetings and I think quite a lot of centres are doing it. What they are not doing is the same meticulous analysis that Richard Cooke has done for his in-patient service and which the Northern Region has done, but it is the recommendation of the Department of Health, and maybe you should ask, that they are there to collect a lot of data and they are thinking of setting up a confidential inquiry into neonatal death. There is quite a lot of activity in the Department in this area.

Chairman

1040. What I think you have been saying, certainly Professor Cooke, is that it is possible that if you live in a particular area of the country and you have a very lightweight, vulnerable baby, that baby will die because they have not got the appropriate intensive care specialist facility that they have in Merseyside. Am I right or am I wrong?

(*Professor Cooke*) I think you are right. The problem then comes when people say, "Show me exactly which one died because of that", which is something that somebody will inevitably lead to. The difficulty is that there is still a presumption among many members of the general public, and certainly even some members of the profession, that very small babies tend to die anyway and that if a doctor is faced with phoning three, four or five different hospitals around the region and outside his region in order to try and place a small child and in the end he does not succeed, he may well simply cover this up a bit by saying to the parents, "I do not think transfer would help" or "Nothing else can be done" or something like that. In that very stressful time for the parents one is not going to say, "Well, clearly this is a lack of provision that has caused your child to die" etc. This sort of information is therefore difficult to collect and tends to be anecdotal.

1041. Professor Levene, then Dr Rivers, and I suspect that Professor Hull may care to come back. Then I want to pass on to other questions.

(*Professor Levene*) Two brief points. Three or four years ago the British Association of Perinatal Medicine commissioned a survey to see how many babies who were referred for neonatal intensive care could not be got into a unit at all and approximately ten per cent of babies who were referred could not be got in. We do not know what happened to those babies, which brings me on to the second point that simply counting the number of dead babies, the perinatal mortality, disguises a very important aspect which is that babies may not die in the centre that is referring, that cannot get the baby in. They may survive to be handicapped and if we are auditing the service it is not just perinatal mortality statistics that we need but we need good national outcome statistics as well, and this is done extremely badly through the country.

1042. Would the Clinical Standards Advisory Group be an appropriate body to deal with this matter, to examine standards, etc?

(*Professor Hull*) You are going much faster than I can. The Audit Commission is currently looking into acute medical services in children as well and they have just been scrutinising our units in Nottingham in depth with a view to setting up an audit standard. They are not actually looking precisely at the figure that you keep on going for, which is in fact not neonatal services but the care of a very small fraction of newborn babies who require level three intensive care. Looking for the data that you are asking for, the Northern Region has looked for it. The size of the maternity unit does not seem to correlate to the perinatal mortality rate. They have got specific data for the whole of the country on this. Therefore getting the precise data in mortality statistics, I think you would have difficulty finding it. Getting paediatricians who say that they would like to transfer a baby and the baby died because it was not transferred would not be that difficult, but I have to say that when you talk about regional centres, as I represent the British Paediatric Association at the moment, there are a lot of general paediatricians who do level three care in small units who have never ever transferred their babies for level three care to the neonatal centre and would not wish to do so and would object to doing so if there was an arrangement set in which said that they should.

1043. Thank you. Dr Rivers?

(*Dr Rivers*) I have three points. One is that I would just like to refer back to the Royal College of Physicians Report of 1988 on newborn care which examined the effects really of two models of care, one centred more on regional units and one devolving the intensive care to many small district hospitals, and the really major effects on staffing implications, both medical staff and particularly nursing staff that that would entail, and I have referred to that in my document. Secondly, I think it is also very important to make this point about adequate follow-up if we are going to know what happens across the country to these very low birth weight babies. There must be some sort of national follow-up system. Thirdly, in terms of the cot provision in London which has already been alluded to, I think we have something like half the number of intensive care cots in London that we should on the basis of 1.5 cots per thousand live births. We did a brief survey over a period of four months last year on just how long it takes individual units to find a cot for a baby that needs transfer, and it took anything up to four hours to find a neonatal cot and in some circumstances it took up to three hours to get an ambulance and in some cases it took up to three hours for the ambulance journey of the infant, so some of these babies are being transferred quite long distances in order to get them into a regionally designated intensive care unit.

Audrey Wise

1044. Do any of our witnesses know of any regions which have what would be regarded professionally as sufficient cots?

(*Professor Cooke*) No.

(*Dr Rivers*) None of the Thames Regions.

Chairman

1045. Mersey?

(*Professor Cooke*) No.

1046. North?

(*Professor Hull*) No.

Audrey Wise: And I know North West does not.

Rev Smyth

1047. May I go back to the question of contracts and charging for block contracts. How do you think charges should be calculated?

(*Dr Rivers*) I think it should be done on intensive care cot days and held at region on a block contract and a unit should be funded on that basis, and some system certainly in London of cross-regional payments should be evolved on an extra-contractual basis perhaps.

[**Rev Smyth** *Cont*]

1048. That of course is one of the questions of the money following the patient.

(*Professor Cooke*) Yes, I think there are certain costs for volume which works out the number of days and the level of care. The problem that certainly our accountants raised against that, which we suggested as the original best way of doing it, was that the further you go into working out the precise costs the more that costs and that it was not actually worth doing.

1049. Money for the accountants in other words?

(*Professor Cooke*) They felt that a simple block contract based on £8,000 per case was the cheapest and easiest way of doing it. They are still looking at the possibility of going for cost for volume but until there is any form of computerisation in place that is virtually an impossibility.

(*Professor Levene*) On exactly the same point, in the trust hospital that I work in the charges are per intensive care day, which has some benefit to it but it is very costly actually to get that data because someone has to go round every day and look at every baby and decide whether they have intensive care or special care or occasionally just ordinary care, and they may change from day to day. The baby may move from being a medical baby to a surgical baby within the same day. If you are going to do it properly you are going to need to employ skilled people to collect that data, which is money away from patient care.

1050. This raises the question again that Professor Hull referred to and that is the size of units and we are going back now not to simply neonatal care but to obstetric provision. I got the impression that you favour the concept of larger units, two and a half thousand or so, or were you coming out in favour of what some of us might call the corner shop instead of the co-operative?

(*Professor Hull*) I think the concept of wanting three large units with highly expensive services and all the women trooping to them is just not reasonable. I keep on saying that you are talking and they are talking about level three care all the time as to what is very expensive, and it needs to be costed out because it is very expensive and maybe the accountants will determine that they do not want the hospital to do it because they do not want a lost leader, so it has got to be worked out how much it costs the hospital to do it. But every unit in which babies are born has got to have a neonatal service which looks after level one and level two care as well as the routine examination, and then the question is, can the hospital afford to send the very ill ones on to somewhere else for level three care and how much does it cost them and can they control it, because often we would keep a child in for a few weeks, maybe two or three or four weeks; it becomes in the interest of that unit if there is money that flows with days occupied to hold the baby whereas it would not be in the interests of the baby to have that situation. I think one ought to take advice from the British Army in the Rhine when it actually bought neonatal level three services from the German services and they were very expensive.

Chairman

1051. Can I pursue that because I think it was you or Professor Levene saying I think it was per day charging for intensive care. Our evidence, and this is the Department of Health's evidence, is that most units are charging a flat rate for an intensive care admission, not by the day, and therefore I put to you, perhaps Professor Hull and Professor Cooke and Professor Levene, what are the disadvantages of that, ie a flat rate charge for admission irrespective of the length of that admission as against a per diem charge?

(*Professor Hull*) If you are talking about a flat rate that we would contract to take all the babies needing that sort of care from another health district, that is the "level playing field" language, then that arrangement seems to me to be a sensible one in so far as we would then agree to take all those babies needing level three care say from, in Nottinghamshire, the Lincoln Hospital, knowing its delivery rate is, say, 2,000, knowing that 2,000 on our previous experiences generated so many babies needing transfer for level three care, and for them to have a block contract with us to look after all those babies that come from that unit in a year and then review it year on year depending on the workload that is generated. That seems to me to be the sensible way. If that is what the Department said to you then I think that is the arrangement we have at the moment. Correct me if I am wrong. That would be a sensible thing to do, so Lincoln and South Lincolnshire and North Lincolnshire draw up block contracts with Nottinghamshire to look after their level three care, knowing that their previous work in the previous year was that much and they will pay to have that much again. If it goes grossly above that we agree a proportional increase and the workload would be the transfer of baby days.

(*Professor Levene*) A disadvantage of charging per day is clearly the possibility of overcharging, keeping babies in intensive care when they should be going back. In the present situation in this country there is no risk of that at all because there are just far too many babies demanding intensive care in our units. We have to get the babies out often before we feel it is reasonable to do so. In the future if things change then we would have to look at it again. The advantage of that system of charging per day is that often with the in utero transfers where a hospital will refer a woman to a regional perinatal centre, the baby is born in surprisingly good condition, as often happens if the care in the pregnancy has been good, and the baby may need only two hours of intensive care, yet the district will be charged £10,000 for that block contract. What I prefer to see actually is not the districts paying as the purchasers, but the region paying for the work that we are doing.

1052. That does not fit in very well with directly managed units, trust hospitals, etc, does it?

(*Professor Levene*) It does not, no, but the situation is at the moment that the purchaser/provider split is fine providing there is enough money in the pot to pay for it, but there is not and this is the problem that we alluded to earlier. If the region wants to have a regional service, which I believe that it should have, then the region I think has to make some financial commitment to that. Top

[**Chairman** *Cont*]
slicing to the trust hospitals is not necessarily the answer.

Rev Smyth

1053. Can I take you to part of your evidence where you said that there is a danger that glamorous but inadequately evaluated therapies such as ECMO, that is, extracorporeal membrane oxygenation, will be offered by trust hospitals, consuming scarce resources, but without significantly improving outcome. Can you explain why you think that there is this danger?

(*Professor Cooke*) The particular treatment I have mentioned there is given purely as an example rather than my being particularly for or against that treatment. If you take what has happened with this particular very high-tech therapy for very sick infants that has been developed largely in the United States, where it has taken off very quickly and has been adopted by many of the big leading hospitals, which function rather in the way of trust hospitals would do here, because it makes them look glamorous and there has been no good evaluation at all of this therapy, there is no doubt that it works. The question is that other people suggest that they can do just as well using very much cheaper therapies, much more conventional therapies. Nevertheless it has taken off simply because people like doing it and people like buying it.

1054. Taken off here?

(*Professor Cooke*) Sorry, no in the States. There is only one centre in this country at the moment, but I believe another three are coming on line very soon and will be capable of doing it.

1055. And you think therefore that this will consume funds without providing the results. Is that what you are saying?

(*Professor Cooke*) It will consume funds at a great rate because it is very expensive treatment, and the amount of benefit one may get for this will be relatively small compared to the amount of money you are putting into it.

1056. Then will purchasers buy it? I am not talking now about private purchasers; I am talking about general practitioners or districts who are contracting. Will they be going for that if there is adequate provision that gives as good if not better results?

(*Professor Cooke*) The problem is of course the general practitioners and similar primary care people will not come into it because this is really a tertiary level therapy. It would be one district hospital acutely requesting a centre to do this. My fear is that the evaluation will not take place. There is some suggestion that an evaluation may take place with this particular therapy beginning next year, but it has not happened yet. There are many others like this.

1057. In other words you are suggesting that they should be examined?

(*Professor Cooke*) I am suggesting that no new therapies should be introduced before they are properly evaluated.

1058. Professor Hull wants to come in.

(*Professor Hull*) It seems to me that the answer to this question lies in commissioning. Somebody has got to give evidence and guide the commissioners and they have got actually to say whether they are prepared to commission for this service or not. What is important is they have got to say "no". It is very expensive and within their priorities they cannot afford it. This is a very difficult thing to say. The only way to cope with that is to say that any very expensive treatment is not introduced in this country until it has proved to be efficacious. The reason it has come on in America is that no unit that does not have that toy is held to be very good and there is no restraint because there is no money bar. For a GP to say, "I refuse to let my patient have that because my budget is short", is going to be an impossible position for him, so he has to have some central help there on his moral position.

1059. Can you suggest who might do that accreditation?

(*Professor Hull*) I think that is a proper task for the professional side of the Department, to give guidance on that matter. At the present moment the evaluation is done by the neonatal services getting together and doing it but that does not stop an individual practitioner saying, "We think it works and we do not want it evaluated" and there is no way of stopping that.

Sir David Price

1060. I want to go on to some of these cost figures. Can I ask you generally have you got secure information as to what neonatal intensive and special care costs and how does the cost compare with for instance intensive care for adults?

(*Professor Cooke*) There are a number of costing studies that have been published in this country and abroad. Sticking to the ones published in this country from about the mid eighties onwards, putting it at today's prices, intensive care costs approximately £500 a day for the newborn, which is probably rather less than it does for adults. The problem is that it depends exactly what you are doing to them, but the costs are slightly higher for adults, the hotel costs and so on tend to be higher and so it is comparable. If you take special care, it is very much cheaper. At 1986 prices we estimated it at around £180, £190 a day for special care, which is well below the standard cost of somebody lying in bed not doing very much in an adult medical ward.

1061. Could we go back to a question which you sort of half answered? Have you evidence that mothers with very high risk pregnancies and very ill babies are being refused admission to regional perinatal centres because of lack of cots? We got the impression from the Thames region that there was a shortage there.

(*Dr Rivers*) Yes indeed. We do have information that the major perinatal centres are turning away about half of the cases that are being offered to them. It is certainly true in North East Thames and South East Thames.

1062. About half?

(*Dr Rivers*) Yes.

1063. Is this problem special to the London Region or is it fairly general?

(*Professor Levene*) The figure nationally which we looked at in 1988 and was published in the British

[**Sir David Price** *Cont*]

Medical Journal was that 10 per cent of all referrals throughout the country cannot be got into a neonatal unit and in some of those cases the referring doctor would make eight to ten telephone calls to different units before they gave up. I think every region finds that there are not enough intensive care cots. We are not talking about the regional centres demanding the babies. We are talking about the doctors, paediatricians in the district general hospitals who themselves feel incapable of looking after those babies. Certainly in my own unit we have turned down eighty babies this year for intensive care.

Chairman

1064. What has happened to those babies?

(*Professor Levene*) We do not know because we do not have the resources to find out what has happened to them. Most of them I think are looked after in the hospital that refers them. The doctor clearly is not happy to do that because he has attempted to move them somewhere else, but he ends up looking after them anyway. As I said before, simply counting whether they die or not is not satisfactory because they can survive and they may be handicapped as a result.

Sir David Price

1065. Because the Department of Health apparently does not collect these figures?

(*Professor Levene*) No.

1066. Going back to our questions earlier about figures, it strikes one as important they should do so, or again is this the responsibility of the National Health Service Executive? They are managing the service, or supposed to be.

(*Professor Levene*) I find it difficult to know who should be collecting the figures. I think they should be collected in a nationally agreed manner. There is no point in my collecting them and my colleague in another part of Leeds collecting them because we may be collecting the same baby. One needs a name or a hospital number in order to trace how many different hospitals that baby is being referred to. One baby referred to ten hospitals may be counted ten times. It is actually only one baby. It becomes quite complicated to track these if you are going to do it properly and I am not clear in my own mind how this can be done properly.

Chairman

1067. There is one question I would like to get clarified. Could you give us the cost of what I would describe as average adult non-intensive care cost within the National Health Service? Do you know what that figure is? I believe it may well be around £300.

(*Dr Rivers*) That was the information I got.

1068. So to an extent the cost of intensive care for any baby of £500 is actually good value for money, is it not?

(*Dr Rivers*) Yes.

1069. Would you accept that as clinicians?

(*Professor Cooke*) Naturally.

1070. Even Professor Hull?

(*Professor Hull*) Just because I keep trying to change the subject does not mean I do not agree there is a need for level three care and the cost has got to be weighed not against life and death, which I do not think is the issue; it is to do with the quality of survival, and if in fact you compromise that it is very expensive and on the legal evaluation it is a million pounds a time if you get it wrong.

Audrey Wise

1071. I would like to go back to what you said about evaluating treatments because this seems to me to be important for a number of reasons. One is that money might actually be wasted, money and skill resources. Another is that perhaps a baby is given treatment which is not the optimum treatment. Another treatment would have been better for it, and of course it is possible some treatments may actually do harm. It is also possible that some treatments if evaluated would show up as being extremely useful and could therefore be made more widespread. It seems to me to be a very important matter. I am not clear whose responsibility you think it should be to ensure that new or indeed existing treatments should be evaluated and how we should ensure that this work is funded.

(*Professor Cooke*) If I could comment on how it happens at the moment, it is evaluation that largely comes out of work from university departments up and down the country. A recent development during the eighties has been the involvement of the National Perinatal Epidemiology Unit in Oxford which has a clinical trials service of which you are probably aware, and this has worked with the British Association for Perinatal Medicine, both in running a number of quite large trials in this country successfully which have produced useful results, but also most recently in compiling a database of all obstetricians and paediatricians interested in joining in large collaborative research projects. The reason these projects need to be large is that the benefit or otherwise of any new therapy these days is not likely to be stupendous. Progress is made by lots of small steps and each change in treatment may have a relatively modest effect, and in order to discover that effect with any confidence you need to have a very large study with a lot of patients and a lot of doctors involved in it. The co-ordination through organisations like NPEU, which is supported by the Department of Health, has been very valuable in this respect, but an awful lot more needs to be done. It is just the beginning.

(*Professor Levene*) I think it must be the profession itself that sorts out these problems and evaluates them. I do not think it can be imposed upon us, but in fact neonatologists are extremely amenable to assessing new treatments. We have a good record for doing this.

1072. What about funding, the paying for it?

(*Professor Levene*) I think if the Department of Health believes that it is important the Department of Health must pay for it. The funds cannot come from other sources. Perhaps the Medical Research Council if it considers itself to be interested in that, but I think that the MRC and the Wellcome are much more interested in basic science these days and not clinical science.

[**Audrey Wise** *Cont*]

1073. Thinking of the Perinatal Epidemiology Unit at Oxford, they do have a very long list, not only about perinatal care but maternity care in general, of forms of care with unknown effects which require further evaluation. The Department does fund that unit. Do you think there should be a clearer responsibility and expectation that the Department will fund evaluations such as the NPEU find to be necessary?

(*Professor Cooke*) Yes of course. We would support that very strongly. We are hoping that the new approach to research funding within the National health Service might go some way to doing that. We do not know yet what is going to come out of it but we understand now that 1.5 per cent of the National Health's funding should go towards research. One is very pleased to hear this. What we do not yet know is how this is to be carried out.

1074. Do you know how that compares with what is spent on research at the moment? Does anybody gather information about what is spent on research at the moment?

(*Professor Cooke*) I think the difficulty is that money gets into research by all sorts of devious routes and it is very difficult to work out exactly what is spent on it at the moment and I think this is an attempt to do that.

Sir David Price

1075. May I ask you a quick question which I am sure you can answer very quickly, just for our record. Are staffing levels adequate to run a satisfactory service for neonatal intensive care?

(*Professor Hull*) Can I answer that in the general sense of neonatal care because it is an issue that I did and would like to leave on the record. This is in relation to providing a 24-hour medical cover for babies wherever they are born and the appropriate cover when they need special care in neonatal units, that the Minister has made the statement that doctors will not work for more than 72 hours and wishes the task force to implement that by 1994. It has also been agreed with the Joint Consultants Committee in the Department that consultants would not be resident in hospitals to provide emergency cover for emergency services. Those are the two facts of the matter. The evidence of the facts is that SHOs in neonatal medicine and in paediatrics work very long hours as in this publication on paediatrics which I do not think you have seen, which actually states that they work far longer than any other SHOs, and that when they are on night call—that is when they are on call—they are usually working all the time and at most they get four hours' sleep a night as a maximum. In many parts of the country (but this is not necessarily in tertiary centres) paediatricians who were providing this service only had SHO on VTS training between themselves and the child. If in fact we then apply the two requirements that are being imposed—and this is since we wrote our evidence to you—then I have to say that quite a large number of neonatal services round the country will have to close down at certain times because there will not be staff available to cover them. This is a simple straightforward consequence of the Minister agreeing with the profession that doctors will not work long hours and consultants will not be first on call in residence in hospitals. There has got to be some solution to that.

1076. What would be your solution? Presumably at one end more consultants?

(*Professor Hull*) We have obviously brought this to the attention of the management executive and the CMO and to the staffing section of the Department, and the solution rests, quite rightly you say, on having more doctors. You cannot do it by putting them on rota arrangements because they are already working excessively long hours.

Chairman

1077. What feedback have you had from the Department? You say you put it before that great body, the National Health Service Management Executive. Have they responded?

(*Professor Hull*) No, but they have this document, they have the information, they have the analysis, we have put the data in from our own evaluation and this is concerned with covering neonatal units for level three care as well as neonatal units—

1078. When did you put that booklet in front of Duncan Nicol and his colleagues?

(*Professor Hull*) That was about six to eight weeks ago.

1079. And no response yet?

(*Professor Hull*) They have received it.

1080. No, no. I was not asking about receipt. I was asking whether there has been a response.

(*Professor Hull*) Not to my knowledge. We have had a meeting with the Department staffing and they are aware of the problem.

Sir David Price

1081. Could you give us rough overall figures of the shortage both at consultant level and at junior level, very roughly? What sort of percentage?

(*Professor Hull*) I can leave you the book with them in if you wish. On the calculation it just depends what sort of agreement the Minister wishes to make to SHO's but it is nearly like doubling the numbers.

1082. It is as much as that?

(*Professor Hull*) Oh, it is indeed, and the solution that they are looking for, which the JCC and the Chairman of the Manpower Committee were meeting with the Department about, was some sort of conversion of CMOs and SCMOs to do on-call rotas, but you cannot achieve that instantly and you certainly cannot achieve it by 1994, so there is going to be a severe embarrassment which will effectively close down units unless it is resolved.

1083. Could I follow that up, as we have colleagues from the Thames region: you presumably are already aware of this?

(*Dr Rivers*) Very much so, yes.

1084. What does it mean in your terms? Very much what Professor Hull has been telling us?

(*Dr Rivers*) Yes. The implications will be exactly similar.

1085. And you are already short, you tell us, of cots?

[**Sir David Price** *Cont*]

(*Dr Rivers*) There is under-staffing and there is certainly a great shortage of cots and of nursing staff, which has never been adequately established and funded. Also this will have major implications for medical staff.

Audrey Wise

1086. Perhaps I could address myself primarily to the Neonatal Nurses Association, could you summarise the role of your organisation and how does it relate to that of midwives and paediatric nurses?

(*Mrs Hale*) The goals of the Association are to promote a common standard of nursing care for the newborn, to promote education of neonatal nurses, to promote communication and co-operation between neonatal nurses, to promote an awareness of the needs of the newborn and his family and to communicate with the newborn and his family. In relationship to the midwives, we welcome paediatric nurses and midwives and neonatal nurses within the Association and we say that each of those professionals contributes to the care of the newborn but that we would draw your attention to neonatal nursing as a specialty within its own right.

1087. What do you think is the role of midwives in neonatal units and how does it differ from your role? Are there potential conflicts or is it relatively straightforward to define the roles and to work out co-operative arrangements?

(*Mrs Hale*) Neonatal nursing is a diverse specialty and that diversity is our strength. Midwives are practitioners who care for the normal newborn, and neonatal nurses tend to act as nurses who will care for the baby who would be abnormal in this respect, that is, the baby with specialist needs. We would see the role of midwives and nurses as those two working together to provide optimal quality care for babies and their families with close networking of both of those professionals. The midwife has a role in neonatal units but that would be with an extension of expertise into neonatal nursing and over and above that qualification of midwifery.

1088. We understand that working in a neonatal intensive care unit can be very stressful and there is a high turnover of nursing staff. What do you think can be done to improve matters?

(*Mrs Hale*) That is correct, that retention can be a difficulty. If we can come back first to neonatal units and the provision of care, the single most common factor for not being able to admit a baby into care is the lack of availability of the qualified-in-specialty nurse, the nurse with competencies and expertise to care for that baby. Many of the stressful situations result from the fact that the question of establishment has never been addressed. We are chronically under-resourced for neonatal nurses who are qualified in the care of the newborn. We lack support teams to support nurses who are giving that care. We lack adequate access to education and the whole issue of professional development of neonatal nurses needs to be addressed. Some of the areas of our concern were well expressed in the survey of nurses working in high technology care in 1989 and they suggested and made recommendations for how some of those stresses could be helped, mainly in more imaginative access to education for neonatal nurses who were frozen by geography in their situation or their domestic situation or the lack of funding to reach out for education, or the fact that simply it is sometimes impossible to send a nurse away for further training to promote good care in her own unit because you have not got a person to work in her place whilst she is away on a training programme. In addition to those factors there are the conditions under which neonatal nurses work. Neonatal units are highly pressurised. Sometimes we feel there is misuse of the facility and that one needs to look very critically at how the facility in neonatal units could be used. One example of this would be to welcome babies for care next to their mother as far as it is possible, and by this we would be referring to small well babies who require minimal clinical monitoring, phototherapy and tube feeding, where they can safely be nursed in the midwifery unit and embraced into the midwife's normal role and stay next to the mother which is where every baby should rightly be. This would help alleviate some unnecessary admissions to neonatal units which would then save the expert neonatal nursing care for the babies who needed it most[2].

1089. In following the point in a different way about misuse, the British Association for Perinatal Medicine in their evidence to us said that the proportion of nursing shortages related to the use of the nursing staff for non-nursing tasks, such as clerical and cleaning duties and in trying to get defective equipment to work ..."

(*Mrs Hale*) Those were the support teams to which I referred. There is very little in the way of support teams for neonatal nurses. Neonatal nurses in fact fill in all the gaps and deficiencies in the provision of the service and in this we are referring to housekeeping teams, clerical support, receptionist support. Large amounts of dedicated nursing time will be spent in routine non-nursing duties. In addition, specialist support roles, for example in the areas of family care and education are required.

1090. The point about the equipment interested me because in one of our trips out to seek evidence we were told—in fact I think it has arisen more than once—that a good deal of the equipment in neonatal care units actually comes from voluntary subscription, that this is a very good issue for fund-raising; people respond very well to it. Then the problem arises with maintenance and replacement because the funds raised supply the equipment and then what happens later on? When I saw a reference to trying to get defective equipment to work I wondered whether in fact some of this process was at the root of what happens. How does your experience go in relation to the balance between how neonatal care equipment is funded and then how it is maintained and what preparations are made for its replacement.

[2]*Note by witness:* "The Neonatal Unit as a Working Environment—A national survey of neonatal nursing". This three year research project, funded by the Department of Health, is being carried out by a research team based in Child Health at the University of Bristol. The main aim is to document many aspects of the work environment particularly from a staff viewpoint. The focus is on the work and experience ofprofessional care-givers that affect delivery of care.

[**Audrey Wise** *Cont*]

(*Mrs Hale*) Neonatal care requires today, due to the advancement in the management of the newborn, large amounts of sophisticated technical equipment. That equipment must be checked, cleaned, monitored, assembled, re-assembled, set up, prepared for use. It must also be obtained and it must be replaced when it goes wrong. There has been again major under-funding with regard to the purchase and maintenance of technical equipment. The money simply is not there to replace equipment and we must rely upon charitable organisations to donate it and actively campaign to get that money from charitable organisations because of the lack of funding.

1091. And it is perhaps harder to get equipment replaced than it is to get it supplied in the first instance because possibly the general public feels, well, it has made its contribution and now it is up to the NHS. Is that so?

(*Mrs Hale*) It is really very difficult all round. If it is a compulsory replacement you may be successful. If it was condemned and felt to be unsafe you might be successful in getting it replaced.

1092. Only may be?

(*Mrs Hale*) You may be. It is very much dependent on what you are talking about, how much it is and how much of it you require and it simply is not forthcoming in the amounts in which it is required to do the work.

1093. Do neonatal nurses have to spend their own time and energies in such fund-raising?

(*Mrs Hale*) I believe a lot of neonatal nurses spend a lot of time doing public talks and generating an interest in groups to collect and contribute towards the purchase of equipment, and again going out to thank them. Some areas have set up small trusts and have people to help them organise such funding. It does take a lot of time but also medical colleagues are equally involved in the promotion and work of trying to get extra funding for medical equipment.

1094. Turning to another aspect of staffing, do you think that there are sufficient staff on post-natal wards for transitional types of care?

(*Mrs Hale*) The answer to that across the country is no. There are not enough midwives available to be able to give that slight extension of care which we feel should be within the normal role of the midwife to allow the baby to stay with his mother in the post-natal situation.

1095. So the picture we get—at least the picture I get—which you might confirm or otherwise—is that there are some babies who are just a little bit under par but who should be nursed with their mothers and are sent instead to a higher level of intensive care than they need, and there are other babies who need intensive care who cannot get it?

(*Mrs Hale*) That is right. A survey carried out in Trent indicated that from an inborn population there could be as little as 4.8 per cent of babies admitted against 25 per cent of all those deliveries, and when you looked critically at the population within the neonatal unit 40 per cent of those admissions may not necessarily have had to be admitted to a neonatal unit.

1096. But possibly that happened because of staffing and other problems on the original ward?

(*Mrs Hale*) That could be a lack of staffing or perhaps what might also be required would be a change in attitude and an examination of the provision of the facility.

1097. Moving on to something rather different, in some parts of the country I believe neonatal nurses are being trained to take over some of the duties of junior medical staff and are then described as "nurse practitioners". Is that happening in your experience and do you think it is a good idea?

(*Mrs Hale*) Neonatal nurses across the country do not have an established norm in which duties that they do that in some areas could be delegated as medical tasks and in other areas would be considered an extension of the nurse's role. The word "practitioner" to us suggests a stage of expertise and it is quite reasonable to accept that nurses might carry out certain delegated tasks as part of their expanded or extended role. It could be done, and some of those tasks with fairly minimal training. The practitioner role to which I believe you are referring is the model which is being set up in the Wessex region which is due to commence in January 1992 and this model suggests a role of advanced practitioner and with "advanced" we would mean that that would be a nurse of professional excellence but who would develop advanced clinical skills and take over a number of medical tasks. The Association has concerns with relation to advanced practitioners. We welcome the concept of a practitioner and of an advanced practitioner but we feel concerned that in a situation where we are chronically under-resourced for qualified in specialty nurses and we lack the adequate nursing structure to be able to give care effectively with job satisfaction, another key element, and to feel that we are providing an acceptable level of care, that to deflect the available nursing time into the undertaking of what is at the moment SHO activity could prove very difficult for neonatal nursing.

Audrey Wise: Thank you.

Chairman

1098. We have obviously got limited time if we stick to our hopeful timetable. Perhaps to the questions I now intend to put to you, particularly to Professor Hull in the first instance, if your responses could be brief and succinct I would be grateful. I think, Professor Hull, you told us in the evidence from the Paediatric Association, that paediatricians are responsible for resuscitation of babies at birth and the routine examination of all babies. Do you think that midwives are currently able to do this? Do you think that they could be effectively trained to carry out this important role, and how long would it take to train them all to a sufficient standard in this new responsibility?

(*Professor Hull*) I will deal with the resuscitation exercise first, the 24-hour resuscitation of asphyxiated babies. It was suggested that midwives twenty or thirty years ago should be trained with tracheal intubation resuscitation and that was an endeavour in which I was involved. It came to nothing. If it is the view that babies may adequately be resuscitated with the face and mask, which is the view and the way they have solved the problem in Sweden, then certainly midwives are well able to do

[**Chairman** *Cont*]

that, and it certainly is a skill they should have, but in Sweden they have found that there are still occasional babies whose life depends on tracheal intubation and artificial lung ventilation. I think experience has shown us that midwives on the whole do not do it frequently enough to acquire the necessary skills. As far as the routine examination of the newborn, midwives currently as I understand it do examine every newborn baby, looking for abnormalities and defects, and they do it soon after the baby is born. As far as them becoming the persons who do the first major appraisal of any child that is born, then that is a very big exercise and there are elements of it that the midwives I am sure could do as well, properly trained and with sufficient midwives and time, as anyone else, but part of this examination includes listening to the heart and although they might well be trained to do that we are beginning to look at a training that is close to that of a doctor to perform that task. They would also have to have some sort of feedback evaluation as to whether they are effective or not and they would have to be midwives who did a lot of it rather than those who did it very infrequently. Whilst it is possible, I am not quite sure that it will be a complete advantage to do it that way.

1099. Professor Cooke, do you agree or disagree with what Professor Hull has said, and Professor Levene I would ask you similarly.

(*Professor Cooke*) I broadly agree. In our own practice midwives have largely taken over the role of the second examination. Most babies who are in for not more than a short time are examined first at about twenty-four hours and then again before discharge. Provided no problems have arisen it is now routine for midwives to examine these children prior to discharge in order to speed up the discharge process because mothers stay for such a short time these days.

(*Professor Levene*) All midwives must be trained in basic resuscitation skills. Few I believe can be trained because of the infrequency of the problem in advance resuscitation skills which includes intubation and the giving of drugs, often through an intravenous or intra-arterial line. Those are difficult skills to achieve if you are not doing it regularly.

1100. Dr Rivers, Dr Hamilton?

(*Dr Hamilton*) We are very short of midwives on post-natal wards. We do not and they do not feel they enough time to devote to breast feeding, so I am not sure that at the current staffing levels there is enough time to take on that role or to devote to extra training.

1101. Let us move on then to another question which follows from an answer we have just heard, talking about the speedy discharge of babies and mothers. Are there any dangers to babies of very early discharge following a domino delivery, and how should these dangers be overcome? Who do you believe is best placed to be responsible for identifying serious illness in babies at home and who should be responsible for referring the baby to hospital and what is your attitude to home births or to delivery in small GP maternity units? I hope they can be brief and succinct responses. I suspect I am asking rather a lot.

(*Professor Hull*) I think if the domino delivery is done within a unit that has 24-hour anaesthetist, obstetric and neonatal support, then that gives you the back-up and the safety, but the general practitioner and the midwife who are sensitive to the child and the family do the total care with the GP doing the routine examination. There is no reason why, and this might be a solution to the staffing problems, all GPs should be appropriately trained and be the doctors who have performed the examinations whilst they were SHO's in paediatrics. I have no difficulty with that at all. The debate on the statistics about safe home delivery—there are books and books written on those and you recall that it was a misunderstanding of the original statistics of the 1958 study that led to babies all being delivered in hospitals. The data was there and was not scrutinised clearly enough. I think one has to look after it carefully but my view would be that babies can be safely delivered at home. My anxiety about that position rests on covering the liability.

(*Professor Levene*) My views are exactly those of Professor Hull.

(*Professor Cooke*) My last two children were born at home so I have to be considered to be a supporter of home deliveries. I think that the important thing is that if we are to move to a greater involvement of general practitioners and community midwives in taking over the surveillance procedures which are now largely done by hospital staff, they must have the training for it, and recently when the British Paediatric Association was looking at the training for general practitioners it became obvious that less than half of them have had any paediatric training at all following qualification. That really cannot be a satisfactory basis for suddenly giving childhood surveillance over into the community. It is a desirable aim but it must be supported with appropriate training.

Audrey Wise

1102. Could it not be that it need not be 100 per cent of GPs? They may not all want to do so much of that work, but we have got quite often now fairly large practices with more than one doctor and a reasonable proportion, a sufficient proportion, of doctors, properly trained and interested, would be what is needed rather than to say that every single doctor needs to do it because then you might never achieve that.

(*Professor Hull*) That is absolutely fine. There is no reason why it should not happen. It is just getting Medical Defence Union cover for them to do it that is the difficulty. It was that legal restraint that closed general practitioner units. It was not that the general practitioner unit provided a bad service. It was one case of birth asphyxia for which they might have been responsible that cleared them out, and I do not know how, unless you give them Crown indemnity for doing it, they are ever going to do it.

1103. I do not know what your views are but there could be different arrangements for caring for situations where things go wrong at birth because at the moment of course people are almost forced to assume if there is any possibility of it at all that it has been somebody's fault so that they can sue so that at some time some years later they can get some

[**Audrey Wise** *Cont*]
compensation. If there were perhaps better arrangements for compensation or help without having to prove negligence, could that not help in easing this situation?

(*Professor Hull*) No fault compensation has been looked at in great depth. The Lord Chancellor has got very clear views about it and he is not for it. He is actually wanting the tort arrangements to stay in position and argue causation and that has been pushed very hard to the highest point. It is a sad position but that is what happened.

1104. I think there are a good many members of this House, perhaps for all I know both Houses, who might not agree with the Lord Chancellor. I am just saying that some backing for our views might be quite helpful.

(*Professor Hull*) But you cannot actually transfer the indemnity off the doctor and the midwife that is actually doing the practice if that is what you were suggesting.

Audrey Wise: What I am suggesting is that at the moment the only route for getting adequate financial help is the route of blaming somebody and suing and that this may lead to unnecessary legal action. There is a great deal of wasted time and professional stress and if we found a different way of caring for infants where something has gone wrong, which mostly will not be anybody's fault anyway, then that would relieve the possible oppression of the legal system and be helpful to the profession and helpful to parents of handicapped children too.

Chairman: I think we could have a major debate on this which is not entirely relevant to this.

Sir David Price

1105. I think the aspect that worries me most is the evidence that the fear of legal action may distort clinical judgment and that people may take extra tests they do not need to take. From quite a number of studies from the United States for example we get very clear evidence of even putting young medical students off certain specialties—obstetrics is an obvious one.

(*Professor Hull*) The staffing position is difficult in paediatrics because of the reason I gave you. The staffing position in obstetrics—again we have been to the Chief Medical Officer and the position there is bad and getting worse and there is not a solution on the skyline.

Chairman

1106. Mrs Huxton, did I see you wanting to come in on this?

(*Mrs Huxton*) It is about an earlier point about care of the infant after early discharge. I would have thought that the community midwife would have been the first in line person to keep an eye out and detect the early problems with access to the hospital and to the paediatricians and neonatologists for help and advice. In my own area we do that. I do not know about other areas. They will either ring up or bring the baby back if there is a problem.

Chairman

1107. Could I very quickly ask those that would care to respond: how do you view the current state of research into illnesses affecting mothers and their babies and what would you consider should be the priorities?

(*Professor Hull*) I am in writing on that one, in a response to the Green Paper, the "Health of the Nation", the major burden on our units at the moment is babies born prematurely and very prematurely. The reason our figures are worse than Hong Kong's and Japan's and now Ireland's is that we have a much higher prematurity rate. We have a higher low birth weight, a higher pre-term birth rate. Ours is like seven to eight to nine per cent; it is like three to four per cent in Hong Kong and Japan and it is four to five per cent in Ireland. The reason why our figures are not as good as other people's is that our babies are being born early and small and at risk. That contributes to the perinatal mortality figure two or three or four points. If it does that it also contributes to the handicap rate because the very small ones have a 15 to 25 per cent handicap rate. It seems to me then the solution is to have a major research programme in identifying and dealing with prematurity, and that is a multi-factorial outcome. It is not going to be open to a single magical solution.

1108. I think that is very positive. I assume by the silence and the total acquiescence in the eyes of our other witnesses that they go entirely along with you.

(*Professor Levene*) It is important but I think there are other priorities as well. The causes of handicap are very important, which may or may not be related to prematurity. I think we need to look very much more carefully at that. One of the very important areas in neonatal medicine, the reason that babies stay in neonatal units longer, is chronic lung disease. We also need to have that as a priority.

Sir David Price

1109. Have you got any sort of general response, any thought you would like to leave us with, as, given the present state of medicine, the most important ways of reducing perinatal deaths further and reducing the number of disabled children in the community? I think what Professor Hull proposes on research is quite a good lead.

(*Dr Rivers*) I think it is a matter of introducing adequate screening and selecting the mothers at most risk so that their babies, if they do have to deliver prematurely in the current evidence before we can understand the techniques that might reduce the premature very low birth weight delivery rates, can be delivered in units that can look after them properly and where there is the expertise twenty-four hours a day.

1110. Initially we are talking about better screening for all?

(*Dr Rivers*) For a selection of mothers.

1111. At the beginning?

(*Dr Rivers*) Yes.

1112. And presumably following that up with genetic counselling where necessary?

(*Dr Rivers*) If that is applicable.

[**Sir David Price** *Cont*]

(*Professor Hull*) I think that it ought to be recognised that that is our major health problem in this area, that they are born prematurely and we ought to attack that, recognising that it needs immediate and full attention of all professionals concerned and premature babies are not left to the delivery of SHO's, they are not left in the hands of untrained SHO's when they are born there: they are high quality, highly expensive babies and we ought to optimise their care right from the very beginning, and I think that will do a lot of good.

Chairman: Dr Hamilton, Dr Rivers, Professor Levene, Professor Cooke, Professor Hull, Mrs Hale and Mrs Huxton, can I thank you for your tolerance, can I thank you for your very helpful replies and can I thank you for the major contribution that by your evidence this afternoon you will have made to our inquiry. Thank you very much indeed.

WEDNESDAY 27 NOVEMBER 1991

Members present:
Mr Nicholas Winterton, in the Chair

Mr Tom Clarke
Mr James Couchman
Mr David Hinchliffe
Alice Mahon
Sir David Price
Mr Andrew Rowe
Mr Roger Sims
Rev Martin Smyth
Audrey Wise

Examination of Witnessess

MRS SUSAN MAUNSELL, Under-Secretary, MR PETER TANSLEY, Assistant Secretary, and MR BOB LAYTON, Senior Principal, Policy Division, Department of Social Security, examined.

Chairman

1113. Good afternoon and welcome, Mrs Maunsell, together with the members of your team. For the purpose of the record, will you be kind enough to introduce yourself and your colleagues.

(*Mrs Maunsell*) Good afternoon, Mr Winterton. I have with me Mr Tansley, who is an Assistant Secretary, to help us with income support questions and Mr Layton, who is in my division and who deals with maternity benefits.

1114. You are here to give us facts and figures and to help us in our inquiry. Obviously you will indicate which of your colleagues, if it is not yourself, will deal with questions put by Members of the Committee. I start the ball rolling by asking you a very straightforward question. Perhaps this is in Mr Tansley's territory. What amount in the income support for pregnant women is intended to meet the costs of a satisfactory, sound, good diet?

(*Mrs Maunsell*) We expected that you would address the question of adequacy in income support, but I think perhaps not as the first question. Income support is intended to cover all day-to-day living expenses. There is not a specific amount for diet.

1115. So there is no allocation at all, no amount, no sum in income support for pregnant women which is hopefully there to enable them to have a good sound diet during pregnancy?

(*Mrs Maunsell*) No, Chairman. The basic income support level is intended to cover that and other living expenses.

1116. The second question that I put to you is that the Maternity Alliance—you have heard of them, a very reputable organisation—has calculated that the cost of an adequate diet for pregnancy represents 51 per cent of the income support rate for a single woman aged between 18 and 24 and 68 per cent of the rate for a 16 to 17-year old single woman. You will now understand the reason for my putting that first question. My second question is what research is conducted into the amounts actually spent on food by pregnant women to help your Department reach a decision about the appropriate level of income support for pregnant women?

(*Mrs Maunsell*) I will answer your first question first and then ask Mr Tansley to comment on the research, if I may. The indications that we have are that an adequate and healthy diet can be afforded within the basic income support level. The figures that you have quoted, relating to 16 and 17-year olds and the figures on which the Maternity Alliance arithmetic was done, were for girls who are not living independently. Girls who are living independently get a higher rate of income support and then the first figure you quoted would apply to them.

1117. Mr Tansley, do you have anything to add to that? Clearly there may be some differences between you as to the adequacy of income support between the amount that is available—that is obviously a political decision and one entirely for you—and the Maternity Alliance, which is an organisation committed to helping those who are pregnant.

(*Mr Tansley*) As Mrs Maunsell has said, there is no specific amount within income support allocated specifically to meet dietary needs, or any other specific item. How income support is spent is very much a matter for those who receive it. It is for them to choose how to spend it. So far as the question of adequacy and the question of dietary needs are concerned, as Mrs Maunsell has said, our advice is that generally speaking a balanced and adequate diet need not be expensive and the monitoring of income support generally suggests that it is entirely possible to obtain an adequate diet within the levels of income support.

1118. But, Mr Tansley, has the Department conducted any research into this matter and, if so, what research?

(*Mr Tansley*) We have not conducted research directly relating to what people spend on food or on the question of dietary needs. We have professional advice, of course, about dietary need which shows that a balanced and nutritious diet can be obtained in a number of ways which need not particularly be expensive. So far as pregnant women are concerned, again the advice is that a report published in July by the Department of Health's Committee on Medical Aspects suggested that in the case of pregnant women a modest increment to food intake for the

[**Chairman** *Cont*]
purposes of maintaining energy was necessary in the final three months of pregnancy. Of course we take account of information from a number of sources from people who write to us, from research and surveys carried out by other groups as part of the role for continually monitoring both the structure and levels of income support which, as you will know, has to be reviewed each year.

1119. I suppose it is perhaps a difficult question for you to answer and if you think I am out of order in asking it please tell me. Do you think it would be helpful to have more research into what the cost of providing a good diet for a pregnant woman was to enable that to be built in to decisions relating to income support?

(*Mr Tansley*) I am not an expert on this Chairman. One of the difficulties I foresee, both in relation to diet and indeed perhaps to other aspects as well, is securing a consensus on the range of items on which someone claiming income support should rely. It may be quite difficult to achieve such a consensus.

Chairman: I accept your answer at this stage, but I hope that when our Report comes out the Department will study it carefully.

Alice Mahon

1120. Can you tell us what the levels of income support are in cash terms?

(*Mrs Maunsell*) We both have the same table in front of us and it is quite a complicated one. Perhaps if I give you the rates for a single girl and a couple.

Chairman: Take a single girl 16 to 17.

Alice Mahon

1121. And a single woman aged 18 to 24, because the percentages differ. Perhaps you can give us both those.

(*Mrs Maunsell*) Certainly, a single girl not living independently, aged 16 to 17, receives a personal allowance of £23.90 increasing next April to £25.55. Do you want couples, or single people only to start with?

1122. Single only, please.

(*Mrs Maunsell*) The 18 to 24 year olds get a personal allowance of £31.40 and that goes up to £33.60 in April. That is also the rate which applies to the 16 or 17-year old who is forced to live independently. For the over 25s the rate is £39.65 at present increasing to £42.45 in April 1992. I would perhaps like to make the point that if a woman is on income support, and once the child is born and if she is single, there is a substantial increase on the birth of the first child. In all cases that is at least £26.75, when you take account of the family premium, the lone parent premium and the payment increase for the first child.

Chairman

1123. Thank you, Mrs Maunsell, that is very helpful. Can you let us have that? We would like to have it as part of the evidence that will be published in due course.

(*Mrs Maunsell*) We will send you the chart*.

*See p 463

Mr Couchman

1124. I am slightly confused about why pregnant women under 25 should receive a lower rate of income support than those who are over 25. It seems to be an arbitrary age and there seems to be little difference in their circumstances. Perhaps you can explain that to the Committee?

(*Mrs Maunsell*) I will start and if I miss out anything my colleague can pick it up. This really goes back to the review of, as it was then, supplementary benefit which was conducted in 1986-87 and the reforms that happened in 1988. At that time there were two rates of benefits, householders and non-householders. That was obviously not something that we wanted to continue, or that the Government at that stage wanted to continue. It was decided that in order to help the people who had the greatest expenses, who were the over-25s, these differential rates would apply. It was also true that the Government of the day had incentives very much in mind and that for younger people one did not want to construct a benefit system which would encourage people not to seek work.

1125. I can understand the young pregnant girls, the 16-17-year olds being considered to be living at home unless otherwise proved, as it were. But I do not see how the difference came about between a single woman of 24 and a single woman of 26 probably living in similar circumstances.

(*Mrs Maunsell*) It was also found at that time by looking at who was getting benefit and what were their responsibilities, that the under 25s had fewer family responsibilities and were much more likely to be living with family and friends and did not have the expense of fully independent living.

(*Mr Tansley*) The only point to add, Chairman, is that also generally speaking many had not yet fully established themselves in employment. They certainly had lower earnings expectations and so the combination of the various factors—the need to maintain incentives to get into employment and the factors that Mrs Maunsell has pointed out, that many of them were living as part of households and not bearing the full responsibility of the household.

Sir David Price

1126. What firm data do you have for your assertions in answering Mr Couchman's question for the difference between the 24-year old and the 26-year old? Do you have firm data done by any respectable surveying organisation, whether OPCS or any of the independent ones or any university? All of us find what you are saying incredible. You both say it with great certainty and I assume you have some solid basis, other than just the view of the Department on which to base it.

(*Mrs Maunsell*) Lines are not easy to draw and there are always people on either side to whom the line does not strictly apply.

1127. Why draw a line at all?

(*Mrs Maunsell*) That is because it would not have been appropriate in the view of the Government at the time to enable everyone to be paid at the level at which we pay people of 25 plus. The data that we had were clear data from our own statistics which were available of the kind of people who had the full

[**Sir David Price** *Cont*]
expenses of running households. Most of those were over 25, though not all.

1128. You are making a brave attempt. Would you prefer to say that this is a question that we ought to put to your Ministers? Would that be the fair answer?
(*Mrs Maunsell*) It does ultimately come to a political question. I am trying to answer you factually.
Sir David Price: You have had a brave shot at it, but you are not convincing us and you know it, do you not? We do not want to embarrass you. Would you rather we reserved that and put it to your Ministers to explain?

Mr Couchman

1129. This opens up an intriguing question. What happens in the case of a married couple on income support where the woman is under 25, but the man is over or where both are under 25? Are there different scales as well?
(*Mrs Maunsell*) No, they both get the over 25 rate, do they not?

1130. So if it is a married couple, even though the woman is only 24, her part of the income support is at the same rate as if she was 26?
(*Mrs Maunsell*) Yes, it would not be a full amount because she would—

1131. I recognise that it would be the married rate.
(*Mrs Maunsell*) The system is what I said previously, which was that they have assumed the full expenses of living independently. So it is in line with the sort of principle that applies.

1132. Some I suspect are 24-year old women living on their own?
(*Mrs Maunsell*) No. Can I make one further point, Chairman?

Chairman

1133. Please, we are putting you through it, Mrs Maunsell.
(*Mrs Maunsell*) There are two further points, both factual. One is that if one were to give the same amount to all under 25s as we do to the 25-pluses, the cost would be £250 million. The second point is that there is some relationship between earnings and age and earnings go up with age and therefore it is perhaps not entirely unreasonable for the income support—
Mr Couchman: That £250 million may be the key to our puzzlement.
Chairman: I do not like to intervene, but this will perhaps come up again.

Mr Hinchliffe

1134. Am I right in assuming that pregnant women of the ages of 16 or 17 cannot claim income support until 11 weeks before they have the baby, unless they have some form of physical or mental disabilities?
(*Mrs Maunsell*) That is right if it is based on pregnancy alone. Pregnancy alone is not a reason for claiming income support, but any young person between 16 and 17 may at any time seek to have his case for income support considered under the special hardship rules.

1135. Can I put to you an individual case and ask you what guidance is given to local officers and adjudication officers in terms of interpretation? I had a constituent who I believe was 17 who was pregnant and as a result was unable to go on to the various YTS schemes that were available at that stage because of her pregnancy. She was ineligible for income support on the basis of being less than 11 weeks away from the delivery time. She had absolutely no benefits whatsoever and she was dependent on her partner who had next to nothing himself to live on. What kind of advice do you give local officers in those circumstances about their interpretation of what is available to them in a situation such as that?
(*Mrs Maunsell*) In the case you describe, if there were really no other resources, where the girl was living independently or as part of a couple, the advice would be to apply to the severe hardship unit.

1136. I am speaking from memory and I may be wrong, but when she came to me she had done everything possible and received no help whatsoever. I suspect that that experience is reflected elsewhere. My colleagues may raise similar cases. It seems to me very wrong that someone who is carrying a child in these circumstances is expected to try to feed and produce a healthy baby but she cannot have any access to any form of benefits whatsoever. That was the problem in this case.
(*Mrs Maunsell*) It is hard to comment on individual cases.

1137. I accept that. I am asking you about the principle.
(*Mrs Maunsell*) The principle would be, if there really was no alternative means of support, I would have expected the severe hardship unit to use the Secretary of State's discretion sympathetically in that case. The question of 16 or 17 year old pregnant women in general has to be seen against the general background that, until they come towards the end of pregnancy, unless they are ill, there is no reason why they should not participate either in work or education in the youth training schemes which they have a right to.

1138. Will you accept that in this case the YTS did not feel it appropriate for this person to be involved because of her fairly advanced state of pregnancy at that stage?
(*Mrs Maunsell*) Yes. I do not know that I can say any more on what was obviously a very sad case.

Chairman

1139. Is there anything on that piece of paper that is fluttering in front of you that may be helpful to us?
(*Mrs Maunsell*) My colleagues are reminding me that 20 per cent of the special hardship unit's claims are from pregnant girls and over 80 per cent of those are successful. Where they are not it is mostly because they are living at home and have support from their parents.

Mr Hinchliffe

1140. This particular girl was not.
(*Mrs Maunsell*) Things may have improved over the years.

[**Mr Hinchliffe** *Cont*]

1141. I hope they have because I found it unbelievable.

(*Mrs Maunsell*) That would certainly be the advice now.

Alice Mahon

1142. What research are you conducting into the material circumstances of teenage pregnancy? We have heard a report recently of a high percentage of teenage pregnancies in the group of young girls leaving care. Has any research been done into that? Are we comparing income in this age group? Is there any research into comparing income with countries in the EC, for example? What happens there?

(*Mrs Maunsell*) There are a lot of questions there. We have done no particular research into pregnant teenagers. The Department of Health may have done so. I am not sure.

1143. I wonder whether the hardship fund was being used by this particular group of 16 and 17-year olds who naturally have no access to any income up to the eleventh week. There is a group there with no access whatsoever. I have had a case similar to my colleague's. They cannot get on to a YTS because of their condition and they cannot get a job. So they call on this hardship fund. I believe you said that 20 per cent of all the hardship fund cases was this particular group. I would have thought that that would have led itself to some kind of research, but perhaps that is a political question as well.

Chairman: I think it probably is.

Mr Clarke

1144. It has been suggested that a premium should be paid in income support for pregnancy, in the same way that a family premium is paid. Has the Department made any estimate of what this would cost?

(*Mr Tansley*) Just to make an observation about premiums to start with, premiums are the means by which the income support system focuses resources on groups with particular needs. Generally speaking premiums are intended to meet some kind of continuing recurring weekly expenditure, the family premium being a case in point where someone has assumed a lasting and significant responsibility of a family. Hence we pay a premium in that case. In the case of pregnancy it is not clear that, until childbirth, that there is the same kind of lasting and recurring responsibility that might justify a weekly payment. Let us suppose that the family premium were extended nonetheless, back into pregnancy, perhaps for the last three months of pregnancy, we reckon that would cost about £20 million a year.

Chairman

1145. Have you any evidence that that might be money well spent in that a number of more healthy babies would be born without complications?

(*Mr Tansley*) We have discussed diet and our advice is that by and large that if a mother gets a balanced and nutritious diet, which ought to be possible within the current income support levels, that there will not be any significant need on that account. One has to bear in mind that mothers on income support receive milk and vitamins. If in particular cases there is a need for some other supplement, such as iron, then that is available on prescription. There are other benefits like the maternity payment and the Social Fund itself to meet the undoubted expenses which attend upon a birth.

Mr Clarke

1146. I am not sure whether your paper on Maternity Benefits was drawn up by anybody here or by an individual person, but it indicates that in 1991-92 an estimated 172,000 maternity payments will be made from the social fund. The latest figure for births in England and Wales is 706,100. This suggests that about 25 per cent of births are to mothers in receipt of family credit or income support. Do you feel that £100 is an adequate sum to meet the needs of a quarter of all pregnant women?

(*Mrs Maunsell*) I will start and if there is anything to add my colleague, Mr Layton, will come in. £100 has always been intended to be a contribution to the costs of a baby, not the full cost of having a baby. This is because it has always been thought that a baby is an event you can plan for, can work towards and to which most people can look to family and friends for some help. Before the social fund payments started people just got £25, a frozen amount which had been frozen for many years, which was obviously really no use at all. So £100 was a substantial increase for those people who were thought really to need it.

Mr Clarke: When Mrs Maunsell says that most people can look to family and friends, I think she will agree that in some cases that is not so?

Alice Mahon: Children leaving care.

1147. Yes, indeed. And yet there are these cash limits in individual offices, so that when the budget is used up at a local office—Mr Layton seems to be disagreeing, I am open to be corrected.

(*Mrs Maunsell*) It is a mistake that a lot of people make and I am glad to have the opportunity of correcting it. The maternity payment and the funeral payments from the social fund are payments as of right to people who meet the criteria. They do not come out of the budget and they are not cash limited, so that if you are on income support or family credit and if you have capital of less than £500, you automatically qualify.

1148. I certainly welcome that clarification, but can I come back to the point about most people having families and friends. The fact that most people might have them suggests that some do not. Where then is the safety net for what might be a sizeable minority?

(*Mrs Maunsell*) I suppose this is where one has to say that the social security system cannot solve every human problem. If a mother had no other source of help there would be a possibility of a loan or even of a community care grant from the social fund which would be cash limited. There are sometimes other sources of help which health visitors who are in contact with pregnant women and midwives can use to help someone who is entirely on her own in the world to find a way.

1149. I think that this, too, may be an issue that we might want to raise with the Minister.

[**Mr Clarke** *Cont*]

(*Mrs Maunsell*) Perhaps I should add one more thing. Under the new Children Act the local authority—Mrs Mahon mentioned children leaving care—has a duty to befriend and advise children who have been in care right up to the age of 21.

Alice Mahon

1150. Is there any cash going along with that?

(*Mrs Maunsell*) There is no automatic cash going with that, no.

Mr Hinchliffe

1151. I, along with Tom Clarke, served on the Standing Committee. I would not want the impression to be given that that legislation in a sense was a means of assisting the DSS to reduce its budget. It certainly was not that. It was not seen that way at all. It was more of a practical assistance rather than specific cash aid, as I recall it. I think local authorities would be very unhappy about the idea being given that they may be able to offer substantial cash assistance in the circumstances you have described.

(*Mrs Maunsell*) I am sorry. I was not meaning to imply that. What I was intending to say was that a girl who had been in care would have a right now to ask for advice and support from the local authority that had been responsible for her, and might have some source of other sorts of help, if not cash.

Chairman: The point that David Hinchliffe is making is that local authorities themselves are under some pressure in respect of capping, particularly where they are likely to exceed their budget. Therefore, although you have indicated that help will be available through advice and counselling from the social services, from what Mr Hinchliffe has said—he has experience of that side of things—there is likely to be little if any money available. I think that is the point, is it not?

Mr Hinchliffe: Yes.

Mr Clarke: May I make a very brief point? As Mr Hinchliffe said, some of us were on the Standing Committee dealing with that Bill. Mr Sims was there too. We attempted to make it a bit more specific in terms of not just this phrase "befriend and advise", but we tried to bring resources into it. Yesterday our colleague, Dawn Primarolo, put a specific question to Michael Heseltine when he was announcing the rate support grant settlement in England and Wales, quite specifically about the Children Act. I think you will find, if you have time to read the reply, that there was nothing definite about specific allocations being made to local authorities for these purposes.

Mr Sims

1152. Can I turn to the question of multiple births and ask what consideration has been given to special help for them? We have had evidence from several sources about this, the gist of which is that the cost of triplets is rather more than the cost of three children born at intervals for various obvious reasons, not least that you cannot take advantage of handing on clothes and so on from one child to the next.

(*Mrs Maunsell*) The short answer is that we have not been asked or required to give any specific consideration to additional payments for triplets or quadruplets, which is really what you are talking about. But what we would rest on is the availability of automatic payments of child benefit for every child, regardless of means, and the £13.60 that goes with the arrival of every new child, if a woman or a couple are on income support, plus the fact that they would also be given credit for the extra children in family credit. So they would come higher up the scale for payments under family credit. Specifically, no, nothing for the individual child.

1153. So the case has not been specifically put to you or considered? You have not, for example, looked at the Australian scheme which allows for extra benefits?

(*Mrs Maunsell*) Yes, we are aware of the Australian scheme which does give quite generous payments of £30 to £40 a week, but as I understand it, the Australian scheme does not have the automatic payment of child benefit that we have. Their child benefit payments are also means tested. If you look at the scheme as a whole we make quite a lot of provision for children in whatever order they arrive.

1154. It is always difficult to start making comparisons because details of the systems are different. I appreciate that. What I really wanted to establish was whether, within this particular area, consideration has been given to some kind of addition to the child benefit or something of that sort. From what you say the answer would appear to be no. Nor does it sound as if those who have made representations to us have made representations to your Department that should be considered.

(*Mrs Maunsell*) No.

(*Mr Tansley*) No.

Sir David Price

1155. Can we now move on to Europe, particularly to the European Community Draft Directive on the protection at work of pregnant women or women who have recently given birth. Just to give the context a little more clearly and why we are concerned about this, the Parliamentary Under-Secretary of State for Employment in giving evidence to our European Standing Committee B earlier on the year said—and on this I want to base one or two questions to you: "The United Kingdom fully supports the protection of health and safety of pregnant women where there are specific risks". I will come back to what we mean by specific risks. "However, the draft Directive, which covers maternity leave and pay, goes much further. Those employment protection and"—this is relevant to yourself—"social security matters have no place in a Directive based on Article 118(a). Frankly, that is an abuse of the Treaty". Do you agree, first of all, that there are specific risks and that is the only thing we should be concerned with? What are the specific risks as opposed to the generality of pregnant women?

(*Mrs Maunsell*) Perhaps in order to answer that may I scene set for a moment because I think things have moved on a good deal since the Under-Secretary of State gave evidence in March. We are now in a position where Ministers, including Mr Forth representing the Secretary of State for Employment, have reached political agreement on the directive. It still has in it provisions relating to social security and the UK is still unhappy that social

[**Sir David Price** *Cont*]
security should have appeared in a Directive which is essentially about health and safety and subject to qualified majority voting. That was why in the end Mr Forth abstained from voting for the directive. But going back to what you were saying of what he said about supporting the general thrust of the Directive and the health and safety proposals in it, he supported the content of the Directive despite doubts about the legal base. I hope that answers you.

1156. It helps, but not completely. In the real world can one make these rather nice distinctions which may suit divisions in Whitehall between health and safety and social security? In the real world, in terms of a pregnant woman at work, surely they all come together, do they not?
(*Mrs Maunsell*) That was the European Commission's argument.

1157. But should it not be asked? Remember, we represent that person on the top of the Clapham omnibus, the ordinary person or the pregnant woman on the top of the Clapham omnibus. Is it not being just a little too much a Whitehall view of making these rather subtle distinctions? Are not the problems of a pregnant woman at work the same and cover all three aspects?
(*Mrs Maunsell*) Yes. What my Secretary of State is concerned about in addressing social security issues through qualified majority voting is that there is a danger in having considerable expense imposed on Government or employers from the European Community as a whole.

1158. Yes, it is the idea that it is somebody outside normal Treasury control should impose a charge on your Department that does not come under the normal way in which these matters are settled in the UK, rather than the rightness or the wrongness of whether there should be such a charge. Would that be unfair?
(*Mrs Maunsell*) I think we are now getting into dangerous waters, Sir David.
Chairman: What Mrs Maunsell is saying is that it is a matter for Ministers.

1159. Perhaps you will tell us whether I am being unfair or any of us are and whether this is a matter for your Ministers and not yourselves as senior members of the Department. Are we right in the estimate that we have that the draft Directive was going to cost your Department something between £400 and £500 million in a full year? I know that was the March figure, but is that now accepted as correct?
(*Mrs Maunsell*) No, Sir David. As a result of the negotiations which the Secretary of State for Employment has undertaken, although we are not able to do a final costing yet, it looks as if the Directive will cost a good deal less than that.

1160. So Treasury wise, it is rather more containable?
(*Mrs Maunsell*) Yes, that is correct.
Chairman: When you say it will be considerably less, it would be helpful if you are able to give us the figure. What is that figure?
Alice Mahon: And exactly what are we getting?

1161. You know what we are interested in and we do not ask you about other departments' aspects of this Directive, it would be helpful if you could give us an update. I think we would all find it helpful.
(*Mrs Maunsell*) Yes, indeed.
Chairman: Are we talking about £100 million?

Audrey Wise

1162. And can we ask what we are getting for that?
(*Mrs Maunsell*) What we are getting is that the leave for pregnant woman has to be at least 14 weeks, but we presently provide 18 weeks on full pay.

1163. On full pay?
(*Mrs Maunsell*) Sorry, not on full pay, on maternity pay. I am sorry. The Directive also contains a requirement that conditions should not be worsened, so one can put two and two together from that. The limit of maternity pay is to be equivalent to what a woman would get if she interrupted her employment for reasons of health. That probably means a relationship with sick pay of some kind, but exactly what we have yet finally to settle. That is why I cannot give you more than a ballpark figure. The ballpark figure for the amount is something round £65 to £80 million, but it all depends and it needs to be worked out in detail.
Sir David Price: This again may be an unfair question, but why is it related to sick pay? Part of our inquiry is on the basis that pregnancy is a perfectly normal activity. It should not be regarded in the same attitude as somebody being sick at work.

Chairman

1164. In fact, it is a very healthy activity.
(*Mrs Maunsell*) That was exactly the line taken by Madam Papandreou and that is why the Directive is drafted in the rather curious way it is, which is about a period of interruption for reasons of health, rather than ill health. That is why we in turn are having some difficulty in sorting out exactly what this means for UK legislation.
Sir David Price: Productivity might be a better word.
Chairman: That would be very acceptable to the Treasury.

Audrey Wise

1165. May I just complete this by asking about qualifying conditions?
(*Mrs Maunsell*) The qualifying conditions are down to member states to apply.

1166. Does that mean that there will be length of employment qualifications in Britain?
(*Mrs Maunsell*) There is a restriction on the length of employment. We cannot require that a woman is employed for more than a year in order to get statutory maternity pay.

1167. Does that apply whether she is full time or part time? Because at present there is a big distinction in Britain.
(*Mrs Maunsell*) Yes, it does.

Chairman

1168. I know Audrey Wise probably has not finished, but we have been talking about anecdotal cases, or certain David Hinchliffe has. Do you think

[**Chairman** *Cont*]
that the existing system is correct where somebody, through no fault of their own—such as the liquidation of the company for which they have been working has meant that they have not been in employment with the same employer for two years—does not get the full rate of maternity allowance or pay? In other words, they do not have broken employment, but the company for which they worked went out of business and was taken over. They therefore stayed in employment, yet because they have not been working for one employer for two years they lose out on the higher rate.

(*Mrs Maunsell*) I am told they do not, Chairman.

Chairman: I am afraid that I have just had a letter from the Department saying that they do. If I can refer it to you, Mrs Maunsell, I would be very happy to do so.

Audrey Wise

1169. I think I can cast some light on that. In certain circumstances the take over firm accepts continuing employment. In that case then the person is treated as having been employed. On the other hand it does not always apply, so sometimes the person is a victim of the kind that the Chairman mentioned. Can I clarify some things on a factual basis to make sure that the record is perfectly clear? When you were discussing the under 25 and over 25 rate, Mrs Maunsell said that it would cost £250 million to give the same rate. Am I correct in thinking that that would be to everybody, not just to pregnant women?

(*Mrs Maunsell*) Yes.

(*Mr Tansley*) That is correct.

1170. Do you have a figure for pregnant women?

(*Mr Tansley*) No, we do not.

1171. Can you find out, do you think?

(*Mr Tansley*) We can certainly try. There may be some assumptions in there that we have to look rather carefully at, but we can certainly look at that.

1172. While totally disagreeing with the dividing line anyway, some of us feel the greatest possible sense of urgency where it involves a pregnant woman. That would be an easier dividing line to draw, if I may suggest. Can I also ask, again for the sake of clarity, this question? Mrs Maunsell you compared the £100 maternity grant which people on income support and therefore in poverty get, with the £25 maternity grant which was abolished a few years ago by this Government. Would it not be more correct to have compared that £100 with what a person then on supplementary benefit could have got? The £25 was payable to everybody, but if a person was on supplementary benefit at that time, then a considerably greater amount was received. Am I not right in thinking that that amount would certainly be considerably greater than £100 is now?

(*Mrs Maunsell*) Yes, I think that Mrs Wise is quite correct to pick me up. I should have mentioned that, to balance the whole picture, it was possible to receive a substantial payment in total single payments but not everyone received the maximum amount. At that time it was only available to people on supplementary benefit, as it then was, and not to poor families, which was an improvement which came in with the social fund.

1173. Also for the sake of accuracy, when discussing the 16 and 17-year olds, you made a number of references to severe hardship and the severe hardship unit. I served on the Standing Committee which looked at the Bill when the arrangements were made for 16 and 17-year olds. It is worth putting on the record—you will correct me if I am wrong—that although the unit may be referred to as a severe hardship unit, the actual qualification is that the girl has to show that she is in severe hardship. That is the term used, not simply hardship, even though she is pregnant, but severe hardship. Has the Department given any guidelines at all—I do not think you were clear in answering my colleague—about what constitutes severe hardship for a pregnant 16 or 17-year old?

(*Mrs Maunsell*) Yes, we have some guidelines. If you bear with me I will find them.

1174. In that case, I will move to your colleague while you are looking. You said that it ought to be possible to have a nutritious and balanced diet within income support levels. When you make that statement I presume you have some grounds for it when you say "it ought to be possible". Can I ask, treading a little on the ground already covered by my colleague, Sir David Price, whether the Department has any evidence for that assertion? Is it an assertion based on hard evidence, or is it just a wish?

(*Mr Tansley*) The basis for my statement was the advice we received about people meeting the basic needs of nutrition. There are a number of ways that might be done. It is not a case of having one particular diet, but a number of ways of meeting basic requirements for nutrition. The report I mention, published last July, was a fairly dense scientific report which explained what was required in terms of particular nutrients and work continues on that. There may be other reports coming out in due course which give more direct advice about food. My reasons for linking that to the adequacy of income support were simply that the experience of people in the field and our ongoing monitoring of the scheme suggests that we have no evidence to point the other way, that people are having significant difficulty in obtaining an adequate diet.

Mr Couchman: How on earth would you know that?

Audrey Wise

1175. When you say people in the field, to which people do you refer?

(*Mr Tansley*) People in our local offices, for instance.

1176. But they are not experts on the nutrition of pregnant girls?

(*Mr Tansley*) No, but—

Audrey Wise: Do they invite pregnant girls into the office and ask them what they are eating and then seek any scientific confirmation or anything?

Chairman: I am not sure that you were here at the time, Audrey. We tackled this subject right at the beginning and our witnesses indicated that they actually had undertaken very little, if any, research. They relied upon certain medical and other advisers on this, but they lacked research into precisely what

[**Audrey Wise** *Cont*]
sum was required to be built into income support to cover diet.

Audrey Wise: I am aware of that and therefore I take issue with the categoric statement being made later on in the evidence that "it ought to be possible" to get this balanced and nutritious diet within income support levels. If you do not have sufficient evidence, then, with respect, you do not have sufficient evidence to make a categoric statement in your evidence to us.

Chairman: Our witnesses are in some difficulty here because they perhaps believe, as I am beginning to believe, that this might be a question to put to a Minister rather than to a civil servant.

1177. I shall move on to a different aspect here. Are you aware that the babies of very young mothers are at the greatest risk? Have you done any research into that aspect? Do you seek any advice?

(*Mr Tansley*) No, not into that specific issue.

Chairman

1178. To wrap this up before the final questions to you from Reverend Martin Smyth, my colleague Mr Couchman responded in an explosive way just now. Were you surprised that he responded explosively to the statement you made, Mr Tansley?

(*Mrs Maunsell*) I do not think he can answer.

Chairman: You remain silent, so I will not press you on that.

Mr Couchman: I was indeed astonished that the basis of research appears to be "We have not heard to the contrary".

1179. I think Mrs Maunsell has the answer to Audrey Wise's earlier question.

(*Mrs Maunsell*) Mrs Wise wanted to know what guidance had been given to the severe hardship unit. It is a unit which operates at the Secretary of State's discretion, so there are no absolute set rules which say what severe hardship is and each case is looked at on its merits. But the sort of things they look at is whether the pregnant woman has any money or not; whether she can expect to get any money through a job or training allowance; whether she has any other sources of help, that is whether she is living at home or not; whether she is threatened with homelessness or is homeless and whether she is ill or disabled. I am translating those general questions into cases. A young pregnant girl living independently who had no other source of income would almost certainly qualify for a severe hardship payment, exactly the case that Mr Hinchliffe raised earlier. A pregnant girl living independently who only got a bridging allowance between YTS schemes, which is only £15, who said she could not manage would almost certainly be successful. Also a girl living at home with her parents who were on income support would probably be successful. But, as I said, those are examples and each case would be considered on its merits by the unit.

Rev Martin Smyth

1180. I want to press you a little on the research. Some of it has been coming out. I looked at this in the light of the £400 to £500 million which, in a sense, you have already answered. The other day we had a similar kind of response from a Minister on a different subject. It seemed to me that this was common to an ordinary person who would say that it would cost millions, in other words it had not been costed. Can I therefore press you a little? The Family Policy Studies Centre has estimated that it takes £2,200 a year in the child's first year to feed and clothe that child. Would you challenge that estimate? What research have you done which leads you to recommend to Ministers the policy that is now being followed through in the grants? For example, how many people would qualify for that £100 and how many people are left outside the net who might qualify?

(*Mrs Maunsell*) I find that a very difficult question to respond to. The best evidence to balance their assertion that £2,200 is what you need to feed and clothe a child is that self-evidently many families do not have that money, cannot therefore spend that money and still manage to feed and clothe their children. If you looked at what you might perfectly want in an ideal world, which this is not, to feed and clothe a child perhaps that is the figure you would come up with, but it is self-evident that that is not necessary.

1181. I appreciate the point you make. But have you folk done any research to estimate what might be required in a normal situation? Some of the people of whom we have been speaking would not be in a normal situation to have friends and others to hand things on to them. I am looking for the hard research. I regret that I have to say that when we are looking at it and thinking through the answers I felt a little like the scripture parable, the rich man was already inside feeding and Lazarus was outside having his wounds licked by the dogs. It is at that level that I am looking for hard evidence rather than culture comfort.

(*Mrs Maunsell*) I do not think we can say very much more than we have already said, which is that it is difficult to do research into income support levels and what they should cover. As we have already said, the difficulty of establishing to everyone's satisfaction exactly what should be included would be extraordinarily difficult. There is also the point to make that the Committee seems to be looking for some degree of scientific validity. One has to say that all social security benefits, and income support is no exception, are set according to some judgment about what can be afforded as well as what is ultimately, in an ideal world, desirable. That is true of income support.

Chairman

1182. I think that is a very good point at which to finish.

(*Mr Tansley*) May I make another clarificatory statement in relation to my figure earlier of £250 million for increasing income support from the 18 to 24s to the adult rate? I should have said that that figure includes the consequent increases in housing and community charge benefit. That is just to get the record straight. It also occurs to me that that may have the effect of making some estimate for pregnant women difficult because we may not have the source of information about pregnant women getting the housing community charge benefit, but we shall try.

(*Mrs Maunsell*) We shall do our best.

Chairman

1183. Thank you for that clarification. Mrs Maunsell, to your and your colleagues thank you very much for coming. I hope that all of you will read our Report when it is published and we hope it may have some influence on decisions that are made within your Department by your Ministers. Thank you very much indeed.

(*Mrs Maunsell*) Chairman, we shall look forward to it.

		16-17 years single (1)		16-17 years couple (2)		18-24 years single		18-24 years couple (3)		25+ single		25+ couple	
		1991	1992	1991	1992	1991	1992	1991	1992	1991	1992	1991	1992
Expecting first child	personal allowance —adult	23.90	25.55	47.30	50.60	31.40	33.60	(3)	(3)	39.65	42.45	62.25	66.60
	BENEFIT INCOME	23.90	25.55	47.30	50.60	31.40	33.60	(3)	(3)	39.65	42.45	62.25	66.60
On birth of first child	personal allowance												
	—adult	23.90	25.55	47.30	50.60					39.65	42.45	62.25	66.60
	—child	13.60	14.55	13.60	14.55	(3)	(3)	(3)	(3)	13.60	14.45	13.60	14.45
	premiums—lone parent	4.45	4.75							4.45	4.75		
	family	8.70	9.30	8.70	9.30					8.70	9.30	8.70	9.30
	BENEFIT INCOME	50.65	54.15	69.60	74.45	66.40	70.95	(3)	(3)	66.40	70.95	84.55	90.35
Increase on birth of first child		26.75	28.60	22.30	23.75	35.00	37.35	(3)	(3)	26.75	28.50	22.30	23.75
During second pregnancy	Benefit remains at	50.65	54.15	69.60	74.45	(3)	(3)	(3)	(3)	66.40	70.95	84.55	90.35
Birth of second child	personal allowance												
	—adult	23.90	25.55	47.30	50.60					39.65	42.45	62.25	66.60
	—child	13.60	14.55	13.60	14.55	(3)	(3)	(3)	(3)	13.60	14.45	13.60	14.45
	—child	13.60	14.55	13.60	14.55					13.60	14.45		14.45
	premium—lone parent	4.45	4.75							4.45	4.75		
	family	8.70	9.30	8.70	9.30					8.70	9.30	8.70	9.30
	BENEFIT INCOME	64.25	68.70	83.20	88.90	(3)	(3)	(3)	(3)	80.00	85.40	98.15	104.80
Increase on birth of second child		13.60	14.55	13.60	14.55	(3)	(3)	(3)	(3)	13.60	14.45	13.60	14.45

Notes: (1) = not estranged.
(2) both eligible; not estranged.
(3) same as 25+.

/Continued

THIS TABLE SHOWS THE INCOME SUPPORT APPLICABLE AMOUNTS FOR SINGLE PEOPLE AND COUPLES WITH UP TO TWO CHILDREN

CHANGE OF EMPLOYER DURING THE STATUTORY MATERNITY PAY QUALIFYING PERIOD

1. Statutory Maternity Pay (SMP) is payable for up to 18 weeks to women who have been employed by the same employer for a period of at least 26 weeks into the 15th week before the expected week of confinement—the qualifying week—and whose average weekly earnings in the last eight weeks of that period have reached the level at which liability to pay National Insurance (NI) contributions arises (£52 per week from 6 April 1991).

2. For the first six weeks of the maternity pay period a higher rate, equivalent to nine-tenths of the woman's average weekly earnings, if payable to those who have been employed by the same employer for at least two years into the qualifying week, working for at least 16 hours a week, or for five years if working for between 8 and 16 hours per week.

3. The employer, for SMP purposes, is the person who under section 4 of the Social Security Act 1975 is liable to pay secondary Class 1 Contributions in respect of the womans earnings under her contract of employment. In the case of Agency workers, it is the Agency which is normally regarded as the employer, not the client to whom she is contracted to work by the Agency.

4. In general, a change of employer during the SMP qualifying period means that continuity of employment is broken and may affect entitlement to SMP. However, SMP Regulations provide that a change of employer does not break continuity of employment where—

- the employer's trade or business or an undertaking (whether or not it is an undertaking established by or under an Act of Parliament) is transferred from one person to another;
- by or under an Act of Parliament, one corporate body takes over from another as the employer;
- the employer dies and his or her personal representatives or trustees keep the employee on in employment;
- there is a change in the partners, personal representatives or trustees who employ the employee;
- the employee moves from one employer to another where at the time of the move the two employers are associated employers, that is if one is a company of which the other (directly or indirectly) has control or if both are companies of which a third person (directly or indirectly) has control;
- a teacher in a school maintained by a Local Education Authority (LEA) moves to another school maintained by the same authority (including maintained schools where the governors rather than the LEA are the teacher's employer).

COSTS OF PAYING PREGNANT WOMEN AGED 18-24 ON INCOME SUPPORT THE RATE FOR THOSE AGED 25 AND OVER

1. When Departmental representatives gave evidence to the Committee on 27 November 1991, they estimated at £250 million the annual additional cost of providing the income-related benefits—Income Support, Housing Benefit, Community Charge Benefit—to those aged 18 to 24 at the rates appropriate for those aged 25 and over. The Committee asked for a corresponding estimate if such a step were taken only in respect of pregnant recipients of the income-related benefits.

2. As was explained to the Committee, such an estimate is very sensitive to the assumptions made. The fundamental one is of course the proportion of those in the relevant age group who are receiving income-related benefits at the 18-24 rate and who are pregnant.

3. Young women who are married or living with someone in a stable relationship receive the benefit rate for couples. Those receiving the 18-24 rate of personal allowance are therefore single women. We have no direct information on the incidence of pregnancy among single women aged 18-24 and claiming the income-related benefits. Nor can we derive a valid estimate from demographic data on live births among those classified as unmarried women, because many of those so classified will, as explained, be receiving the "couple" rate.

4. If one simply applied the birth rate for *all* women aged 20-24 in 1990 to single women under 24 receiving Income Support, and assuming that Income Support were paid at the 1991/92 rate to the number of pregnant women on that benefit and aged 18-24 (so estimated), the annual cost-assuming Income Support was paid throughout pregnancy—would be about £4.5 million.

5. It is much more difficult to derive a corresponding estimate for Housing Benefit and Community Charge Benefit, but applying to the above Income Support estimate some crude assumptions about the ratio of expenditure on these benefits to that on Income Support, suggests that £1 million should be added, to yield an overall estimate for the additional annual cost of paying income-related benefits to pregnant women who in 1991/92 received the 18-24 rates of around £5.5 million.

6. It must be stressed that the broad assumptions used qualify this estimate as simply indicative of the possible order of magnitude of cost and not in any sense a robust assessment.

Memorandum submitted by the Association for Improvements in Maternity Services

SUMMARY

1. The provision of maternity services in this country has been largely determined by a mistaken belief that obstetricians' increasing monopoly of maternity care has brought about the fall in the perinatal mortality rate since the 1930s. AIMS would like to see a proper recognition of the central role and status of the midwife in the provision of maternity care.

2. The decision of where the baby will be born, home, GP unit or consultant unit, at present very much determines the antenatal care a mother receives. With the aim of achieving continuity of care, women should be able to choose a midwife (the trained professional in normal pregnancy and labour) as the first point of contact for maternity care, starting with pregnancy testing and advice on health. The midwife should be able to decide, with the woman, on the most appropriate antenatal care for each mother booked and refer on to the consultant those who need specialist attention.

3. AIMS believes that the staffing of the maternity services should be revised with more effective use of midwives, fewer obstetric posts, and an urgent review of the general practitioner's role. There is a need to provide alternatives to expensive, often inappropriate, centralised care. Many health authorities and obstetricians have pursued a profligate policy involving largely inappropriate interventions, closures of small potentially cost-effective maternity units, and the routine use of unevaluated expensive technology and procedures. Many of the proposals called for by parents and user groups are not costly and can actually save money.

CHANGES IN MORTALITY RATES AND MORBIDITY

1.1 The planning and provision of maternity services must be based on ensuring the health and safety of all mothers and babies. In this respect the perinatal mortality rate has been taken as the crude indicator of success or failure and, more importantly, has been the basis on which policy has been formulated. The Peel Report (1970) [1] stated, "We consider that the greater safety of hospital confinement for mother and child justifies the objective of providing sufficient hospital facilities for every woman." The Report gave no statistical evidence to support its assertion, however attention was drawn (para 29) to an increase in hospital confinements on the one hand and a decrease in perinatal and maternal mortality on the other. The implication was clear and the past 20 years have seen the closure of a great many local maternity hospitals, the centralisation of maternity services in large consultant units and the reduction of home confinement to only 1 per cent of all births. Once the health authorities had accepted the 'medical model' of childbirth the provision of all maternity services became determined on this basis, the vital role of the midwife was marginalised and women's choice reduced.

1.2 The argument that obstetricians' increasing monopoly of maternity care has brought about the fall in perinatal mortality rate since the 1930s is constantly cited as justification for the medical management of all aspects of maternity care. AIMS has been foremost in expressing the view that this argument is mistaken and certainly unproven. However we would draw the Committee's attention to the National Perinatal Epidemiology Unit's report Where to be Born? (1988) [2] which concluded, amongst other findings, "There is no evidence to support the claim that the safest policy is for all women to give birth in hospital." Marjorie Tew in her analysis of maternity statistics [3] went further, concluding that "had the official policy (of 100 per cent hospital births) not been so effectively pursued between 1969 and 1976, and had the proportion of births in hospital not increased, the stillbirth rate would have fallen each year by more than it did."

1.3 Since the place of birth has such a bearing on the planning of all maternity services we should look more closely at the justification given for 99 per cent of all births to presently take place in hospital. Perinatal mortality rates began to decline appreciably in the 1940s. In war-time Britain maternity care was forced to be less interventionist since most of the younger doctors, recently trained in obstetrics, were withdrawn for military service. At the same time, the enlightened policy for food rationing, combined with the higher incomes from full employment, ensured that a greater proportion of childbearing women than ever before were adequately nourished. However obstetricians persuaded nearly everyone, and most importantly the authorities who control the provision of maternity services, that the steady improvement in outcome was principally the result of their greater management of maternity care. It was acknowledged that overall death rates were always much higher when birth took place in hospitals than in general practitioner units or at home but the explanation given was that this disparity was only to be expected because they had to care for all the births predicted to be 'high-risk'. This ignored the inference that consultant care could not be effective in significantly reducing the risks and also overlooked the fact that these births made up only a small proportion of all hospital births and therefore would not greatly raise the average death rate based on the majority of births which were at lesser predicted risk. [4] Comparisons of death rates for births at the same degree of predicted risk but having care in hospital under obstetricians' control or outside hospital under the control of midwives or GPs could have been made from the data obtained from national perinatal surveys conducted in

1958 and 1970 under the auspices of the Royal College of Obstetricians and Gynaecologists [5], [6], [7]. These comparisons (Table 1) show that perinatal mortality rates were in fact higher for hospital births at every level of predicted risk, low, moderate or high, whether on account of single risk factors or a score constructed by obstetricians in 1970 to measure the combined risk from all the most important factors. Thus their own evidence falls short of supporting obstetricians' claims that their management makes birth safer at any level of predicted risk.

Antenatal Care

2.1 *Pre-conception and pregnancy advice*

AIMS has urged that the effectiveness of this advice be questioned and evaluated as rigorously as every other intervention carried out during pregnancy. For example, general advice to eat a healthy balanced diet is likely to be beneficial to women but cannot at present be justified in terms of preventing malformations or low birthweights. [8]. At present it seems that the beneficial effects of pre-conception advice are likely to be modest and cannot automatically be regarded as harmless. Supplementation with trace minerals and vitamins cannot be justified in the present state of knowledge [8].

Whilst there is clear evidence that smoking and alcohol have an adverse effect of the development of the baby, the aim must be to have a healthy society in which smoking and alcohol are recognised as undesirable for all. There is uncertainty about the safe lower limit for alcohol intake for pregnant women and many who continue to smoke and drink, even moderately, in pregnancy suffer chronic stress and anxiety for doing so. The effects of such stress on the pregnancy, labour and on the lasting relationship with the child are unknown.

2.2 *Continuity of care*

Research has shown that much of the antenatal care available to the majority of women is inappropriate and could, with considerable benefit, be organised differently. Steps should be taken to ensure that the potential of adverse effects of routine procedures antenatally are minimised. We would draw your attention to the study Effective Care in Pregnancy and Childbirth [8] which should provide a background to the work of your Committee. This study found, "There is strong evidence that continuity of personal care combined with efforts to provide social and psychological support during pregnancy and childbirth, is preferred by women, and that it has a number of other beneficial effects; furthermore, there is no evidence that it has any adverse effects."

We would also draw your attention to the "Know Your Midwife Report" [9] which analysed a trial at St. George's Hospital 1983–1985 offering women continuity of midwifery care. While this was clearly a system appreciated by the women, there were also savings for the Health Authority. In the area of antenatal care the actual costs were 20–25 per cent less than those for women who had consultant care. A survey of Lothian Maternity Services [10] in 1987 also bears out these findings. They found that the majority of mothers made it clear in their responses that they wanted continuity of care during their pregnancies. In conclusion the survey found, "Women want more and better information; they want better and more equal relationships with the doctors and midwives; they want to be part of making decisions about their care; and they want as little medical/technical intervention as is safe for them and their babies."

AIMS would again urge that continuity of care be a basis of policy planning for the maternity services.

2.3 *The organisation and operation of antenatal clinics*

Recurring complaints to AIMS over many years have been; the unecessary length of time women have to wait, the numbers of different people seen, and the difficulties women experience in getting information from the professionals involved. These complaints were put to the Maternity Services Advisory Committee when it was taking evidence for the reports Maternity Care in Action [11]. These reports, "A guide to good practice and a plan for action" were welcomed by AIMS and include valuable checklists at the end of each chapter to which we would draw your attention.

In the Lothian Study [10] the results showed that women's estimation of the quality of the overall care they received very much depended upon (a) the amount of information they received and (b) how easily they felt they could discuss things with the staff. This study also found that despite the popularity of the preference for continuity of care only 13 per cent of women did in fact see the same staff at each hospital visit and one-third of all women *never* saw the same person. [10]

Women cared for in Know Your Midwife Scheme [9] did not wait long for their clinic appointments, did not have problems obtaining information and felt more confident as a result of the personal care they received.

2.4 *Antenatal education*

The popularity of antenatal classes with parents is an indication of their desire to know more about pregnancy and childbirth. Antenatal education is undertaken by Health Authorities provide classes and also by independent organisations such as the National Childbirth Trust and Active Birth Movement.

AIMS has been concerned for many years, about the quality of advice and information given at Health Authority classes. These do not encourage parents to take responsibility for their pregnancy and health but seem designed to ensure they accept the care that is available at the hospital. In some areas women are actively dissuaded from seeking information from other sources or attending independent classes. Very little information about user groups is available in NHS classes or clinics. We would draw the Committee's attention to Chapter 6 Effective Care in Pregnancy and Childbirth [8].

We are concerned also about the appalling quality of much of the official information that is available. It often talks down to women, fails to inform them properly and jollies them along into accepting the "doctor knows best" view. An example of poor quality information would be the free publication given to pregnant women in recent years, "New Baby—A Health Visitors' and Midwives' Handbook for Parents" and critically reviewed by AIMS Journal [12].

2.5 *Indentification of women at risk*

AIMS is concerned about the quality of antenatal care given to high risk women. A study of antenatal clinics at London teaching hospitals conducted by Margaret Arnold [13] revealed that the system of allocating women to specialist care depended on the consultant going through the case notes and choosing to see doctors' wives, lawyers wives and other higher income group women. The Senior registrar would then choose to see the next grade down. This meant that the high risk women in lower income groups were seen by the most junior doctors. A rational allocation would suggest that the most senior staff would be seeing the women at highest risk, but this did not happen.

We would also draw your attention to research by Dr Jane Robinson [14]. She investigated perinatal mortality in a Midlands Health Authority area with high perinatal mortality correlated with poor social conditions. It is assumed that the social conditions alone (eg unemployment, poor diet, poor housing, low social class) are largely responsible for the high perinatal mortality and therefore mostly beyond medical control. In a well-designed study in the health authority with one of the highest perinatal mortality rates in the country, Dr Robinson demonstrated that poor health services, including failure to communicate properly with women could be responsible for a number of these deaths.

There were two hospitals in the area, the one with the better results was where doctors and midwives worked together as a team. Communication is often interpreted as women listening to the professionals and "complying with their instructions". Robinson, however, demonstrated that one of the major disadvantages of low social class is that professionals may not listen to them or give adequate importance to the problems and symptoms reported by these women. Her findings correlate very strongly with the complaints and letters that AIMS receives from the public.

Reference should also be made to the study and assessment of antenatal care in Aberdeen [15].

2.6 *Antenatal screening*

Antenatal screening has, for a very small minority of women, a very real benefit and AIMS was pleased to have been actively involved in drafting the information leaflet for the randomised controlled trial of Chorionic Villus Sampling and Amniocentesis [16].

This was the first time a user group was involved in the early stages of a research project in maternity care. We are of the opinion that before any new technology is introduced on a large scale it should be subjected to a well-designed randomised trial to determine its value. This could involve the setting up of an Office for Health Technology as suggested by AIMS some years ago, and now included in the Labour Party' document "Fresh Start for Health" [17]. Few developments in antenatal screening have adopted the principles of the CVS trial and we are very concerned about the lack of the information that women are given about the possible risks and benefits of any proposed tests and treatments.

The Committee should take note of the list of screening tests and processes given in Effective Care in Pregnancy and Childbirth [8] as having "unknown effects which require further evaluation". These include (for perinatal morbidity) all biochemical and biophysical tests of fetal well-being and (for maternal and perinatal morbidity) routine ultrasound for fetal anthropometry and congenital malformations.

Performing X-ray pelvimetry in cephalic presentations is listed as a form of care that should be abandoned in the light of the available evidence.

Ultrasound: This technique has been widely introduced without a careful evaluation of its long term safety, efficacy, or cost effectiveness. There is little good evidence that ultrasound saves babies' lives or has any

significant effect on infant mortality rates. AIMS has long been concerned about the misuse of this technique on pregnant women.

The World Health Organisation stated in 1984 that, "the data on clinical efficacy and safety do not allow a recommendation for routine screening at this time, there is a need for multi-disciplinary randomised controlled clinical trials for an adequate assessment" [18].

No large scale randomised controlled trials have ever been carried out on ultrasound. John Patten, when Parliamentary Under-Secretary of State for Health in 1984, stated that, "Given the publicity there has been recently about the possible risks of ultrasound scanning we would not expect any Health Authority to be advocating screening during pregnancy for all mothers as a routine procedure" [19].

Although obstetricians claim that ultrasound is safe, the more responsible clinicians are concerned about the possible long term effects. Stark et al [20] found an increase in the numbers of children suffering from dyslexia following ultrasound exposure in utero, and no research has been carried out into the numbers of healthy fetuses aborted following a mis-diagnosis. The Royal College of Obstetricians, in their report on ultrasound, acknowledged that in a small study at a centre which specialised in ultrasound one normal fetus had been aborted following a false positive diagnosis of hydrocephaly [21].

AIMS is concerned that:

(a) the majority of unborn children are being routinely exposed to an unevaluated technology whose long term effects are still largely unknown.

(b) there is an urgent need to carry out a randomised controlled trial to establish whether or not ultrasound is effective and safe.

(c) there is an urgent need to establish properly what are the real costs of routine ultrasound examinations.

3.0 *Use of staff in providing antenatal care*

3.1 Consultants: obstetricians are experts in abnormality but in the last 30 years they have departed from this role and taken on the overall care of all women. This approach means that the majority of fit and healthy, low risk, women are subjected to a system of care which focusses on abnormality and as a result this group of low risk women often suffer unnecessary interventions.

The Know Your Midwife scheme [9] showed that women who had consultant care antenatally requested epidurals more often during labour. By having midwifery care the savings in this small group, in epidural anaesthesia alone, amounted to over £12,000.

The study conducted in Aberdeen [15] which examined antenatal care concluded that "the benefits that might be achieved from routine antenatal care had perhaps hitherto been over-estimated." They revealed that the majority of emergency antenatal admissions could not have been predicted. On the other hand, some conditions such as pre-eclampsia and smallness for gestational age were over-diagnosed. The authors pointed out that such over-diagnosis may lead to over-investigation and unnecessary admission, induction or operative delivery, with all the consequent hazards, distress and costs that these may involve.

Although intrapartum care will be covered in the next part of the Committee's inquiry, it is relevant to draw your attention here to the two-part study by Klein et al (1983) which compared low risk women who were booked for delivery in an attached GP unit and those who were booked in the consultant unit, John Radcliffe Hospital, Oxford. [22].

3.2 General Practitioners: AIMS is extremely concerned about the quality of some GP care and particularly when it involves "shared care". GPs are paid separate fees for antenatal care, intrapartum care and postnatal care, in addition to their capitation fee, yet often they only duplicate the care of midwives.

Information given by GPs is also often inaccurate and misleading and often simply channels women towards the local hospital without offering any possibility of choice. In the Lothian Maternity services survey [10] for example 6 per cent of the women said they had considered having a home birth. However all those who approached their GP with the request met sufficient resistence to end up with a hospital confinement. It is important to note that while 6 per cent might seem a low proportion wanting a home birth, it actually represents an annual figure for Lothian of over 600 women.

While AIMS accepts that the GP has a role in providing continuity of care for the whole family we feel that the GP's involvement in maternity care is often a duplication of either the midwives or the obstetricians.

As there is now an Association of General Practitioners in Maternity Care, AIMS feels the time is right for the Royal College of General Practitioners to review the role of their members in the provision of maternity services. This review should also examine how best GPs can be trained for their role—rather than being trained in the abnormal by the obstetricians, they shoud be familiarised with the normal by the midwives.

3.3 *Midwives*

While recognising that there has been an increase nationally in the numbers of midwives employed by the NHS there is, nontheless, a serious shortage of midwives in many areas. This is compounded by the numbers of midwives who are not practicing midwifery but are involved in administration and obstetric nursing. Evidence is available from the Royal College of Midwives, the Association of Radical Midwives and from our own members about this shortage. The regrading of midwives in the recent review has shown little regard for the status of the midwife as the trained professional in normal pregnancy and labour and morale has suffered.

Proposals have already been made in "The Vision" by the Association of Radical Midwives and "The Future Role and Education of the Midwife" and "Towards a Healthy Nation" from the Royal College of Midwives. These proposals, if implemented, would ensure that the majority of midwives give continuity of care and practice midwifery as opposed to obstetric nursing. Although this would increase job satisfaction, the low level of midwives pay is perhaps a more critical problem, especially in London and the South East where housing is expensive, a situation not helped by sales of hospital or health authority accomodation.

AIMS supports the restructuring of midwifery practice so that midwives are responsible for their own case loads and also believes that midwifery beds should be available in all hospitals so that low risk women, who wish to have a hospital birth, can book in directly with the midwives. There is now sufficient evidence to show that care from teams of midwives reduces mortality, reduces the amount of unnecessary interventions and morbidity, increases satisfaction amongst mothers and is cheaper that the present consultant centred care that the majority of women have.

We could draw your attention to the paper "The Vision" referred to above. [23]. This is a proposal for the future of the maternity services which was prepared over several drafts by the Association of Radical Midwives. It involved close consultation with many midwives and mothers as well as AIMS, the National Childbirth Trust and other user groups. It represents a well researched and well documented proposal which AIMS supports and, rather than set out whole sections in full here, recommends to the Committee for consideration.

If midwives were able to provide continuity of care this would go a long way towards meeting women's needs. We also believe that quite a number of the midwives who have left the profession because of dissatisfaction with their role, would return if new systems are introduced.

AIMS believes that the maternity service would be greatly improved by every hospital having an allocation of midwifery beds, all low risk women given midwifery care if that was their choice, and proper provision made for home births for those who choose them—estimated to be perhaps 10—15 per cent [2].

In this view obstetricians will have the time to concentrate on giving a good standard of care to high risk women, for whom their care is appropriate and potentially valuable.

Table 1 Percentage of births and perinatal mortality rate (PNMR) at different labour prediction scores (LPS) in different places of birth.

LPS	Level of risk	Percentage of births		PNMR/1000 births	
Hospital*	GPU/home	Hospital*	GPU/home	Hospital*	GPU/1000
0–1	Very low	39.4	59.4	8.0	3.6 (*a*)
2	Low	23.0	22.3	17.9	4.8 (*b*)
3	Moderate	15.6	10.6	32.2	2.0 (*c*)
4–6	High	18.2	7.5	53.2	14.2 (*b*)
7–12	Very high	3.8	0.2	162.6	166.6 (*d*)
0–12	All levels	(n = 11141)	(n = 4660)	27.8	4.9

*Obstetric beds only

Differences in PNMRs in these large samples of births have the following chances of being real:

(*a*) 97.5 per cent; (*b*) 99.5 per cent; (*c*) 99.9 per cent; (*d*) 2.5 per cent.

Source: Unpublished data from the British Births 1970 survey.

REFERENCES

1. Peel Committee Report, Standing Maternity and Midwifery Advisory Committee (1970), HMSO (para 248).

2. Campbell R, Macfarlane A, Where to be Born? The Debate and the Evidence, National Perinatal Epidemiology Unit, Oxford.

3. Tew M (1985) The practices of birth attendants in the safety of birth, Midwifery, 1.4.

4. Tew M (1990) Safer Childbirth? A Critical History of Maternity Care, Chapman & Hall, London.

5. Butler N & Bonham D (1963) Perinatal Mortality, Churchill Livingstone, Edinburgh.

6. Chamberlain R, Chamberlain G, Howlett B & Claireaux A (1975) British Birth 1970 Vol. 1, The First Weeks of Life, Heinemann.

7. Chamberlain G, Philipp E, Howlett B & Masters K (1978) British Births 1970 Vol. 2, Obstetric Care, Heinemann.

8. Enkin M, Keirse M & Chalmers I (1989) Effective Care in Pregnancy and Childbirth, Oxford Medical Publications.

9. Flint C & Poulengeris P (1985) The 'Know Your Midwife' Report Available from 34 Elm Quay Court, Nine Elms Lane, London SW8 5DE (price £8.50).

10. 'Users Opinions' Survey of Lothian Maternity Services (1987), Edinburgh Health Council's Working Group on Maternity Services.

11. Maternity Care in Action, Part I Antenatal Care (1982), First Report of the Maternity Services Advisory Committee, HMSO.

12. AIMS Quarterly Journal, Winter 1987/88, p14.

13. Arnold M, The Cycle of Maternal Deprivation, Community Nurse, Midwife & Health Visitor, December 1987, Vol. 23, No. 12.

14. Robinson J J A (1986) A Study of the Policy Implications arising from a Local Survey of Perinatal Mortality, PhD Thesis, University of Keele.

15. Hall M et al (1985) Antenatal Care Assessed, Aberdeen University Press.

16. Patient information booklet: A Comparison of two different special tests in pregnancy—Amniocentesis and Chorionic Villus Sampling.

17. 'Fresh Start for Health' (1990) Labour Party policy discussion paper.

18. World Health Organisation letter to the Lancet, 11 August 1984, p 361.

19. Patten John, Ultrasound Scanners, Written answers, Hansard, 24 May 1984, p 502.

20. Stark et al, Short and longterm risks after exposure to diagnostic ultrasound in utero, Obst. Gynaecol 1984, 63, pp 194–200.

21. Report of the Royal College of Obstetricians and Gynaecologists' Working party on routine ultrasound examination in pregnancy, RCOG, December 1984, p36.

22. Klein et al. Comparison of low risk pregnant women booked for delivery in two systems of care: shared care (consultant) and integrated GP practice unit. I Obstetrical procedures and neonatal outcome II Labour and delivery management and neonatal outcome. Br. J Obs & Gynae, Feb 1983, Vol. 90, pp 118–128.

23. The Vision, Proposal for the future of maternity services, Assn of Radical Midwives, 62 Greetby Hill, Ormskirk L39 2DT.

Supplementary memorandum submitted by the Association for Improvements in Maternity Services

CONTENTS

Summary of AIMS submission

1. AND 2. WHAT IS AIMS? AND INTRODUCTION

Summary of this section not included.

3. MIDWIFERY CARE

Continuous care from midwives from the beginning of pregnancy would provide the safest, cheapest and most supportive care for most families. Women should be able to choose birth at home or in a midwifery unit. (Paras 3.1–3.11).

4. GENERAL PRACTICE AND MIDWIFERY CARE

The pay structure encourages GPs to provide fragmented care. GPs should only provide antenatal and postnatal care if they are also delivering babies. Initial training is inadequate and they should also have to take regular refresher courses as midwives have to do. (Paras 4.1–4.22).

5. HOME BIRTH

Women choose home births not because they are "more pleasant" but because their own experience of hospital births tells them that they are safer. Women choosing home birth are removed from GPs lists, intimidated, browbeaten and lied to. (Paras 5.1–5.25)

Flying Squads

This service has been discontinued in many areas leaving mothers with planned or unexpected births outside hospital at risk. (Paras 5.25–5.33).

6. PROBLEMS WITH HOSPITAL CARE

Choice has been greatly reduced because so many units have been closed and referral outside the district is more difficult. Costs and inconvenience of travel are therefore greatly increased.

If women are going to make choices they must have statistics on caesarean section rates, forceps, induction and acceleration rates etc. It is difficult to change one's obstetrician. The unseen labour ward protocol may dictate how long a woman is allowed to be in labour and the right to a slow labour is disappearing. All protocols should be published.

All maternity hospitals should have a separate unit of midwifery controlled and staffed beds where midwives admit, care for and discharge women and provide total care without doctors. (Paras 6.1–6.31).

7. MANAGEMENT OF RISK

Consultants prefer to care for women of higher social class rather than highest obstetric risk. Some are failing to supervise and train juniors properly. Their work patterns should be examined. (Paras 7.1–7.13).

8. CRITERIA FOR ASSESSING MATERNITY CARE

Mortality statistics are inadequate as a yardstick, physical and mental injuries to mothers are seldom reported in medical journals and treatment is inadequate. The consequences for the family can be disastrous. (paras 8.1–8.8).

9. MONITORING QUALITY AND EFFECTIVENESS OF CARE

Amateurish and poor quality "market research" on maternity care can be misleading. When staff inadequacies are identified management action is often ineffective (see House of Commons Select Committee questions on Ombudsman's reports). Staff contributing to risk should be quickly identified. Management cannot rely on statistics alone as they can be misleading or "cooked". (Paras 9.1–9.8).

10. SOME CURRENT CONCERNS

Managers have allowed large sums of money to be spent on equipment before its safety or effectiveness have been evaluated. Only the consumers have questioned this profligate policy. It is the one area of health care where patients were demanding less, not more. (Paras 10.1–10.2).

Electronic Fetal Monitoring

Despite many complaints from consumers that EFM equipment was uncomfortable, unreliable and sometimes dangerous, it was universally adopted without adequate evaluation.

Its use has been shown to increase the caesarean section rate for premature babies, its use is associated with increased risk of cerebral palsy. (Paras 10.3–10.11).

Ulrasound

One of our major worries is possible long-term risks. Ten years ago AIMS wrote to the Minister of Health deploring the expenditure on expensive equipment which had not been evaluated and could have long-term risk for current and future generations.

Possible adverse consequences include damage to cells, increased miscarriage rate and dyslexia. Early detection of fetal abnormalities is seen as a "benefit". However, such diagnoses can be wrong, leading to termination of healthy pregnancies. Even where the mistake is detected in time, women are caused great anxiety and distress. We have no idea how common such mistakes are since no adequate research has been carried out. (Paras 10.12–10.33).

Episiotomy

Unnecessary episiotomies, which were until recently routine in the majority of hospitals, have caused long-term suffering and disability to many women and have also affected marital relationships. However, AIMS still receives reports of long-term damage caused by careless cutting and inexpert suturing. Although well-designed studies have shown some suture materials to be better than others, suturing material which is known to cause greater long-term pain is still used in some hospitals. (Paras 10.34–10.38).

Caesarean sections

Caesarean sections increase costs for both the hospital and the family, and increase risks for mother and baby. Yet widely different caesarean section rates have not been questioned by management. Modern obstetrics can increase rather than decrease the risks of a mother having an unnecessary caesarean operation.

But a mother who really needs a section may be operated on too late or by an inexperienced doctor. For many years confidential enquiries into maternal deaths have pinpointed surgery by junior doctors as a cause of avoidable death. Poor quality postnatal care is one of our frequent complaints. (Paras 10.39–10.49).

Vaginal Birth After Caesarean Section—VBAC

Women who want a vaginal birth after a previous caesarean section are subjected to obstetric management which reduces their chances of a normal vaginal delivery. Half the women who died following elective caesarean section were only having surgery because a previous baby had been delivered by caesarean section. (Paras 10.51–10.56).

Breastfeeding

Lack of support and conflicting advice are common complaints. Women who have had surgery or difficult deliveries need extra help and often do not receive it. Good care is patchy and there is enormous variation.

We are concerned that mothers' and babies' rights are violated daily in hospitals where babies are fed bottled formula or dextrose despite mothers' specific instructions that the baby is to be entirely breastfed.

GPs and some health visitors are often inadequately trained and are unable to advise breastfeeding mothers. (Paras 10.57–10.73).

11. Research

Past history shows that when new procedures are introduced, short-term research is not enough. Possible long-term consequences must be sought, eg extra oxygen given to premature babies later caused blindness, hormones given to pregnant women later caused cancer in their adult daughters and exposure to X-rays before birth increased leukaemia in the children. Despite these well-known examples, provision has not been made for seeking long-term effects when new treatments are introduced. (Paras 11.1–11.10).

Epidural anaesthesia

Epidurals are now more commonly used partly because induced and speeded up labours are more painful and they are also used for many caesarean sections. The only research on possible long-term adverse consequences for the mother, which was carried out after pressure from AIMS has shown an increased risk

of long-term back-ache. Other suspected damage is reported by women, but has not yet been studied. Exposure to the drugs involved short-term, but again long-term consequences, if any, are unknown. (Paras 11.12–11.18).

Drug Addiction

Well-designed research from the prestigious Karolinska Institute in Stockholm has shown that babies whose mothers had more drugs in labour, are more likely to become drug addicts in later life. This shows the need for urgent research into long-term risks in Britain. For many years AIMS has been critising hospital practices which increased women's need for pain relief, we have also campaigned for women's rights to conditions and attitudes which *reduce* women's need for pain relief. (Paras 11.19–11.30).

12. Training

All training in normal birth, including that of medical students, junior doctors and GP trainees, should be conducted by midwives, who are the experts in this field, and not obstetricians.

Medical students should only be present with the woman's prior permission, and if the student is to deliver the baby her consent should be asked in advance because it is difficult to refuse when one is in labour, and the student should be required to attend for the whole of the labour. (Paras 12.1–12.10).

Junior Doctors

The RCOG has said that recruitment to obstetrics is reduced and they attribute this to litigation. Our medical contacts tell us that dissatisfaction with training is an important factor. Poor training of junior doctors and their inadequate supervision are currently major risks for women in childbirth. (Paras 12.11–12.19).

13. When Care Goes Wrong

AIMS' complaints files show that common causes of avoidable mishaps are: unnecessary intervention, use of locum doctors and midwives, GP trainees in hospital, junior doctors dealing with cases beyond their competence, incompetent GPs and staff not believing women.

Health Authorities' responses to complaints are often disappointing, defensive and dishonest, and families are driven to litigation they had not originally intended. (Paras 13.1–13.9).

14. Complaints

Complaints against General Practitioners

The procedure is unsatisfactory. The time limit of thirteen weeks excludes a number of serious cases and the chances of a complainant being successful varies enormously according to where she lives. Complaints which cover both GP and hospital care have to be pursued through two entirely different procedures and this is exhausting, frustrating, unsatisfactory, and unnecessarily time-consuming. (Paras 14.1–14.6).

Complaints against hospital staff

The Clinical Complaints Procedure in our experience invariably leaves complainants frustrated and dissatisfied and nowadays we seldom recommend it.

The health authority is powerless to take action against doctors who have moved on to employment elsewhere and this means that dangerous locums who move from place to place can cause many problems.

If the Association suspect that a midwife is for any reason dangerous as a practitioner we feel there is a reasonable chance of having her investigated by the National Board and then the UKCC. Midwives can be removed from the Register if they commit "Professional Misconduct" and if suspicious incidents are reported the UKCC will itself investigate. Doctors, however, can only be investigated by the General Medical Council if they are suspected of "*Serious* professional misconduct", and complainants themselves have to produce evidence that there is a *prima facie* case.

> Note: Not a single hospital doctor was investigated for serious professional misconduct in relation to medical care by the General Medical Council last year.

Because health authorities do not report doctors to the General Medical Council, and because the Council itself does not investigate complaints, mothers and babies are at risk. We urge the House of Commons to conduct an enquiry. (Paras 14.7—14.20).

15. LITIGATION

The increase in litigation has had enormous publicity and it is seen as a problem which is distressing to obstetricians and expensive for health athorities. The real problem, of course, is the fact that there are avoidable serious injuries to mothers and babies, and negligence only succeeds in a British Court if proved to the hilt.

Litigation has increased because of widespread dissatisfaction with complaints procedures and because there are now more experienced lawyers to help complainants. Despite many incidents of negligent care, obstetricians used to practice without fear of litigation and they are now indignant because a small percentage of families who have been damaged are exercising their right to sue. Most people, however, do not qualify for legal aid and cannot afford litigation. (Paras 15.1—15.15).

1. WHAT IS AIMS?

1.1 The Association for Improvements in the Maternity Services (AIMS) is a voluntary organisation, established in 1960. It is the only pressure group which is solely concerned with maternity care. We—

help parents with enquiries about how to get the kind of care they want,

give information about obstetric and midwifery practice,

give assistance with complaints,

liaise with other organisations, including similar groups overseas,

give talks to midwives and health authority staff and present papers at conferences in Britain and overseas,

respond to requests for information from health authorities and health professionals,

monitor obstetric and midwifery journals and text books,

produce information leaflets and a quarterly journal,

have local groups in England, Scotland, Northern Ireland, Wales and Eire.

1.2 A copy of "What is AIMS ? is attached, enclosure 1.

1.3 We are aware that as a group which deals with many complaints we may be seen as having a biased view. We know that for most women the outcome of preganancy is a happy one. We know that there are good hospitals and caring and sensitive obstetricians and midwives. Indeed we spend a great deal of time referring women to midwives, doctors and hospitals who are most likely to meet their needs. However, we believe that our 30 years experience of the difficulties families have with maternity care may be useful to the committee.

2. INTRODUCTION

2.1 One of the major problems we see in maternity care is the lack of continuity—lack of continuity in antenatal care where women see a series of different junior doctors in hospital clinics, or "shared care" between GPs and hospital. In labour we have been aware of a number of serious adverse consequences arising from shift changes. Postnatally women are cared for by professionals who have had no involvement in their labour, and may have had no involvement in the antenatal care either.

2.2 We shall only get continuity if the emotional and physical needs of families are put first—above professional and managerial interests.

3. MIDWIFERY CARE

3.1 At one time the local midwife on her bicycle was known in every town and village in Britain, where she was recognised by children she had delivered many years before. Midwives were very much part of the local community.

3.2 Most deliveries in this country are conducted by midwives. Yet maternity care policies have been dominated by obstetricians. Since midwives have had to work on hospital premises under the control of the health authority, they have become more like nurses—accepting doctors' orders rather than being professionals in their own right. They have had to follow clinical policies laid down by the medical staff, even when they felt this was not in the interest of the woman they were caring for. They were reduced to "doing good by stealth"—comforting women on whom distressing procedures had been imposed, or hinting that the woman had a right to refuse. Some of the best midwives we know left the profession, and increasingly those attracted to or retained in hospital midwifery were attuned to being obstetric nurses rather than midwives.

3.3 Expensively trained midwives are being used for trivial work in hospitals, the community and GP practices. Many of them no longer deliver babies. In our view a midwife who does not do deliveries is not a midwife.

3.4 As well as campaigning for user interests AIMS has spent a considerable time supporting ordinary midwives, and even midwifery managers who were greatly stressed by the confict between the care they were

forced to give and the care they wanted to give. Both obstetricians and management will often prefer to appoint midwifery managers who make life easy for them by following the party line.

3.5 We believe the local midwife should be the first contact for pregnant women. Individual midwives or teams should give complete care—at home or in midwifery units under midwifery control. Midwives will, of course, call in obstetricians for advice when they consider it necessary, as they do at present, but this should be a senior obstetrician not a junior trainee.

3.6 The obstetrician will not necessarily take over the case, but may advise and leave the midwife to continue care. Where a woman needs transfer her own midwife should accompany her. The woman who develops complications has the greatest need for continuity of emotional support.

3.7 We hope that groups of midwives will put in proposals to health authorities for contracts to provide care in the community and in midwifery units. We think that they could provide low cost, effective and satisfying care for the majority of women in this country who will, of course, have normal births.

3.8 *Recommendations:*

3.9 The local midwife should be the first point of contact for pregnant women.

3.10 Individual midwives or midwifery teams should give complete maternity care—at home or in midwifery units under midwifery control.

3.11 Where a woman needs transfer the midwife should accompany her.

4. General Practice and Maternity Care

4.1 At present the GP is usually the woman's first contact when she believes she is pregnant. This immediately establishes a pattern that she has a "medical" condition. Since only a minority of GPs deliver babies and the number of GP units has declined, the usual procedure is for the GP to arrange a hospital booking.

4.2 The GP does not tell the woman that she has a right to other types of care. It would not be in his financial interest to do so. Without changing her doctor, she could register with a GP obstetrician for total care, if there were one in her district. Or she could ask the health authority to provide a midwife to deliver her at home. Comparatively few women use these options, because they do not know they exist.

4.3 Because most GPs are now out of practice in doing deliveries, they are understandably reluctant to be involved. What is unfortunate is the reaction of some who, in anger or panic, promptly remove women who want home confinement from their list, even if the woman has arranged midwifery care. We are aware of cases where not only do GPs strike off the woman, they also strike off the whole family. When that family lives in a rural setting this action is seen as extremely threatening and is used "pour encourager les autres" to toe the line and give birth in hospital. (Enclosures 2–9).

4.4 Older GPs describe building up their practice on the maternity care they provide. Two factors have influenced the change: firstly, pressure from obstetricians—who were understandably concerned at the poor quality of care some GPs provide, and tarred the rest with the same brush; secondly, the new pay structure created by the DHSS.

4.5 GPs are now comparatively well paid to do antenatal and postnatal care, but the reward for actually delivering the baby is modest. The DHSS did not have to formally oppose women's demands for home births. They simply agreed to a pay structure which inevitably led to GPs opting out and losing their skill.

4.6 What many women now have is called "shared care"—the GP doing ante and postnatal and the women giving birth in hospital. AIMS has even had reports of high-risk women being told by consultants: "I'll send you back to your GP so he gets his money".

4.7 We have had reports of a number of adverse outcomes because of discontinuity and lack of communication arising from shared care, eg. hypertension was detected but each party seems to have assumed it was being monitored by the other.

4.8 "Shared care" too often means fragmented care; it means the woman's needs can be separated so that the GP gets his pay and the obstetrician gets control.

4.9 Where true GP-midwives still exist, they are greatly valued by their patients, who enjoy continuous care of the family. The little boy with earache is seen by the doctor who delivered him, and doctor and mother have an immediate rapport. Where GP care is total and works well, it is first class, but of course the GP needs enough midwifery practice to retain skill. This can be achieved by having one specialist in the practice.

4.10 In Oxford a comparison was made of the outcome of low-risk women delivered in the GP unit and the consultant unit in the same builidng (Klein *et al*, 1983). Induction of labour, epidural anaesthesia and forceps delivery were all less frequently carried out in GP unit women. 11 per cent of the consultant unit babies required intubation (none in the GP unit) and 17.5 per cent of consultant unit babies had low Apgar score (a scale for determining how fit the babies are at birth) compared with only 1.6 per cent GP unit babies.

4.11 The logical outcome from this would be to expand the GP unit and get better health outcomes for less expenditure. This has not happened and we wonder why.

4.12 One GP-midwife told us "It concentrates the mind wonderfully when you are giving antenatal care and you know you will be delivering the baby." We suspect that GPs who hand over deliveries to the hospital may take less notice of women's symptoms—hence some of the failure to act reported to us.

4.13 In order to stay in practice midwifes are obliged every five years to undergo a statutory refresher course. There is no such obligation for GPs or hospital doctors. There have been a number of occasions when GPs, including those on the obstetric list, who have received extra training and therefore extra payment, have made serious and basic errors. These include failure to act on common symptoms of pre-eclampsia. There seems to be no provision for ensuring that such doctors receive extra training or for getting them removed from the obstetric list, even after they have been disciplined by the FHSA for breach of terms of service, we have tried a number of times and failed.

4.14 The most recent Confidential Enquiry into maternal death (1985-7) reported: "The diagnosis of maternal thrombosis or pulmonary embolism did not even appear to have been considered in the majority of the fatal cases which occurred during the course of pregnancy. Unless there is a high index of suspicion, the diagnosis will continue to be missed by those involved in the care of pregnant women."

4.15 In order to remain in practice, midwifes have to take compulsory refresher courses every 5 years; doctors do not. We believe that ante and postnatal care should be given *only* by those who also do sufficient deliveries to maintain their skills. We welcome the continued involvement of GPs who give total care. They should however, be required to keep up to date as midwifes are.

4.16 In her 1981 study Gutteridge reported a history of opposition to fragmented care. The RCOG in 1944 had criticised local authority clinics which gave antenatal care but did not manage labour. The 1959 Cranbrook Report recommended that the local authority doctors should be replaced by the GP obstetrician because it was not sound pratice for him to provide antenatal care when he was not responsible for deliveries." In 1968 the Royal College of General Practitioners report stated "it is undesirable for doctors who hold no responsibility for deliveries and conducting antenatal clinics." Since then the RCGP has done a volte face.

4.17 There is no place in maternity care for the GP who gives only partial care. Women should in the main receive total care from midwives. We recognise this change will be difficult to bring about because of the financial interest involved. If GPs have to be bought off to enable women to get continuity of care, so be it.

4.18 RECOMMENDATIONS:

4.19 GPs should only be paid for maternity care when they provide a total package of antenatal and postnatal care and also conduct the delivery.

4.20 In order to remain on the obstetric list and receive the higher levels of payment from the NHS for maternity care GPs should be required to update their knowledge at regular intervals by taking compulsory refresher courses every five years.

4.21 Since the way pay is structured can have profound effects on the care users receive, we think that users should have a seat at the table when pay structure is being negotiated for health care workers.

4.22 The question of GPs involvement with maternity care when they have not had additional training should be examined.

5. HOME BIRTH

5.1 In 1967, 503 Northampton mothers who had given birth at home or in hospital were interviewed (Alment E, 1967). 63 per cent preferred home birth. When women who had experience of both a home and a hospital birth were asked, 82 per cent preferred home.

5.2 The women who had given birth at home had shorter labours, fewer stitches, were more likely to breast feed and their babies had fewer infections.

5.3 The author, who later became President of the RCOG concluded "a combined hospital-domiciliary service is required in which midwives would have continuous supervision of mothers both at home and in hospital."

5.4 Despite this strong evidence of user preference, three years later, the Peel Committee recommended provision for 100 per cent hospital births.

5.5 The report "Where to be Born? The Debate and the Evidence" states that "There is *no evidence* to support the claim that the safest policy is for all women to give birth in hospital." (Campbell R and Macfarlane A, 1987).

5.6 Marjorie Tew has demonstrated that "increased hospitalisation actually kept the perinatal mortality rates from falling as much as it would inevitably have done in step with the improving health of parents." (Tew M, 1985).

5.7 The national statistics on home birth show that fewer than 1 per cent of women gave birth to thier babies at home in 1987, compared with 26.1 per cent in 1965. Although we understand the home birth statistics may have improved very slightly since 1987 it has yet to reach 2 per cent in the majority of health authorities. In Torbay, however, approximately 12 per cent of women give birth at home.

5.8 AIMS believes that one of the most significant factors which has led to the decline in home birth is the pressure to which women are subjected by doctors and midwives, when they indicate their preference. AIMS spends a considerable amount of time helping and advising parents who often have to battle throughout their pregnancies to obtain a home birth. Many of them give up under the pressure. It is quite common for women who ask for a home birth to be struck off their GP's lists.

5.9 Women have a right to book a home birth and the health authority has an obligation to provide a midwife—no matter what their risk category. Women are not told this, and many are told that they cannot have a home birth because it is not "allowed" in their area. On the Isle of Wight a community midwife told a mother "I do not deliver babies. You will have to go into hospital". The misinformation that women are given ranges from "We don't do home confinements in this area", "what you are doing is illegal and immoral", to "If you want a dead baby, go ahead" or "I am afraid that's absolutely out of the question, my dear". One of the most worrying aspects of the many letters and telephone calls we receive is the common story that women are told that they cannot give birth at home because they have a particular complication eg. placenta praevia or high blood pressure. This causes considerable anxiety to the pregnant woman and, of course, this anxiety could continue to subsequent pregnancies. Some subsequently discovered that the complication had not existed. When they went into hospital with "placenta praevia", no preparations were made for a caesarean section and they had a normal vaginal delivery.

5.10 After the fourth case of fictional "placenta praevia" in one health authority, AIMS wrote threatening legal action if we had any further instances. This is an example of how the law is the last resort, and in some cases the only sanction which otherwise powerless women can use. When doctors complain that women do not always follow advice they should remember that sometimes they have been given cause for mistrust in the past.

5.11 In another area a pregnant women found that domiciliary visits by midwives amounted to harassment. They always arrived in pairs and insisted that she produced her urine samples in front of them. Such was the pressure on women in that district that we had to advise women who wanted a home birth not to announce their intentions until they were near delivery, so that they could have a relatively stress-free pregnancy.

5.12 There are times when AIMS members have been puzzled by the levels of antagonism and resistance from health authority staff to women seeking home births. Earlier this year we found an explanation. We were sent a copy of the papers disseminated by SE Thames Regional Health Authority to district health authorities, and supervisors of midwives, within their region. This advice was so inaccurate, misleading and intimidating that we wrote a detailed critique to the Chairperson in April and await a reply. A copy of this letter and relevant documents is enclosed. (Enclosures 10–17).

5.13 Some health authorities require women to sign forms of indemnity. Enclosed is an example from Basingstoke and North Hampshire Health Authority. Following a complaint from a mother, and from AIMS, the health authority has withdrawn the form and produced an agreed procedure which no longer requires the mother to sign such a form. (Enclosures 18–19).

5.14 These authorities apparently have the erroneous belief that by signing such a form the parents would lose their right to sue the authority for negligence. This, of course, is quite untrue but it has been used successfully to persuade parents to drop their legitimate request for a home birth.

5.15 We know of at least three cases where women have been threatened with enforced hospitalisation under the Mental Health Act when they asked for a home birth. One of these actually went abroad to have her baby. In another case, reported recently in the AIMS journal (AIMS, 1990), the obstetrician admitted that she had mentioned the Mental Health Act in her interview with the woman, but denied that it had been used as a threat.

5.16 Obstetricians say that women ask for home confinements because they want an enjoyable birth experience. It is interesting that they are not denying that birth is likely to be more enjoyable at home. However, they imply that the woman may be ignorantly or selfishly putting her own pleasure before the baby's need or safety. On the contrary, the women we see who are insisting on home birth do so because they believe it is safer and there is considerable evidence to support that view. A majority of them have previous experience of hospital birth and it is precisely to avoid the complications caused by their treatment at that time that they are opting out of hospital. A few women are so terrified of re-entering hospital that the fear would be likely to inhibit the birth process.

5.17 AIMS believes that an efficient home birth service in every area will increase user satisfaction and lead to a significant decline in morbidity, and considerable cost savings. Some Health Authority managers are now beginning to appreciate the advantages of home birth and are suggesting that low risk women should give birth at home if they wish.

5.18 We shoud point out that whether or not women choose home births some unplanned births, both premature and full term, will always take place at home and in taxis, ambulances, shops etc. Facilities have to be provided for these.

5.19 One of the advantages of a home birth is that the power relationship is different. The woman is on her own territory, surrounded by her own family, she can move, eat or drink as she chooses, invite in or exclude anyone she chooses, and is more able to refuse any intervention or medication she does not want. She is therefore able to have the kind of surroundings which she intuitively knows are right for her labour. A number of women choosing home birth after a hospital birth do so because they are given interventions despite their refusal.

5.20 In an observational study of birth in a consultant unit, GP unit and at home (Kirkham M, 1983) the researcher concluded "Patients at home were on their own territory. They did not use humble techniques for gaining information ... the patient was able to refuse a procedure and some did, which was not seen in hospital... This provided a sharp contrast with the hospital patient's great efforts to conform to the standards of the institution which she had to learn from observation and humility."

5.21 There is a great deal of research about the effect of disturbance on the length of labour in both animals and humans. We cite just one example, a randomised study in a Canadian hospital of Leboyer childbirth, this is a method whereby the newborn child is delivered into a dark, quiet, environment and treated with great gentleness. Although the management of the labour in both groups was the same, those women allocated to the Leboyer group had significantly shorter labours. The mere knowledge that when the child arrived it would be treated with gentleness was associated with shorter labour (Nelson et al, 1980). It does make one wonder whether some of the speeding up of labour that takes place in hospital is only necessary because going into hospital slowed it down in the first place.

5.22 One aspect of care for home births which needs examination is paediatric care. Quality of paediatric knowledge and care by GPs varies. There may be a need for more paediatricians to do home visits, to see care being given in this setting and to give advice to midwives and GPs. We believe that such visits would also be useful for trainee paediatricians. Their baseline for "normal" might change after observing the behaviour of the newborn and mother-baby interaction after an unmedicated delivery in home surroundings, compared with a hospital ward or nursery.

5.23 The centralisation of maternity care into large obstetric units has resulted in increased pressure on obstetric beds and a reduction in the length of stay. While many women are delighted to get out of hospital as soon as possible, for others it is detrimental and they do not have a choice. Those who have had operative or difficult deliveries, have other medical conditions, difficult social circumstances etc, may need longer hospital care and are nowadays sometimes sent home before they are ready.

5.24 The community midwifery service is required to absorb the increased workload that short hospital stays produce, and AIMS has been approached by community midwives in many parts of the country who are worried about the large numbers of women they are expected to visit post-natally. (They have a legal obligation to visit up to ten days post-natally, and in some areas, because of the heavy workload midwives are telephoning instead of visiting in person). No research has been conducted to establish what a reasonable workload is, or what effect shorter post-natal stays would have.

5.25 We have had many reports from midwives who have been unable to order appropriate tests without aproval of a GP or obstetrician. In many cases the women have not had GP cover. We consider this a bureaucratic nonsense, midwives should be able to order appropriate tests directly.

5.25 *Emergency Obstetric Units (Flying Squads)*

5.26 With little public discussion and no evaluation the flying squad service in many districts has been discontinued. The flying squad consisted of a team of specialists—including an obstetrician, anaesthetist and a senior midwife, and where appropriate a paediatrician. This team would go to a home or outlying unit, or to any pregnant woman needing expert medical aid. The discontinuation of this service has left many community midwives feeling vulnerable and unsupported.

5.27 Obstetricians now define themselves as doctors who work in hospitals rather than doctors who provide an expert service wherever it may be needed. The patient must come to them, rather than their going to the patient, even if it would be safer to give treatment to the patient before she is moved. GPs and midwives are now told, in many areas, to call an ambulance rather than the flying squad. We should point out that ambulance men have two hours obstetric training, and even additional training suggested, by obstetricians, for them is never going to turn them into obstetricians or paediatricians.

5.28 Obstetricians justify the closure of the flying squad service on the grounds that calls to isolated maternity units and births outside hospital will deprive the hospital patients of their expert assistance, and as there are few home births there is little need for the service. If they are less involved with the care of normal women (as we hope) they will then have more time for complicated and emergency cases. Likewise, if fewer unnecessary caesarean sections are done anaesthetists will have more time available.

5.29 *Recommendation:*

5.30 Midwives postnatal responsibilities and work loads should be investigated.

5.31 Midwives should be able to order appropriate tests directly.

5.32 There should be an urgent enquiry into the provision of appropriate obstetric and paediatric facilities outside hospital and the views of users of the service and midwives should particularly be sought.

5.33 Arrangements to provide for obstetric emergencies outside hospital should be investigated.

6. Problems with Hospital Care

6.1 The public have been told that hospital is "safer" because facilities exist there to deal with sudden complication which might arise at home eg haemorrhage in the mother or a baby which needs resuscitation.

6.2 It is implied that there are no extra risks for hospital birth. Yet day in and day out, AIMS deals with complaints about iatrogenesis (ie disease caused by medical care) of hospital care. There is substantial medical literature and support of our vew that many of the mothers and babies who had problems in hospital would actually have been safer at home, and their care would also have cost less.

6.3 The existance of emergency facilities in hospital does not guarantee that they will be appropriately used, we have cases of sudden complications where the woman would have had better care by staying at home and calling the ambulance.

6.4 *Choice*

6.5 Parents' choice on the place of birth has been greatly reduced within the last 10 years, owing to the numbers of closures of maternity units and the centralisation of maternity care. As well as reduced choice women now have longer journeys, which are more expensive, time consuming and in case of emergencies, risky. Particularly cited are cases where traffic congestion is known to be common eg approaches to popular holiday resorts.

6.6 So far as the the closure of GP units is concerned, it has been impossible to obtain accurate statistics since the Department of Health appears to have inadequate data. When a Parliamentary Question was asked at our instigation, by Mr Michael Latham in 1989, the Minister gave the names of 28 units which had been closed, buty AIMS knew of many more. The final total is unknown. Perhaps your Committee will be able to obtain the figures?

6.7 A crucial choice is made for the woman when the GP decides which consultant to refer her to. Rarely is the woman informed about her right to choose the obstetrician herself. Yet policies of different obstetricians within the same hospital, and their intervention rates, vary widely. The choice of obstetrician can often make a bigger difference than the choice of hospital. Women "in the know"—active members of local National Childbirth Trust branches or maternity care committees of CHCs—know very well which obstetricians they would choose and which they would avoid. But such knowledge is not commonly available. If it were, we suspect that some obstetricians would have a greatly reduced workload, and managers might wonder whether it was worth continuing to employ them.

6.8 In order to make effective choices women need basic information, and sometimes this is not even available to CHCs. Such statistical information would include the rates for:

Caesarean section

Forceps

Induction

Acceleration

Rupture of membranes (ARM)

Episiotomy

Epidurals

Pain relieving methods routinely used

Electronic fetal monitoring

Ultrasound scans

Syntometrine

Breastfeeding on discharge

6.9 Plus a copy of the labour ward protocol.

6.10 The Royal College of Obstetricians and Gynaecologists recommends that each obstetric unit should have a labour ward protocol. This enables junior staff, temporary staff, and new staff, to follow any agreed pattern which should ensure safety for mother and child.

6.11 However, the obstetricians have the major voice in setting these standards. Certain practices have been "de rigeur" in the past (eg. episiotomies for all, or rupture of membranes for all). The length of the first, second and third stages of labour which are "allowed" are increasingly standardized. Unfortunately women's and babies' bodies are not. The right to have a slower labour—where it is right for that mother and baby and neither is distressed—has almost disappeared.

6.12 The labour ward protocol should be given to all pregnant women and the Community Health Council. They would then be in a position to know if it is not being followed when it should be.

6.13 Obstetricians insist that even given statistical information women would not be able to understand its significance since some units deal with more high risk cases, or premature deliveries. We ourselves have never had any difficulty in explaining these points to women of all social classes, and we do not understand why it should it should be considered to be a problem. This service is paid for by the taxpayer and used by the taxpayer, and women are entitled to information so that they can choose how, where and if they will use it.

6.14 In order to make the choice of consultant women need to know more about patterns of care offered by different specialists. Junior doctors and midwifes know that Mr A's patients are helped to have natural labours but Mr B's are to be admitted for induction or speeded up. Women should be able to change if they wish from one consultant to another, but this is very difficult.

6.15 During their pregnancy some women discover that they do not like the approach of the obstetrician with whom they have been booked and realise that they would prefer someone else. It is easier to opt out of hospital birth altogether, or to change hospitals (where this is still possible) than to change consultant. We believe that it should be made possible and indeed easy to do so, and that all women should be informed that they have a right to do this.

6.16 We have received a few complaints from women who wish to change the midwife to whom they have been allocated. Such requests are not always dealt with sympathetically or helpfully. We would point out that having confidence in one's birth attendant may have a profound effect on the course of labour, and at such a time to be at the mercy of someone who is seen to be unsympathetic can have long-term adverse consequences.

6.17 We attach an extract from a recent AIMS Journal (Enclosure 20–21) which shows the difficulties one woman experienced in trying to obtain information about the local hospitals. If women could easily exercise the right to change, the statistics would provide useful information for management.

6.18 A common response by hospitals to enquiries about interventions is "these are done only if medically necessary". Such answers are meaningless without the accompanying statistics. Women are now encouraged to state their preferences in a birth plan. Depending on the hospital and staff on duty this can be a genuine means of helping the woman to achieve what she wants, and respecting her choices, or it can be a smooth meaningless public relations exercise. One woman said that in her hospital a birth plan has as much value as monopoly money. We suggest that a woman's birth plan which includes no artificial rupture of membranes has a different currency value in a hospital where the ARM rate is 80 per cent than one where it is 20 per cent.

6.19 At one time it was possible for a woman to choose to give birth in a hospital anywhere in the country. In recent years hospitals have, without any consultation, introduced artificial boundaries, and women who live outside them are excluded. Even women who are greatly dissatisfied with a previous experience at that hospital have nowhere else to go. In some of these areas the staff are vigorously opposed to home births and domino deliveries so the women are virtually captive.

6.20 We know of no institution or hospital in Britain, either within or without the NHS, where a woman can choose to book for midwifery care only. She must be booked under an obstetrician or a GP unless she is prepared to make a considerable fuss. The only place she can book total midwifery care is at home. Women should not be forced to stay at home as the only option for those who wish to avoid medical care.

6.21 Most pregnant women in Britain will receive a copy of the Health Education Council's booklet "The Pregnancy Book". This glossy, expensive, magazine is promulgated as a guide to maternity care, yet it does not give women information to make effective choices. It subtly directs them towards, and to accept, hospital care, and proceeds to describe the kind of care they could encounter while in hospital. This results in a general acceptance of hospital procedures, and few women will be informed adequately by this book to question any of the treatments they are given. It gives no hint that there could be alternatives, it does not tell them their rights and many women express dissatisfaction with the lack of empowering information. It is addressed, on the whole, to women who are expected to be passive recipients of care.

6.22 Faced by a barrage of user and media criticism of intervention hospitals have reacted with what we call "the pretty wallpaper syndrome". "We have put floral wallpaper in the labour wards—we are listening to what consumers want". The issue is not interior decor but power, and who has control. Obstetricians have used the excuse, that only they speak for the unborn baby and mothers may be irresponsible. Yet as we will show in our evidence, mothers have often been more responsible than doctors.

6.23 *Recommendations:*

6.24 Maternity statistics should be generally available to the public and CHCs.

6.25 Labour ward protocols should be available to the public and CHCs.

6.26 Women should be informed of their right to change obstetricians and how they can do so.

6.27 Women's right to choose a hospital for the birth of their babies should not be restricted by artificial boundaries.

6.28 Women should be able to book for maternity care only with a midwife if she wishes.

6.29 Every maternity unit should have midwifery beds so that women can book a hospital delivery under the care of midwives only. The practice of such midwives should not be controlled by obstetricians or GPs.

6.30 Information booklets such as the Health Education Authority's should be an empowering document not one which addresses women who are expected to be passive recipients of care.

6.31 The aftercare needs of women who have had difficult deliveries should be explored. This could involve an extra stay in hospital or help at home, similar to that provide by the Dutch Midwifery Aid scheme.

7. Management of Risk

7.1 Social class is one of the major factors affecting risk. One would therefore expect that women in highest risk groups—Social Class 5, and those who are unclassified—would automatically receive the most careful and expert management. But this is not so.

7.2 A midwife who was studying social class in relation to perinatal mortality looked at the practice in a number of London teaching hospitals (Arnold M, 1985). She discovered to her surprise that consultants went through lists of new patients and chose to give personal care to wives of men in Social Class 1 eg those married to doctors, lawyers, MPs etc—the group which is at lowest statistical risk. The next most senior person, the Senior Registrar, then selected his patients—which would be Social Class 2. This means that women in the lowest social group, whose babies were at highest risk, not only were more likely to be cared for entirely by junior staff, but also got less continuity of care because juniors in training are continually moving on.

7.3 The outcome for Social Class 1 women was not necessarily improved. Those receiving private care were usually automatically booked for induction on their first antenatal visit, and the caesarean section rate was higher than expected.

7.4 If consultants believe that their care is best for high risk patients why are some of them applying this "inverse care law"?

7.5 It is not that AIMS is recommending consultant care for all working class women. We believe that their best interests would be served by continuous midwifery care with consultants called when appropriate. However, consultants are the most highly paid professional care givers (when they have merit awards, very highly paid). It is, therefore, important that effective and appropriate use should be made of this expensive resource.

7.6 In 1970 the Peel Committee recommended that provision should be made for 100 per cent of births to take place in hospital. This was thought necessary because many high risk women were not getting in. But in fact with an adequate system for managing priorities there were enough beds to go around.

7.7 One problem was that many GPs were not good at identifying risk factors. Another was that women who booked early in pregnancy got the beds. Those who booked early were, of course, the more affluent and well educated, ie lower risk patients. Women who were poor, ill educated, non English speaking, very young, or hoping to conceal pregnancies, booked late or not at all. In the Northampton study we mentioned 24 per cent of mothers giving birth in hospital but only 16 per cent of mothers giving birth at home were Social Classes I and II.

7.8 Where there was a choice of hospital it was usually the well-informed middle class who got the beds in the teaching hospitals and the better units. So even within the hospital birth category the lower risk women got the better facilities.

7.9 In order to ensure beds for the most needy, health authorities therefore had to spend money on expensive capital programmes and running costs which would have been unnecessary with rational priority management.

7.10 Now that we have beds for all, the highest risk group do not get the best available, either from the point of view of clinical care or emotional and social support. It is not expenditure but correct assessment of priorities and proper management, based on *real* as opposed to perceived consumer need which would make a difference. In a case control study of perinatal deaths in the district with the highest perinatal mortality rate in the country, Robinson found that one of the problems for women, seen by staff as uneducated and of low social class, was that when they reported warning signs they were not listened to or believed (Robinson JA, 1986). We suggest that continuity of care from the same midwife would make this less likely.

7.11 Current changes in consultants' contracts may, we hope, deal with the problem which is reported to us by both midwives and junior medical staff that some consultants leave their NHS work, for which they are contracted, to their junior staff while they conduct their private practice, junior doctors say "he's off chasing the golden nugget". Not only are they failing in their duty towards their patients, but they are also failing to supervise and train their juniors.

7.12 *Recommendation:*

7.13 An examination should take place of the duties and work patterns of consultant obstetricians.

8. Criteria for Assessing Maternity Care

8.1 Maternal and perinatal death statistics provide "hard" data by which maternity care is measured. The Apgar score of the baby at birth, and shortly afterwards, can also be used. However, we see many long-term and serious problems caused by poor quality care, which no-one is measuring.

8.2 Obstetricians and paediatricians are of course concerned about injuries to babies including possible brain damage, and we do deal with a number of complaints about alleged avoidable deaths and damage to babies. However, maternal morbidity, both long and short term, and its prevention do not have nearly enough attention or a high enough priority. For example, we have a number of cases of women reporting injuries which result in difficulties in movement, long-term pain, restriction of normal activities, disfigurement, inability to have a normal sexual life, emotional damage, mental illness. Some of the most worrying cases are those with severe post-traumatic stress disorder.

8.3 Many of the cases we deal with are not short term. Often we are contacted by women who have continuing problems several years after delivery and who need help. Others who contact us soon after the birth, are still in touch with us long after that baby has started school. So we see the long-term effects, not only on the mother, but on her relationship with the child, with the baby's father, other children and grandparents.

8.4 The birth of a live baby is not just a success story for the statistics—it is the start of a family. We are in contact with a number of families who started with every advantage: a loving marriage, an adequate income, good housing, and supportive in-laws. Even these families are severely stressed despite the birth of a live, healthy, baby. They count for obstetricians as a statistical "success".

8.5 We find their stories particularly distressing because often the damage was initiated by medically unjustifiable intervention. A successful outcome for maternity care includes a mother who is cheerful and confident, is successfully breastfeeding, and is able to resume a happy sex life. Judged by these criteria some maternity hospitals are not doing as well as they think they are. Some of the problems are mentioned in a recent letter from AIMS to the British Medical Journal (Beech BAL and Robinson J, 1991), enclosure 22.

8.6 We are concerned that the research articles we read on these procedures often say little or nothing about their potential for doing harm to women both physically and emotionally.

8.7 *Recommendation:*

8.8 Effects on the mother should be included in research projects: maternal morbidity, both physical and mental, is a crucial yardstick in the measurement of obstetric care. We need an "Apgar Score" for the mother, as well as the baby, and women should be assessed both shortly after delivery and a year or more later with an open questionnaire.

9. Monitoring Quality and Effectiveness of Care

9.1 We are most anxious that managers should not fall into the trap of assuming that superficial and simple market research type surveys alone are adequate to identify serious problems. The selection of aspects of care to research and the questions which should be asked and the distribution of the subsequent results are all highly political issues. We have seen questionnaires which were clearly biased which did not address the main problems and more which were clearly amateurish and were based on the understanding that anyone could design, distribute and analyse a questionnaire, even if they had no social science training.

9.2 In a study done for one health authority by the College of Health, management priority was to look at the effects of early discharge. However, researchers, using open ended techniques, discovered that in that district the quality of postnatal care was the problem worrying consumers most at that time. Individual complaints can be valuable pointers to larger problems, but are not often used constructively in that way, nor is appropriate action always taken as a result. At almost every meeting of the House of Commons Select Committee on the Parliamentary Commissioner for Administration when health authority representatives are questioned following critical Ombudsman reports, MPs continually ask why no disciplinary action has been taken against doctors or senior management who have made errors, and the only people subject to discipline are junior people or lower grade nurses and midwives. At a meeting of the Committee on 30 January this year, one MP, Mr James Pawsey, was clearly concerned that a manager who had been at fault had now been promoted.

9.3 The early identification of staff who need retraining, relocation or removal could prevent injury and death for mothers and babies. We would cite a particularly important recent study by a midwife at Northwick Park Hospital (Logue, 1990) who was studying postpartum haemorrhage rates in women delivered by senior registrars and midwives. Examination of postpartum haemorrhage rates in women delivered by 13 different registrars doing instrumental delivery showed that one registrar had a pph rate of 1 per cent and at the other end of the scale another registrar with an equal number of deliveries had a rate of 31 per cent: "Having known and worked with all of these registrars their haemorrhage rates seem to be a reflection of their individual personality: the more conservative and patient operators show the lowest rates compared with the more impatient and heavy handed who show the highest score". She also showed that one midwife had a higher rate than her colleagues. This study shows the importance of monitoring the performance of individual professionals and valuable data for management and patients which can be obtained. It is the only published study of its kind that we know of, and this is surprising.

9.4 Management should not assume that statistics are always reliable. When there was great publicity about high induction rates we were given inside information from a number of hospitals that the statistics had changed but the practice had not. For example, women who were induced with an oxytocin drip were categorised as having already started in labour.

9.5 We have also been told that some early stillbirths (at around 28 weeks) have been designated as miscarriages in one district in order to make the stillbirth figures look better.

9.6 Each year maternity units make routine statistical returns. We are concerned that data is not collected on many issues of particular concern to the users e.g. artificial rupture of membranes, resuturing episiotomies, infection rates in mothers and babies. These statistics should be collected and all data should be freely available.

9.7 *Recommendation:*

9.8 Statistics relating to the use of routine interventions and morbidity in the mother and baby should be collected.

10. Some Current Concerns

10.1 One of our major concerns is the rapid spread of new technologies and obstetricians' uncritical enthusiasm for their use, before either their efficacy or their safety has been established. We might also say that they are extremely costly, not only in terms of capital expenditure but also in staff training and time. Money which is spent on expensive equipment before it is of proven value is money which cannot be spent on additional midwifery staff to give women adequate and continuous care, and to deal with user priorities rather than medical priorities. Yet health authorities and managers seem unable to ask straightforward and obvious questions, which users are asking, before authorising expenditure.

10.2 Two widely used technologies are electronic fetal monitoring and ultrasound.

10.3 *Electronic Fetal Monitoring*

10.4 When continuous electronic fetal monitoring became commonly used, we received complaints from women that belts around the abdomen during labour were uncomfortable, and that restriction of movement increased pain and slowed down labour. Some wanted to refuse, but received the standard "shroud waving" response—they would put their baby's life at risk. They also reported that sometimes the staff seemed to pay more attention to the machinery than to the mother, and therefore emotional support and quality of care were diminished. The mother might report something abnormal going on, and she turned out to be right, but the staff listened to the monitor rather than her.

10.5 We received frequent reports of monitors breaking down, or being unreliable, and of staff wrongly discounting alarming tracings from the monitor because they believed it to be unreliable when it was not. Mothers lost out in supportive care because staff took more interest in the machine than in them and often left them on their own with the machine. One husband was so disturbed by his fear that something had happened to his wife when the recording stopped and he was alone with her, that he arranged to have a vasectomy immediately after the birth.

10.6 Fetal scalp electrodes were added to the interventions and women complained of permanent scarring and bald patches on the baby's head. Occasional reports appeared in medical journals eg a baby's death caused by infection entering through the insertion of the scalp monitor, and internal injury to a mother when the clip was attached to her and not the baby.

10.7 One of the reasons why the extra safety of specialist units was insisted upon, was that such monitoring was available there and nowhere else. So women were considered doubly irresponsible if they gave birth at home. AIMS wanted proper evaluation of safety and effectiveness before EFM was universally used. We were criticised by mothers of children with celebral palsy because of our caution which would lead to delay. It is now known that continuous electronic fetal heart monitoring is not effective—indeed it increases caesarean

section rates and thereby the risk to both mother and baby. One study (Shy K et al, 1990) showed that continuous EFM is actually associated with an increased risk of cerebal palsy. Premature babies have an increased risk of this condition. Women in premature labour were randomly allocated to have either continuous EFM or having the fetal heart monitored every fifteen minutes. 20 per cent of the babies given continuous monitoring developed cerebral palsy compared with only 3 per cent of the controls. This study makes us question the current campaign by obstetricians to persuade the public that crebral palsy is very rarely caused by events taking place during birth.

10.8 The introduction of technology does not mean that staff are able to use it successfully. Too often management has agreed to the purchase of expensive machinery with its ongoing training and maintenance costs, without asking pertinent questions. A study last year (Murphy K et al, 1990) reviewed records of monitoring of babies who were born severely asphyxiated. Fatal blood sampling had been carried out in only 16 per cent of them whereas it had been indicated in 53 per cent. Staff did not react more quickly in a dangerous situation than they did when less serious risk was indicated. In one of three infants who had long-term neurological damage, the significance of a very abnormal tracing was not recognised for almost eight hours. This study was carried out at the John Radcliffe—a teaching hospital with a deservedly high reputation for its maternity care. They have high quality medical and midwifery staff. If, in practice, fetal heart monitoring doesn't work there, it will not work anywhere.

10.9 Another problem created by technology which is of great concern to AIMS, is that by relying on monitors the skill of midwifes, and indeed training of doctors to interpret what is happening by listening to the fetal heart through a stethoscope, has been downgraded and diminished and could be lost. Many overseas doctors come from the Third World to train in British hospitals. Their populations are at high risk of perinatal and maternal death. We do them no service to encourage them to believe that their countries too should be investing in expensive but ineffective equipment. It is now know that listening to the fetal heart through an ordinary old-fashioned Pinard stethoscope is better than attaching the mother to machinery.

10.10 Electronic fetal monitoring was introduced in the 1960s. It has taken the medical profession nearly thirty years to learn this lesson, and it has been learnt at enormous financial cost to the NHS and a considerable cost to women and babies. The Short Committee (1980) recommended that "Continuous recording of the fetal heart rate should increasingly become part of the surveillance of all babies during labour" despite lack of adequate evidence. They had not consulted any user organisations and were unprepared for the outburst of indignation which greeted the publication of their report from user groups (who had read the literature). At a conference held to launch it, the speakers were totally unprepared for the barrage of hostile comments which came from all around the audience.

10.11 Obstetricians continue to advocate the use of EFM, now saying that yet more refinements are needed. However, they are having second thoughts because records from monitors have provided evidence for parents pursuing medical negligence actions. The fear of litigation apparently affects them fare more than the results of well-designed clinical trials. Is it any wonder that parents turn increasingly to litigation? It works, if only for some. Our protests, based on women's experiences and careful reading of the literature, have failed to stop the high technology medical juggernaut.

10.12 *Ultrasound*

10.13 AIMS was concerned, from the beginning, at possible long-term adverse effects of ultrasound. The first evidence we saw came with the publication of Liebeskind's 1979 paper showing changes in mouse cells exposed to diagnostic levels of ultrasound. These effects persisted for many generations. This in vitro study carried possible implications for effects on the central nervous system of the fetus.

10.14 In 1982 Liebeskind et al published a paper in the British Journal of Cancer of the cellular effects of pulsed diagnostic ultrasound and concluded "The persistence of abnormal behaviour and motility in cells exposed to a single dose of diagnostic level ultrasound ten generations after insonation suggests permanent hereditary effects ... It is not known whether the in vitro effects of ultrasound also occur in vivo."

10.15 In 1981 AIMS wrote to Dr Gerard Vaughan, then Minister of Health, expressing concern about the "widespread use of technological innovation ahead of proper scientific evaluation" and asked the Minister to investigate. He replied that:

> "In 1976 the MRC's Cell Biology and Disorders Board considered the possibility of a trial to assess the potential benefits and hazards of the use of ultrasound in pregnancy. Since there was no reason to believe that the use of such techniques was likely to lead to any increase in the incidence of gross anomalies in the offspring, a trial would have been unlikely to have done more than to show whether these techniques were responsible for any subtle anomalies that might appear. However such anomalies are extremely difficult to assess, and it would have been virtually impossible to distinguish between any which might have been caused by ultrasound and those due to other environmental factors. In the light of these Council decisions, the Board concluded that a trial would not lead to any firm scientific conclusions.

In the four years since then, the use of ultrasonic techniques have become so widespread that a controlled trial along the lines originally proposed would no longer be ethically possible."

10.16 We strongly question the ethics of exposing the majority of children born in this country to a potentially dangerous procedure whose long-term effects have not been adequately researched.

10.17 Health Rights persuaded Mr Michael Meadowcroft MP to ask questions in the House of Commons in 1984. The Minister, John Patten, replied that tests should not be "performed as a matter of routine".

10.18 The subsequent report of the Royal College of Obstetricians and Gynaecologists published in December 1984 concluded that there was no cause for alarm. It was dismissed by AIMS as "an exercise in allaying public fears and pulling the wool over the eyes of those who are not well informed about this subject." AIMS published a critique, a copy of which is enclosed. (Enclosure 23).

10.19 The British Journal of Obstetrics and Gynaecology in May 1985 commented on the RCOG report that "the scientific analysis does not show the rigour which would normally be expected of its scientific committee".

10.20 Our concern increased with the publication of a study carried out in three hospitals in Denver, Colorado (Stark, 1984) which suggested a statistically significant increase in dyslexia in children exposed to ultrasound in utero. The methodology of the study was unsatisfactory but nevertheless the possibility of such an effect exists and has not been disproved.

10.21 When we talk about "diagnostic levels of ultrasound" we should make it clear that these are usually not measured and they vary widely between different machines and different makes. Users do not actually know the extent of exposure a baby is receiving from any individual machine. We see many published research papers where studies have been done on movements of the fetus in utero, eg breathing, thumb sucking, swallowing etc which are carried out for up to an hour or more at a time. One woman, who telephoned us said she had been involved in a study where ultrasound was used on her baby for two hours.

10.22 Trans-vaginal ultrasound is now being developed, where a probe is inserted into the vagina so that the ultrasound can be nearer to the baby. This is being widely used for research, monitoring development of the fetal brain and organs from the earliest stages. No concern is expressed about possible damage or the need for long-term assessment of exposed infants.

10.23 The World Health Organisation, the Office of Technology Assessment in the USA, and a past Minister of Health (John Patten) have all said that ultrasound should not be used routinely. These statements have been ignored by the medical profession who continue to promote and use this inadequately evaluated technology.

10.24 The information we get from women about the effects of ultrasound screening suggest to us that its efficacy may well be over-rated by obstetricians. We know a number of cases where terminations were carried out because ultrasound had supposedly detected an abnormal fetus, but on examination tragically the baby was in fact perfect. We also have cases of women who are sure of the date of conception, but are told that ultrasound tests have proved them wrong. The baby is induced because obstetricians say the pregnancy has gone way beyond term, but a premature baby is in fact delivered and in some cases had died. Conversely, we have cases where the woman is saying she is overdue and is not believed, because the ultrasound was believed to show a different expected date of delivery. In one such case the staff did not believe the woman's estimation of dates which showed she was at term and preferred to believe the the ultrasound estimate showing a much later expected date of delivery. When she went into labour she was given drugs to suppress what they believed to be premature labour and a full term fetus was tragically delivered dead.

10.25 In a Finnish study recently published in The Lancet (Saari-Kempainen et al, 1990) of 30 apparently abnormal babies detected by ultrasound, 1 later proved to be normal. AIMS knows of a number of cases where ultrasound diagnosis of congenital abnormality has resulted in the abortion of a fetus which proved to be perfectly normal. Mothers are not always told that this has happened, and then carry into subsequent pregnancies their anxiety about the previously "abnormal" baby.

10.26 Screening is meant to be reassuring for women. Of 250 women diagnosed by ultrasound as having placenta praevia in the Finnish study, only 4 had the condition at delivery. The unnecessary anxiety caused to the remaining 246 women can hardly have been negligible.

10.27 It is assumed that parents of abnormal babies invariably benefit from the opportunity to terminate the pregnancy, yet no comparative studies have been done. Certainly, one study of parents who gave birth to live babies with fatal abnormalities who took them home and cared for them until they died weeks or months later felt that they had benefitted from an opportunity to know and grieve for a child whom they had known. Of course perinatal or infant mortality statistics are less satisfactory if the child is not aborted, but recovery from grief in the family may in some cases be better if the child is born and dies later. The emotional impact on the family which has taken the decision to abort a baby with fetal abnormalities has been little studied but we can report the comment of one mother who said "What I have to live with is the knowledge that I killed my baby".

10.28 To assume that the women have a free choice in these matters, or that they are aware of the possible long-term consequences to themselves and others of choosing to terminate or not to terminate is unrealistic. Adequate research has not been done.

10.29 Reliance on ultrasound for detection of breech and twin pregnancies means that, once again, the traditional skills of diagnosing by clinical history and examination are downgraded and lost. Those women who, out of understandable concern, refuse ultrasound, will increasingly be receiving ante-natal care from professionals who are unable to detect potential complications by straightforward examination. The women's risk is increased not by their wilful refusal of technology, but by the professionals' loss of standard skills.

10.30 In a study published last year (Lorenz, 1990) of women at risk of pre-term labour who were randomly allocated to have an ultrasound every week, or pelvic examination, it was shown that 52 per cent of those who had ultrasound went into pre-term labour compared with only 25 per cent of those who did not. The Finnish study, to which we have referred, also suggests that the miscarriage risk may be increased by ultrasound examinations.

10.31 This information is not made available to women. When obstetricians tell women that various procedures are "safe" what they mean is that there have been no studies, or maybe no studies acceptable to them, which show clear evidence of risk. Lack of information because long-term evaluation has not been done is not the same as "risk-free"—the honest answer to women who ask would be "we do not know because the research has not been done. We cannot say that it is safe, nor can we say that it is unsafe."

10.32 Perhaps it is not surprising that obstetricians do not actively seek to determine any possible long-term risks from equipment and procedures which they find interesting, exciting and beneficial to use. However, our trust in their judgement is reduced by their attitude. Furthermore, we are aware that some professionals, for understandable reasons, have financial interests in firms making equipment which they have helped to develop.

10.33 We do not wish to be alarmist: we have tried to be balanced and responsible in our approach from the beginning. Given the complexity of the human brain and central nervous system, adverse consequences could be both subtle and profoundly important. We recall a study of children who had been exposed to progesterone in the womb in which doctors' assessment of exposed children and controls found no abnormalities. It was only because teachers' assessments of both groups were included in the study that it was found that personalities had been affected. For example, boys were less likely to play rough games in the playground and girls were much more likely to be interested in ultra-feminine pursuits, such as dressing-up.

10.34 *Episiotomy*

10.35 Until recently episiotomies have been virtually mandatory in many hospitals, and are still carried out far too often. If episiotomy is considered "normal" treatment, midwives and doctors lose, or do not acquire, the skill of delivering with an intact perineum. Women and childbirth organisations, including AIMS, continually questioned both the necessity for this procedure and the damage to women. As a result we now know that it does not have any relation to preventing prolapse, as obstetricians had claimed and it does not improve outcomes if used routinely.

10.36 A study (Grant A et al, 1989) comparing two different types of suture materials showed that even using the one which gave the better result, 11 per cent of women were still experiencing pain on intercourse three years later. Such research is valuable. However, it does not help women if doctors and midwives do not act upon it. We know that many hospitals are still using the more damaging material which caused pain on intercourse in 19 per cent of women.

10.37 Only a minority of women experience severe problems after episiotomies but for them the effects on their lives can be serious and prolonged. Women write to us about severe long-term pain and discomfort, inability to wear tights and trousers, and ruined sex lives. Some have referrals for remedial surgery but such referrals were often obtained by knowledgeable women after they had exerted considerable pressure; the majority seemed to suffer in silence. Those who obtain treatment, do not always benefit, and relief—if any—may be only partial, despite, in some cases, two or three attempts at surgery. This makes us realise the importance of avoiding such problems in the first place.

10.33 We should point out that many of the severe adverse effects that we hear about from the women who ask for our help are not documented in reports of clinical trials. We suggest there are two reasons for this: firstly, clinical trials are usually carried out at the better hospitals, secondly, when staff know that their care

is being studied they are likely to be particularly careful with that aspect of treatment. Retrospective studies (gathering data from women who were not in hospital when the trial was going on) might better identify such problems, and we might see whether they are more common in some areas than others.

10.39 *Caesarean sections*

10.40 Caesarean sections cost the NHS more than normal deliveries. There are also, of course, greater costs for the family which have never been adequatley assessed. They include travelling expenses for hospital visits (a strain on many family budgets), additional childcare costs for someone to look after the other children while the father visits, fathers having to take additional unpaid time off work, and lack of adequate provision for postnatal care.

10.41 Modern obstetric practice can actually increase the risk of caesarean section, eg use of fetal heart monitors. We also have many stories from women who had oxytocin augmented labours who are certain that the abnormal uterine activity caused thereby led to the fetal distress which made the caesarean section necessary. (Although the confidential enquiries into maternal deaths list risk factors associated with death, eg oxytocin or caesarean sections they do not comment on whether the original intervention, leading to a cascade of problems, was justified in the first place. We think this is an unfortunate omission and makes the reports incomplete).

10.42 The complainants are, however, a minority. We get accounts from women who were grateful that their baby was "rescued" by an emergency caesarean section when we realise from their account of the labour that the trouble was probably caused by the intervention in the first place.

10.43 Caesarean section carries extra risks: death for the mother, a longer recovery period from birth at a time when the mother has a tiny baby, more difficulty in establishing breastfeeding, a higher risk of postnatal depression, greater risk in subsequent births and the possibility referred to in our evidence of long term effects on the baby from anaesthesia, interference with mother/baby bonding and postnatal infection.

10.44 Rates of caesarean section vary from hospital to hospital and consultant team to consultant team. These statistics are not available to the public and often not even to Community Heath Councils. We believe every expectant mother has the right to have these to enable her to make a choice. We appreciate of course that there are good reasons for some variations, according to the type of populations, but we ourselves have no difficulty in explaining such points to women.

10.45 Even in hospitals with a higher than average caesarean rate, there is no guarantee that women who need them will get them. AIMS does receive complaints from women who are not given sections in time, even when the women themselves knew that things were going wrong and were begging the staff to act.

10.46 It is appropriate decision-making that matters, even hospitals with a high section rate can fail to operate on those in real need, or may be operating too late to save the baby.

10.47 The Confidential Enquiries into deaths have repeatedly drawn attention to the fact that an important factor is junior staff dealing with situations which are beyond their competence and we, too, find that this figures in many of our complaints. There seems to be a reluctance, or inability to call in consultants and we have seen no studies of the reasons for this. In some cases anecdotal evidence suggests it is the personality of the consultant, and in others that junior doctors feel their careers may be adversley affected if they are not able to cope. What other factors operate we do not know. Midwives also sometimes fail to call for help quickly enough but we have a number of serious cases which show that when they ask for assistance of the doctor the one who arrives is far less experienced than they are.

10.48 The midwife who finds herself with a high risk patient and an inexperienced doctor finds it difficult to go over his head and call in the consultant on her own responsibility, although it is clear from the midwives' Code of Practice that this is in fact what she should do.

10.40 One of the commonest complaints we get from all over the country is the inadequate standard of postnatal care and support that women receive in hospital after they have had a caesarean section. There seems to be a marked disparity between medical and nursing attitudes towards patients who have had abdominal surgery of other kinds and patients who have had caesarean sections and are expected to breastfeed and care for a baby at the same time. Inadequacy of staffing levels is also undoubtedly often a factor. Therefore, it is even more important that unnecessary caesarean sections should not be performed.

10.50 *Vaginal Birth After Caesarean Section—VBAC*

10.51 In the latest Confidential Enquiry into Maternal Deaths (1985–87) for three of the six women who died following elective caesarean section, the sole indication for surgery was given as "previous caesarean section". These were not classified as avoidable deaths, and yet, perhaps, they should have been. Nor does anyone apparently question the necessity of the previous caesarean.

10.52 The expert medical team of obstetricians, anaesthetists, and pathologists, who conduct the Enquiries does not include midwives. We think it should, as over 75 per cent of babies are delivered by midwives.

10.53 It is said that the philosophy of "once a caesarean always a caesarean" has changed and that it is possible for women to achieve a VBAC for subsequent births.While this may be possible for a minority of women, forms of intervention are routinely used which actually make it less likely for the mother to be able to labour successfully and deliver her baby normally.

10.54 Information obtained from a large number of maternity hospitals in the British Isles showed that the following interventions are commonly used:

Routine electronic fetal monitoring

Early rupture of membranes

Indication of acceleration of labour

Starvation during labour

Intravenous drips

10.55 Women who have had a previous caesarean section are told that they will be "allowed" a "trial" of labour. This terminology conveys to the women that the hospital will graciously consent to her starting labour, but they do not expect her to deliver vaginally. This hardly engenders confidence and she is then all too likely to fulfill the expectations of her attendants. If the culture were changed to an expectation of normality and support, with the understanding that extra care is always there if it were needed we believe the succes rates would be higher.

10.56 We know of women who have had a previous caesarean section choosing to have the next baby at home because there is no possibility in the only local maternity unit of achieving their aim, ie, normal midwifery care without the imposition of standard obstetric policies of management, and a doctor being called in by the midwife only if deemed necessary. It is surprising, once again, that a form of care that women want, which would actually cost the NHS less, is not available because obstetricians dominate policy making.

10.57 *Breastfeeding*

10.58 Infant Feeding (1985) (OPCS) reveals that 65 per cent of mothers begin to breastfeed their babies yet at six weeks postpartum only 40 per cent are still breastfeeding.

10.59 Fortunately, it is now common to encourage the baby to suckle after delivery to get the benefit of protection from infection from the mother's immune system. The discovery of the benefits of early suckling in preventing disease has done more to prevent staff taking away the baby from the mother than years of user protest.

10.60 Continuing with breastfeeding is a problem, and higher success rates are achieved at home than in hospital. One problem that women frequently report to us is conflicting advice from different hospital staff—the advice you get depends upon who happens to be on duty at that particular time. The second problem is the lack of support and basic physical help for women who have had difficult or operative deliveries. Breastfeeding while suffering pain from stitches and having difficulty in moving into the right position, or lifting the baby, can have significant adverse effects on breastfeeding success.

10.61 The third problem, about which we receive many indignant complaints, is fundamentally concerned with who has the right to say what this child receives. No outsider would be allowed to walk into a woman's home, take her baby and give it food which both the mother and reputable medical opinion considered less healthy. Yet this is what happens daily in British hospitals. Mothers who have firmly said that their baby is to be totally breastfed are dismayed to find that night staff "top-up" the baby with artificial food or dextrose—an action which could, in fact, be interpreted as assault on the child. Mothers who have a history of allergy in the family are particularly concerned because artificial feeding may increase the child's risk of developing an allergic condition. Furthermore, these top-ups actually decrease the mother's chance of establishing and maintaining successful lactation. We are beginning to think our only chance of stopping this practice is to raise money to fund test cases in the courts.

10.62 It also causes us concern that staff will remove babies from the mother's bedside and take them away for paediatric assessment without her knowledge or permission. Mothers have often been alarmed to find the baby missing when they return from the lavatory. If a mother were at home, no midwife would take her baby, and no doctor would examine it without consent and without her presence. Women seldom protest overtly, yet we know that many are both anxious and angry.

10.63 It is of great concern to us that mothers have to fight for the right to protect their babies while supposedly receiving expert maternity care.

10.64 Women may make choices either to breast or bottle feed, those choices should be respected and supported and they need good information whichever feeding methods are used.

10.65 After leaving hospital, again conflicting and inadequate advice may continue. General Practitioners often know little about breastfeeding and advise women to give up when the right advice and support would enable them to continue. We also receive enquiries about prescribed drugs getting into breast milk and

affecting the baby; again, this is an area where women seem more concerned to obtain accurate information than their GPs. Health visitors also vary in the extent of the knowledge and their ability to support. In many districts the most knowledgeable and sympathetic advice is often available only outside the NHS from branches of the NCT, the La Leche League and the Association of Breastfeeding Mothers. Professionals, if they were willing, could learn a great deal from them. The Joint Breastfeeding Initiative, organised by these three groups is most welcome.

10.66 *Recommendations:*

10.67 When monitoring the quality of obstetric care management should pay particular attention to the needs of post-operative mothers.

10.68 A study should be done on problems experienced by junior doctors and midwives when they require a senior medical opinion.

10.69 That the expert team conducting the Confidential Enquiry into maternal death should include midwives.

10.70 Every hospital should prepare statistics on type of delivery of women who previously had a caesarean section, and these should be freely available.

10.71 Episiotomies should not be carried out unless necessary. Stitching should be done by midwives and not an inadequately trained junior staff. A doctor's first experience of stitching should not be on a woman's perineum. Greater emphasis should be given in training to delivering with an intact perineum and more research should be devoted to this, outcomes should be monitored.

10.72 That an Office of Technology Assessment be established to look at the efficacy, safety, wider social implications and costs.

10.73 That management should not approve expenditure on such technologies unless it is done in the context of a randomised clinical trial of adequate size, with provision for long-term follow-up of exposed and controlled subjects.

11. Research

11.1 Nowadays prospective parents are well aware of possible long-term risks to the baby from anything they take or are exposed to. We find that couples from all social classes are greatly concerned about effects of toxic exposures in the workplace, diet, medication, poor housing etc. Over and over again, women say to us that they would not even take an aspirin when in pain during pregnancy.

11.2 After the baby is born they continue to worry about food additives, nitrates in drinking water, traffic fumes and so on. They worry about possible long-term effects of standard antibiotics—concerns which only now are arising, and being shown to have possible foundation, in medical journals.

11.3 It is not surprising, therefore, that ordinary men and women express a great deal more worry about possible long-term consequences of childbirth medication or intervention. What is surprising is that obstetricians, and even midwives, have shown so little interest.

11.4 Here we will give some examples of past problems which should have alerted them. They have certainly alarmed us.

11.5 *Retrolental fibroplasia*

11.6 A major epidemic of blindness in children who had been treated with oxygen in special care baby units. It was later shown that this was associated with exposure to higher levels of oxygen, although we probably do not know the full story of causal factors. If this had been introduced in the context of a randomised clinical trial *with long-term follow-up of cases and controls* this risk factor would have been more quickly identified and dealt with and the sight of thousands of children would have been saved. (Silverman W A, 1980).

11.7 *Diethylstilboestrol*

11.8 This hormone was used on pregnant women in the belief that it could prevent miscarriage. Unfortunately, it was widely adopted, particularly in the United States, before any randomised clinical trial was done to show whether it was effective. When such a trial was eventually done the drug was shown not to work. Nonetheless some doctors continued to use it. The time bomb effect came to light when a cluster of young women in one town developed an unusual form of cancer—clear cell carcinoma of the vagina. Had they developed a more common cancer (squamous cell cencer of the cervix) the link would not have been made. They also had other problems, such as abnormalities of the genital tract. However, more subtle difficulties were only discovered when British researchers (Vessey MP et al, 1983) studied the now grown-up offspring of women who had been involved in a randomised clinical trial, half given stilboestrol when

pregnant, the other half were controls. Exposed children were significantly more likely to have serious mental illness and boys were less likely to have married. We suggest that such non physical, but serious adverse effects, would not have been identified but for the fact that exposed girls had developed a particularly unusual cancer.

11.9 In the USA the grand-daughters of women given stilboestrol in pregnancy are now suing for injuries they suffered because of alleged stilboestrol-induced abnormalities in the genital tracts of their mothers who were exposed in the womb. This is an example of how damage may be transmitted from generation to generation.

11.10 *X-rays and leukaemia*

11.11 Babies who had been exposed to x-rays in the womb looked perfectly normal at birth. The work of Dr Alice Stewart, who discovered that an increase risk of leukaemia was associated with exposure in utero is well known. We are concerned that despite this evidence some doctors are still unnecessarily exposing unborn children to x-rays (Robinson JJA, 1986).

11.12 *Epidural anaesthesia*

11.13 Nowadays more women giving birth have epidural anaesthesia. One of the reasons for this is that interventions such as oxytocin used to induce or speed up labour can make contractions more painful than those of normal childbirth, so stronger pain relief is necessary. This increases costs in two ways: firstly, the requirement for more anaesthetists and drugs and, secondly, the increase in forceps deliveries which follows leading to longer hospital stays in some women and more neonatal care for babies.

11.14 It should not be thought that the level of epidurals given at present represents true consumer demand. Women whose previous delivery was badly managed or difficult (perhaps due to intervention) often request an epidural simply because they cannot fact the possibility of a repeat experience. In high epidural units some women are encouraged by staff to believe that they will be unlikely to manage without an epidural, and in these cases only some well-informed women are able to resist. We also have cases of women who have been pressurised into having epidurals they did not want.

11.15 For many years we have been receiving a steady trickle of correspondence from women who insist that they are suffering long-term adverse effects from an epidural they were given for pain relief in childbirth. These include backache, headaches, numbness, and pain and loss of sensation in limbs. We lobbied obstetricians and anaesthetists because they were telling women that epidurals were safe and had no adverse effects. In 1987 the Chair of AIMS in her book "Who's Having Your Baby?" wrote: "Little is known about the long-term effects of epidurals but following the public attention given to a mother who was paralysed and in a coma, as a result of an epidural, Health Rights received letters from 70 women describing their experiences. One of the major complaints was backache, although the medical profession claims that backache is a common complaint following childbirth and cannot be attributed to epidurals. Many of the women had very serious headaches and for some the headaches continued at intervals for years. Some of the women complained about tingling sensations in their limbs or areas of numbness. Had there been adequate research into this technique we would now know whether any of these conditions were a direct result of epidural anaesthesia and how many women it affects each year."

11.16 The Chair of AIMS publicly raised this issue with an obstetric anaesthetist, Dr Selwyn Crawford, at a Maternity Alliance conference in 1986, and he subsequently produced a study confirming our suspicion that back problems were increased. Backache was the only symptom women were asked about in this study, and it contains the rather surprising statement that "no investigations had been published previously on longer-term problems probably because no real concern had ever arisen either on theoretical grounds or from anecdotal commentaries from patients or obstetricians." (MacArthur C et al, 1990).

11.17 Other possible long-term consequences to women are still not researched, and our information suggests that the effects, at least on some women are far from trivial and affect their ability to function as wives and mothers or do other jobs.

11.18 Possible long-term consequences to the baby (since the drugs cross the placenta) are totally unknown. Ten years ago it was shown by Rosenblatt (1981) that when a mother had an epidural, babies studied at the age of six weeks suffered numerous adverse effects which included decreased visual skills and alertness, poorer motor organisation and physiological reponse to stress and control of their own state of conciousness. It is surprising, therefore, that we do not have data on whether these effects or others persist, and for how long.

11.19 *Drug addiction*

11.20 The most recent, and one of the most alarming, possible time bomb effects comes from a research team at the Karolinska Institute in Stockholm (Jacobson B et al, 1990). In a well designed case control study they have compared children exposed to pain relieving drugs in labour, with those who were not, and discovered an increased risk of drug addiction later in life. In 1988 they showed that when nitrous oxide was

given to the mother the child was five and a half times more likely to become an amphetamine addict than a brother or sister born to the same parents. In a more recent paper in the British Medical Journal they compared patients who had died from opiate addiction with brothers and sisters and found that if the mothers had had opiates or barbiturates or larger doses of nitrous oxide the risk of opiate addiction to the child in later life was increased 4.7 times.

11.21 For years, AIMS has expressed its concern at the lack of research, and professional interest, in possible long-term consequences of pain relieving drugs administered to women during labour, and the possible long-term effects of the powerful drugs used in labour on their babies. Many women complain that staff reaction to expressions of discomfort is to recommend drugs when other means of relief would be more appropriate. We know of many cases where women are choosing home confinement because when they were in hospital they had been given drugs in labour against their will.

11.22 Is it any wonder that we, and many ordinary parents, are worried? What we cannot understand is why obstetricians, and even paediatricians seem to show such lack of concern and dismiss parents' worries when they try to reject various forms of intervention.

11.23 We are not opposed to effective pain relief; we simply want long term consequences of all options researched so that women could make informed choices. Knowledge of long-term risks of drugs might stimulate research into non-pharmaceutical methods of pain relief.

11.24 Despite the availability of epidurals, we still receive complaints from women who had agonising labours with inadequate pain relief. This may be due to the failure to provide continuous anaesthetic cover, at some hospitals, but it also seems to indicate lack of empathy and understanding by staff, who seem unable to distinguish between normal pain which the woman is coping well and the situation where the woman needs further help.

11.25 *The Need for user oriented research*

11.26 It was user pressure which stimulated research into outcome of episiotomies and artificial rupture of membranes. Fortunately there is now more midwifery research.

11.27 However, our view of research priorities is still not given adequate weight and there is no formal mechanism for us to channel our ideas (though individual doctors do listen to us).

11.28 When "low-tech" research produces useful results, there is no drug company or equipment manufacturer spreading the news, eg the results of a randomized trial showing that women who were *not* instructed to push had a better outcome of labour than those who were, is largely unknown to the public, midwives and obstetricians.

11.29 *Recommendations*

11.30 A randomised controlling trial of the effectiveness and safety of ultrasound with long-term follow-up should be conducted:

12. TRAINING

12.1 *Medical and Midwifery Students*

12.2 A few years ago both the General Medical Council and the UK Central Council for Midwives, Nurses and Health Visitors expressed concern that it was becoming difficult to provide statutory training for medical students and student midwives in normal birth, because too few normal births were taking place.

12.3 We believe that training in normal birth should not be given by obstetricians, but by midwives—as used to be the case. Midwives are the experts in normal pregnancy and labour, and any training in how to deal with abnormality should be based on a sound understanding of what "normal" actually is. We believe that many of the problems we have experienced with modern obstetrics and medical care stem from the fact that such training is lacking.

12.4 Medical students should be trained in the community as well as in hospital. At present they are expected to deliver a certain number of women—often arriving shortly before the delivery. Junior doctors are also trained in the management of more complex deliveries by arriving late in the labour. This leads to misunderstanding of the processes of labour and birth. If students deliver babies, they should be required to attend for the whole of the labour and delivery, and be involved in the antenatal and postpartum care of that particular woman.

12.5 Participation in home confinements wherever possible should be included. Then they will have the opportunity to observe a woman at ease in her own surroundings, able to move, eat, drink, express pain or pleasure as she wishes. They will also see birth in a family setting. They will then have a base-line by which to judge the hospital's definition of "normal" birth, and also true complications.

12.6 Obstetrics based on a sound knowledge and experience of normal delivery, and respect for midwifery practice would have a different ethos. We are impressed by the knowledge that experienced older midwives have of techniques for assisting the mother when labour and delivery need extra help. Many obstetricians do not seem to understand and value the knowledge which such midwives have. In modern obstetric units midwifery practice is dominated by polices designed by obstetricians and enforced by management. The development and maintenance of true midwifery skills is, therefore, undermined.

12.7 In midwifery training the emotional care and support of the pregnant, labouring and postpartum woman is strongly emphasised. This does not seem to be as effectively covered in obstetric training—hence the numbers of complaints we receive. We would draw the attention of the committee to the Ombudsman's report last year concerning rude and arrogant behaviour by a senior consultant obstetrician in Scotland. "This woman says she's pregnant—let's see if she's lying, shall we?". This subsequently led to the Chairman and officials of Glasgow Health Authority being called before the House of Commons Select Committee on the Ombudsman. They were particularly concerned at the intrusion of medical students without the mother's consent. We were also concerned at what the medical students were being taught by the example of that particular consultant's behaviour.

12.8 Nowadays it is usual, although not universal to ask the consent of a woman to the presence of medical students at a clinic. Medical students are expected to conduct a minimum number of deliveries, which range from four–15, depending on the medical school. Women giving birth are valuable teaching material, and there is often competition between medical students and student midwives. "Of 30 clinical schools in the UK, 12 described competition with midwives as a continuing problem (Biggs J, 1991).

12.9 When a medical student appears at a delivery or actually delivers the baby, it is our experience that women are seldom asked and even if permission were sought, it would be very difficult for her at that point to refuse. We feel that ethically consent can only be properly obtained before the woman goes into labour, so that hospitals will know in advance which women are agreeable to the presence of medical students. This is important not just for the women, but for the quality of training which medical students receive. If from the beginning they learn that patients have independent rights and their consent matters, they are more likely to become the kind of doctors we wish to see caring for us. The consent form suggested by the Review Panel set up to advise the Welsh Health Planning Forum is an good example of the kind of form we would like to see. (Enclosure 24).

12.10 The need to provide a supply of pregnant women for training and research has been a powerful but unstated influence on centralisation of maternity care. The result has been increased expense, increased iatrogenesis and decreased consumer satisfaction. The time has come for students, doctors and midwives to be taught in settings which meet the needs of mothers.

12.11 *Junior Doctors*

12.12 Many of the qualified doctors in training in obstetric units are not planning to become obstetricians. They are doing the obstetric component of the GP training course.

12.13 At a conference of such trainees we were told how dissatisfied some of them were with the courses, and how concerned they were that they were expected to carry out hazardous procedures such as forceps deliveries without adequate supervision or training. When they expressed their anxiety to the GP trainers, they were told that at it was often difficult to obtain training posts for them it would not be politic to make a fuss. Since we have seen many disasters relating to management of difficult deliveries when the doctor on call was only a GP trainee, we are greatly concerned.

12.14 As well as GPs being called upon in some hospitals to do work beyond their skills, we question the relevance of the training they receive for general practice. It is likely to enhance their fears of the "dangers" of normal birth. If they learned from midwives, they might be more confident in supporting their pregnant patients who want low-intervention care.

12.15 The Royal College of Obstetricians and Gynaecologists is complaining about reduction in recruitment to their specialty and blaming this on litigation—although of course excess fear of litigation may have been taught by senior people in the profession. Other specialties have become comparatively more attractive, particularly general practice, where there is great emphasis on communication and trainees get a great deal of support from their trainers and each other. In contrast the difficulties of the hospital obstetric trainee were highlighted in a recent article in the Br Journal of Obstetrics and Gynaecology (Bewley S, 1991) where she spoke for the need for shorter planned training, better defined objectives, improved teaching methods, regional directors and greater accountability. The pattern of obstetrics now being practiced in many British hospitals deters medical students just as much as it deters pregnant women. Despite the high demand by women for the services of a female obstetrician for the majority of women few are available.

12.16 For doctors who are hoping to stay in obstetrics research seems to be obligatory in order to move up the ladder. In a recent edition of the BMJ a keen young woman obstetrician with 10 years experience said that she could not even get short listed for a senior registrar's post without a research degree. "Two years in a laboratory are more important than two years on the labour ward" (Pinion S, 1991). As representatives of

users of the service we question this bias towards research. Keen clinicians with good experience are not gaining promotion or encouraged to stay in the specialty when they may be the very doctors we want, research of doubtful value is being done as part of the career ladder, not to meet real user needs.

12.17 *Recommendation*

12.18 The supply of women obstetricians needs to increase and women should have the right to choose a female doctor to attend her.

12.19 Junior doctors and medical students should be trained by community midwives.

13. When Care Goes Wrong

13.1 Many of the cases we deal with are not short-term. Often we are contacted by women who have continuing problems several years after delivery and who need help. Others who contact us soon after the birth, are still in touch with us long after that baby has started school. So we see the long-term effects, not only on the mother, but on her relationship with the child, with the baby's father, other children and grandparents.

13.2 The birth of a live baby is not just a success story for the statistics—it is the start of a family. We are in contact with a number of families who started with every advantage: a loving marriage, an adequate income, good housing, and supportive in-laws. Even these families are sometimes brought to the brink of destruction, despite the birth of a live, healthy, baby was born and survived, and they count for obstetricians as a statistical "success".

13.3 Women are reluctant to complain about maternity care even when the adverse outcome is serious. Indeed some of those who have complained to us had sent a polite thank you note to the hospital after discharge, as if to appease the gods. Women sometimes cope by repressing painful experiences. When they are pregnant again, and desperate, many of them turn to us for help. Jean Robinson, when Chair of the Patients' Association, dealing with 100 complaints and enquiries a week, noticed that those who were dissatisfied with maternity care were more afraid to complain than those who were dissatisfied with other short-stay hospital care. They had strong memories of feeling vulnerable and in the power of their attendants in labour and feared the consequences of complaining if they had to go back to the same hospital again (Robinson J, personal communication). It should be noted that women's choice to give birth elsewhere has been greatly reduced by the closure of small units and in many areas there is no choice. With the drawing of boundaries we are now receiving complaints that they are not allowed to go to other districts for care—a particular problem in London. Women can feel captive.

13.4 Superficial market research type questionnaires, increasingly used by management, may not pick up many of the problems. Sometimes it has taken us weeks or months of supportive contact before women feel able to give a full account of their ordeal.

13.5 AIMS has more experience than any other consumer organisation of the responses of authorities throughout the British Isles to complaints about maternity care. Our current workload—a typical one—is 79 ongoing serious complaints. This does not include those which clients are able after initial advice, to pursue themselves without support, or those which are dealt with by AIMS members and groups outside the national committee.

13.6 Response from different health authorities is variable, but we often find it to be disappointing, unnecessarily defensive and occasionally dishonest. It is the style of response as much as the original mistake, which has radicalised complainants.

13.7 Our aim when we advise parents on how to complain, is to get the best therapeutic outcome for the family but we are often frustrated; they end up more cynical and suspicious of medical care than when they started.

13.8 Many of the families who are now pursuing medical negligence claims in the courts did not initially wish to take such action. The majority of them have been driven there by disillusionment with the official response to their complaint. That they wanted was

(a) The truth.

(b) An apology—a genuine apology (not the kind of double speak we see eg "We are sorry if you feel that the care you had was unsatisfactory").

(c) Action to make sure that this "does not happen to anybody else".

(d) Information on how this will be done.

(e) Where appropriate, adequate therapy for physical or psychological problems arising from the birth.

(f) Appropriate disciplinary action, or further training for staff, where warranted.

13.9 Because we see so many complaints from all over the country we have been able to identify certain recurring causes of avoidable injury:

(a) Inappropriate use of intervention eg induction, augmentation of labour.

(b) Use of locum medical staff and agency midwives.

(c) Use of GP trainees doing the obstetric component of their training.

(d) Junior doctors dealing with cases which should be handled by more senior colleagues.

(e) GPs who need retraining in, or exclusion from, maternity care.

(f) Staff not believing women when they are reporting abnormal events.

14. Complaints

14.1 *Complaints against General Practitioners*

14.2 Many complaints such as rudeness fall outside the doctors' contract. It is ironic that rudeness by a consultant can be investigated by the Health Authority, the Ombudsman, and the House of Commons Select Committee, but a woman with a complaint about rudeness from her General Practitioner is powerless. These complaints are not necessarily "minor"; they can lead to great distress and women opting out of care altogether.

14.3 Complaints which do come within the GP's terms of service have to be made within the time limit of thirteen weeks (starting from the time of the event not from the time when the woman realised that the doctor did something wrong). This means that the consequences of a GP's failure to refer to a consultant early in pregnancy may not be seen until months later, and long after the time limit has passed.

14.4 Women who are pregnant, or have recently had a baby, may not wish to go through the stress of a formal complaints procedure. In cases where there is shared care between the GP and the hospital, it may be difficult to identify who was at fault. As there is no one complaints procedure covering both aspects of care, the family has to pursue two entirely different systems which are not linked and consequently may be unable to find out the truth.

14.5 Only 20 per cent of complainants who obtain a formal hearing before the medical service committee of the FHSA are successful in proving that the doctor has committed a breach of terms of service. However, the success rate varies enormously from one district to another and in some areas CHCs report to us that they cannot remember a GP ever being found in breach.

14.6 Despite the best advice that we can give, and support from Community Health Councils, complainants often emerge frustrated and angry. Doctors are frequently now represented or advised at the hearing by officers of one of the medical protection societies and the balance is an uneven one.

14.7 Complaints Against Hospital Staff

14.8 One of the few benefits of the GP procedure is that there is a formal tribunal system which gives the complainant the right to present her case to a panel, to question the doctor and to see him or her questioned by medical and lay members of the panel. No such right exists within the hospital care system. Often administrators pass on complaints to the consultant responsible. Consultants are supposed to meet complainants but often do not reply or avoid such meetings. We should also point out that when complainants have had a traumatic experience they are sometimes terrified of going near the hospital building for a meeting.

14.9 Although there is a formal complaints procedure there is a wide range of consultant response. Northern Ireland, for example, is a particularly bad area for getting a constructive response to any complaint. Individual consultants can, and do, effectively impede the working of the procedure. When this happens we would prefer that the administrator honestly told the complainant "the consultant refuses to meet you or refuses to reply or apologise", but in fact administrators end up by acting as a smoke screen for recalcitrant doctors by sending "public relations" type letters which in fact say nothing.

14.10 We see many examples of the sort of letter which purports to be an apology which states "We are sorry if you feel that you have cause for dissatisfaction". Such letters infuritate complainants and send them hot-foot to the nearest lawyer.

14.11 Another cause for frustration is the letters from management which implies that the complainant is lying, eg. "this could not have happened because it is contrary to our usual practice". When hospital staff deny that a particular incident took place, the administrator is not in a position to say that it did not occur unless he himself was actually present. Again, we would prefer honest communication which says "the doctor or midwife's version of events is as follows". We have certainly seen cases where further investigation and interviewing of other witnesses might have established the truth, but there is no sign that real primary investigation has taken place. It is simply a case of getting the "official" version of events and adding the administrator's seal of approval which then enters the correspondence as part of the official record.

14.12 Since we usually have both husband and wife telling us the same story, we are not surprised that the hospital's response often provokes legal action which had never been part of the couple's original intent. Even when some kind of apology is forthcoming there is inadequate information as to what steps may or may not

have been taken to prevent the same thing happening to someone else. Families want to know if the problem was caused by overwork, lack of training, poor judgement, or something else, and what is to be done about it. Often such investigations may have taken place and remedial steps may have been taken but since the information has not been passed on to the family, they are left dissatisfied. Their failure to respond further may be taken by the hospital as acceptance. On the contrary we see their cynicism and future mistrust. They simply give up and say "you cannot win".

14.13 One of the things we wish to emphasise is that when there has been a serious adverse outcome of care eg. the loss of a baby, we find that many people cannot begin to grieve and eventually recover unless they know the truth. Failure to answer questions honestly inflicts further emotional damage.

14.14 There is, of course, the Clinical Complaints procedure, when the Regional Medical Officer calls in two consultants from outside the area to look at a case. However, the level of dissatisfaction from complainants who have used this procedure is so high that we seldom recommend it. Complainants do not have access to case notes, they do not see the report consultants write, and the procedure is not multidisciplinary.

14.15 Often our complaints refer to care by trainee general practitioners, junior doctors, locums or agency midwifes who are no longer in the health authority's employ. They are, therefore, no longer subject to disciplinary action by that employer, and we have no evidence that information is passed on appropriately to other authorities when they are the subject of serious complaints. Since they are no longer on their books the health authority assumes that it can wash its hands of the matter unless litigation occurs. It may be, of course, that the now departed doctor or midwife was not in error, or was not the only one of the team whose care was faulty. Responsibility cannot be apportioned unless an investigation is held which includes all parties concerned, but under the present system this is not done.

14.16 It should be possible to deal with dangerously incompetent doctors or midwives through their professional bodies, ie. the General Medical Council and the UKCC. However, there are particular reasons why the GMC procedure does not work to protect the public. Doctors can only be disciplined for "serious professional misconduct" whereas midwives can be disciplined for "professional misconduct". The public has therefore better protection against potentially dangerous midwives than potentially dangerous doctors. The National Boards for Nurses, Midwives and Health Visitors will accept and pass on the UKCC complaints direct from the public about midwives, nurses and health visitors, whose practice may be dangerous.

14.17 When members of the public complain to the General Medical Council they are advised to take their complaint first of all to the health authority. The rules laid down for the GMC by Parliament, specifically state that they have a duty to investigate complaints which amount to serious professional misconduct. Yet GMC staff tell complainants to go first to the hospital. They do not even investigate to see if any of the doctors concerned have only limited registration (ie. temporary registration given for training purposes and overseas doctors). This means that doctors who are the subject of serious complaints may be granted further limited registration, or allowed to convert to full registration, without investigation. Since there are no tribunal proceedings for hospital doctors, equivalent to those for general practitioners, the complainant never gets from the health authority information which will back a complaint to the GMC and provide firm evidence. It is a fact that the GMC investigates very few clinical complaints against hospital doctors, so the public is in effect denied that protection.

14.18 Health Authorities could, if they wished, report doctors they believe may be unfit to practice to the GMC, but virtually never do so. When lives of mothers and babies are at risk, we regard this as a highly unsatisfactory situation and would ask the House of Commons to take an interest in it.

14.19 *Recommendation:*

14.20 A Committee of the House of Commons should specifically investigate procedures used by health authorities and regulatory bodies like the UKCC and the GMC to see if they are meeting the needs of the public.

15. Litigation

15.1 Obstetricians' anxieties about the increase in litigation have been widely and effectively publicised and have dominated the public debate. The consumer side of this discussion has not been adequately understood.

15.2 It is true that there has been an increase in medical litigation, but it has been an increase from a base-line so low as to represent a scandalous social injustice. The profession is no longer able to cover up as successfully as it did in the past. The issue is not that these ungrateful patients are waiting for any opportunity to sue, but that there is a substantial amount of medical negligence, only a small percentage of which reaches the courts. We know that the level of medical negligence is much higher than that which reaches the courts or is resolved by out-of court settlements.

15.3 In the past, few lawyers were knowledgeable about medical litigation. The defence of most medical litigation cases was handled by the two major defence societies: the Medical Protection Society and the

Medical Defence Union. They used lawyers with considerable medical litigation experience. It was only after the founding of Action for Victims of Medical Accidents that complainants were able to find lawyers with similar expertise, giving them a slightly better chance of success.

15.4 As it is only a minority of the justified complaints ever get to court. Few people are entitled to legal aid and few medical experts are willing to stand up and criticise their colleagues, indeed those few individuals who do, are often victimised or reminded that their medical career will be in jeopardy.

15.5 From long experience we know that there have been many cases of injury and death in obstetric care where there was good cause to believe there was negligence, and yet many families had no opportunity of taking legal action. Only the very rich or those poor enough to qualify for legal aid can get a case off the ground. This excludes, therefore, the majority of the population. There has been small increase in successful cases, largely because there are now, through the workof AVMA a larger number of expert lawyers available to complainants. Medical experts who are willing to give expert evidence for them in such cases are few. This is a small country, and the obstetrician who often gives supportive opinions to complaints may soon find himself unpopular with colleagues.

15.6 We cannot stress too strongly that many of these cases would not even have begun had families been dealt with fairly, honestly and openly through the complaints system. We know of cases where substantial damages have been awarded where the family would have been content, originally with an apology and the truth. It was their failure to get these that drove them to the courts. It may be that access to medical records, which will come into force after 1 November 1991, will meet the needs of such families: the Act has a number of faults and we shall have to see how it works out in practice. We should point out that often when records have been obtained by solicitors essential parts have disappeared or been altered; and this causes greater anger in families and a determination to win at all costs.

15.7 Cases involving serious brain damage get most publicity and cause most concern to health authorities and obstetricians, as they often lead to substantial settlements. We would point out that these children are an expensive burden to society as the child is unlikely to join the productive workforce, and can require a lifetime commitment from the parents. However the money is provided, the most important problem is the prevention of such injuries *not* the prevention of large settlements.

15.8 If the child is kept in institutional care the costs can exceed £1,000 a week. Although awards to parents may seem large, this money simply covers the extra financial burden placed on them. The money has to be found from somewhere, and the problem to be looked at is simply which pocket it should come from. The transfer of responsibility for such awards to health authorities has created financial difficulties for them, and unfortunately some are reacting by instructing their staff to be even more careful about giving out information to parents.

15.9 Perhaps a separate NHS fund should be established. The Government could then monitor at least some of the true cost of poor quality provision of health care—something which has been lacking in the past.

15.10 Obstetricians say that they have been forced into practising "defensive medicine". We wonder at the ethics of a profession which admits that its response to legal action is to practise defensively in order to protect its own interests. Not only has the obstetric profession failed to deal with the issue of negligent practitioners we are aware of cases where they have vigorously sought to protect their colleagues from any investigation. We know of several cases where women who have had disastrous birth experiences have been pressurised, while still in hospital, by medical and midwifery staff because "it would damage a doctor's career". The loss of the baby was apparently unimportant by comparison.

15.11 It is we who have been forced into defensive litigation. We were coping with numerous complaints from women that they had been injected with pethidine after specifically refusing it, or given other interventions they had refused (ie. cases of criminal assault). We had a further problem in that the Medical Defence Union gave unethical advice to its members: "The Union does not consider that a maternity patient need give her written consent to any operative or manipulative procedures that are normally associated with childbirth. When she enters hospital for her confinement it can be assumed that she assents to any necessary procedure, including the administration of a local, general or other anaesthetic". (Medical Defence Union 1974).

15.12 In 1982 we set up the Maternity Defence Fund to help women take legal action. This was widely publicised in professional journals and such complaints became less common. We had tried the normal channels of complaint without success. No-one would take us seriously until we threatened legal action. Instead of individual complaints being ignored up and down the country we were able to influence the actions of doctors and midwives and benefit women everywhere.

15.13 It is, however, interesting that complaints about inflicting treatment after refusal are extraordinarily rare in this country, and yet they are common in maternity care. This, we believe, is an indication of the attitudes of obstetricians towards their patients and illustrates interesting differences from their medical colleagues.

15.14 *Recommendation*

15.15 That a seperate NHS fund be established to deal with compensation and legal settlement.

June 1991

REFERENCES:

AIMS. Home Birth—Insanity? *Association for Improvements in the Maternity Services Quarterly Journal*, Vol 2 No. 1, 1990, pp 18 and 20.

Alment A et al, (1967). Normal Confinement: A domiciliary and hospital study, *British Medical Journal*, Vol 2, pp 530–535.

Arnold M. Where obstetrics fail. *Midwife, Health Visitor and Community Nurse*, 1985, Vol 21, pp 346–7.

Beech BAL and Robinson J. Suicide and Pregnancy—a consumer view. *British Medical Journal*, March 1991, Vol 302, pp 591–592.

Bewley S. The Future obstetrician/gynaecologist. *British Journal of Obstetrics and Gynaecology*, March 1991, Vol 98, pp 237–240.

Biggs JSG et al. Undergraduate obstetrics and gynaecology in the United Kingdom and the Republic of Ireland, 1989, *British Journal of Obstetrics and Gynaecology*, Vol 98, pp 124–134.

Campbell R and Macfarlane A. (1987). *Where to be born? The debate and the evidence*. National Perinatal Epidemiology Unit, Oxford.

Grant A et al. Pain on intercourse associated with the use of glycerol-impregnated catgut to repair perineal trauma. Report of a 3-year follow-up study. *British Journal of Obstetrics and Gynaecology*, 1989.

Gutteridge S. Critique of shared care. Paper presented at the Fourth Human Relationships in Obstetric Practice Seminary. University of Glasgow, 11–13 September 1981.

Jacobson B et al. Opiate addition in adult offspring through possible imprinting after obstetric treatment. *British Medical Journal*, Vol 301 pp 1067–1070.

Kirkham M. Labouring in the dark: limitations on the giving of information to enable patients to orientate themselves to the likely events and timescale of labour. *Nursing Research; Ten studies in patient care*, Ed. Jennifer Wilson-Barnett, Pub. John Wiley 1983.

Klein M et al. A comparison of low-risk pregnant women booked for delivery in two systems of care: share-care (consultant) and integrated general practice unit. I. Obstetrical procedures and neonatal outcome, II. Labour and delivery management and neonatal outcome. *British Journal of Obstetrics and Gynaecology*, February 1983, Vol 90, pp 118–128.

Liebeskind DE et al. (1979a). Diagnostic ultrasound: effects on the DNA and growth patterns of animal cells. *Radiology* 131, pp 177–184.

Liebeskind DE et al. Diagnostic ultrasound: Time-lapse and transmission electron microscope studies of cells insonated in vitro. *British Journal of Cancer* (1982) 45, Supply V 176.

Logue M. Management of the third stage of labour—A midwife's view. *Journal of Obstetrics and Gynaecology* (1990) 10, (Suppl. 2), S10–S12.

Lorenz RP et al. 1990; Randomised prospective trial ultrasonography and pelvic examination for preterm labour surveillance. *American Journal Obstetrics and Gynaecology* 162:, pp 1603–10.

MacArthur C et al. Epidural anaesthesia and long term backache after childbirth. *British Medical Journal*, 1990, Vol 301, pp 9–12.

Murphy K et al. Birth asphyxia and the intrapartum cardiotocograph, *British Journal of Obstetrics and Gynaecology*, June 1990 Vol 97, pp 407–479.

Nelson NM, et al. A randomised clinical trial of the Leboyer approach to childbirth. *New England Journal of Medicine*, 302; 655–660.

Pinion S. Is it worth it? *British Medical Journal*, Vol 302, 9 March 1991, p 599.

Robinson JJA, "A study of the policy implications arising from a local survey of perinatal mortality". PhD Thesis 1986. University of Keele.

Rosenblatt DB et al. The influence of maternal analgesia on neonatal behaviour: Epidural bupivacaine. *British Journal of Obstetrics and Gynaecology*, April 1981, Vol 88, p.p. 407–413.

Saari-Kamppainen A et al. Ultrasound screening and perinatal mortality: controlled trial of systematic one-stage screening in pregnancy. *Lancet* 1990; ii: pp 387–391.

Short R. Second report from the Social Services Committee. House of Commons Paper 1979–80: 663-1, HMSO London 1980.

Shy KK et al, (1990). Effects of electronic fetal-heart-rate monitoring, as compared with periodic auscultation, on the neurologic development of premature infants. *The New England Journal of Medicine*, Vol 322, No 9, pp 588–593.

Silverman W A. *Retrolental Fibroplasia—A modern parable*. Gune and Stratton, New York, 1980.

Stark CR et al. Short and long-term risks after exposure to diagnostic ultrasound in utero. Obstetrics and Gynaecology, 1984, 63, pp 194–200.

Tew M. (1985). We have the technology, *Nursing Times*, pp 22–23.

Vessey MP et al. A randomised double-blind controlled trial of the value of stilboestrol therapy in pregnancy: long-term follow-up of mothers and their offspring. *British Journal of Obstetrics and Gynaecology*, 90: pp 1007–1017.

16. ENCLOSURES LIST

1 What is AIMS?
2–6 Letters from parents
7–9 Letters from local general practitioner
10–13 SE Thames RHA advice
14–17 AIMS response to SE Thames RHA
18, 19 Indemnity forms for home birth
20, 21 Choice—extract from AIMS' Quarterly Journal
22 Letter to the British Medical Journal
23 AIMS Critique of the RCOG report on ultrasound
24 Consent form for medical and midwifery students

Examination of Witnesses

MS BEVERLEY LAWRENCE BEECH, Honorary Chair, MS CHRISTINE RODGERS, Vice Chair, and MRS JEAN ROBINSON, Member of National Committee, Association for Improvements in Maternity Services, examined.

Chairman

1184. Ms Beech, will you introduce your colleagues to us please, for the benefit of all?

(*Ms Beech*) Thank you very much, Mr Winterton. I am Beverley Beech and I am the Chair of the Association for Improvements in the Maternity Services. Christine Rodgers is the Vice Chair of AIMS and Jean Robinson is a committee member of the National Committee of AIMS. She is also, by way of interest, a lay member on the General Medical Council appointed by the Privy Council. She is a past Chair of the Patients Association and she is also a lay member of the Standards and Ethics Committee of the UKCC.

Chairman: I think Mrs Robinson is well known to us, having appeared before not this Committee but its predecessor on more than one occasion.

Mr Couchman

1185. Ms Beech you will have heard our questioning of the Department of Social Security. I think we concentrated quite a bit on their research, or lack of it, and how they reached their opinions on what should or should not be paid to pregnant women. It is about research that I would like to ask you. Can you tell the Committee how you elicit women's views about the maternity services?

(*Ms Beech*) Let us say that we are a national organisation. We do not just elicit women's views. We are also very concerned with men's views and it is the family that we are concerned with. It is often the family that approaches us. On some occasions it is the men who approach us because their wives are so distressed by their experience that the men are taking the lead in seeking help and advice on what they can do. We receive reports from our groups—we have group discussions round the country—and from our members and we have people primarily referred to us by other organisations. I am thinking of organisations such as SANDS (the Stillbirth and Neonatal Death Society), the National Childbirth Trust; professional groups, the Royal College of Obstetricians and Gynaecologists occasionally, and the Royal College of Midwives, the Association of Radical Midwives; other lay groups such as the Caesarian Support Network and home birth support groups, of which there are some 54 in Britain that we know of. What we try to do is to keep very much in contact with all the groups that are involved in maternity care. We exchange journals with those who produce journals and we attend meetings, conferences and that kind of thing.

(*Mrs Robinson*) May I add another point to that? We monitor both medical and midwifery literature and medical sociology literature. There is a substantial amount of research on women's views which we find bears out the voluminous anecdotal evidence we have from individual families.

1186. By what criteria do you judge the quality of maternity care and maternity services?

[**Mr Couchman** *Cont*]

(*Mrs Robinson*) We think it is quite inadequate to judge the quality of maternity care by perinatal mortality data and maternal mortality data, or, indeed, simply the Apgar score of the baby. These are all important criteria, of course, but we judge maternity care by the total health of the family after the birth. We can find, for example, that the family may have experienced what could be seen as a tragedy. There is a death in utero, there is an unavoidable stillbirth or the birth of a genetically damaged baby. Nevertheless the care of that woman and that family has been successful and they emerge full of praise for the care that they have had. Alternatively, we have seen cases of many complaints from districts which have very low perinatal mortality rates. I first became interested in this whole matter in 1974. I live in Oxford where, partly because we have very good physical obstetric care and partly because we have a low risk population, the perinatal mortality rate is low. But I was receiving an enormous number of complaints from women about care in 1974. That is when, I discovered later, the induction rate was nearly 70 per cent. I called up the local psychiatric mother and baby unit and asked, "Have your mother and baby admissions gone up?" They said, "It is funny you should mention that. They have". I called up psychiatric mother and baby inpatient units throughout the country in districts where I knew there was a high induction rate and got the same reply. For us good care includes continuous sensitive care, which takes into account all the family's needs, and the mother's wishes for the type of birth that she has and the physical and mental health of the mother are a crucial account of the assessment of the success of that care.

Chairman

1187. Taking you to a specific question, in your report you talk about complaints against hospital staff, whether they be nurses or whether they be doctors. In your paper, you urge this Committee to conduct an inquiry into complaints against midwives, nurses and doctors. Can you elaborate on this, because it follows on directly from the remarks and comments that you are making to the Committee?

(*Mrs Robinson*) It is the complaints procedures that we are concerned about because they are not meeting the needs of the complainants. When we are dealing with a complaint our aim is to get the best therapeutic outcome for the family. It is not doctor bashing, midwife bashing or administrator bashing. First of all we talk to the family and ask what they want to achieve, what they want to get out of it. Top of the list is always, "I don't want this to happen to anybody else". Unfortunately none of the complaints procedures is satisfactory in enabling us to achieve that outcome. If one looks at the general practitioner complaints procedure, that, by accident of history, dates back to Lloyd George, and is simply designed by the administration to see whether the doctor has met his or her terms of service. For example, the terms of service do not include being polite to the patient, so that however rude a general practitioner is, which may deter a family from calling for care in times of emergency, there is nothing under the contract that one can do. The obverse of that is that if the most senior hospital doctor in the land is rude to a patient, we can take it as far as the Ombudsman and the Parliamentary Select Committee on the Parliamentary Commissioner. In fact they dealt with such a case only recently where the health authority was hauled up before them to apologise and explain for a rude doctor. Another difficulty is that the most serious complaints encompass both general practitioner care and hospital care. You have to go through two entirely different complaints procedures which do not mesh, so any complaints that relate to the lack of integration of those two forms of care are not dealt with by anybody and it requires an emotional and intellectual marathon from the family concerned, which they are unable to cope with. If they go for the hospital one first they find that they are then out of time to deal with the general practitioner one. As I am sure the Members of this Committee will know, the time limit for general practitioner complaints starts not from the time when you realise that the general practitioner committed an error, but from the time the general practitioner actually committed an error. So the time limit may long have passed by the time that you realise you have cause for complaint. If one then gets into the hospital clinical complaints procedure, the furthest that you can go is the regional medical officers complaints procedure whereby he calls in two consultants from outside the district. We have not yet had anybody who went through that complaints procedure who was satisfied with it and we no longer encourage people to go into that procedure. We do not deter them, but we explain that it is there and how to use it. We will support them if they wish to use it.

1188. You are being very articulate in drawing the problems to our attention. How would you like to see those problems solved? That is, briefly, what recommendation would you make to this Committee to remove the problems that you have just outlined to us?

(*Ms Beech*) Before Mrs Robinson does that, may I make one other point which is important for us to make? We have been supportive of midwives and we are confident of midwifery practice broadly—we are not saying that all midwives are absolute paragons and all doctors are terrible; we recognise there is a range. One of the issues that we find of great importance is that we have a complaints procedure with midwives. We can complain to their professional body. When we complain to their professional body we find that in general that professional body takes those complaints very seriously indeed. We do not have a similar confidence with the General Medical Council. Perhaps Mrs Robinson can now go on to say what we think about the General Medical Council

1189. I have no doubt that she will comment.

(*Mrs Robinson*) One of the difficulties is that under the two Acts of Parliament which set up both professional regulatory bodies, midwives are disciplined by the UKCC for professional misconduct. They can be removed from the register is they commit professional misconduct. Doctors can only be disciplined by the General Medical Council for serious professional misconduct. Those two phrases are embodied in Acts of Parliament. So of

[**Chairman** *Cont*]
course we have more confidence in the safety of midwives than the safety of doctors. One of the problems in complaining about a doctor is that many of our complaints particularly are about locum obstetricians. Quite honestly if my daughter were going into hospital to have a baby and I found the person on duty were a locum obstetrician I would be on to the phone to the consultant immediately or get her to another hospital. The commonest of complaints are against locums and are every day practice to us. If one sends in a complaint to the health authority, that obstetrician is now working elsewhere in another hospital, or it may be a trainee obstetrician from overseas who has only limited registration. That doctor has now gone elsewhere and since the General Medical Council now requires the complainant, first of all, to go to the hospital to get the complaint investigated before the GMC will even look at it, we cannot deal with these doctors at all. The public is continuously at risk. I have pointed out twice in full meeting of the General Medical Council that they are acting in breach of the rules which are embodied in the statutory instrument laid down by Parliament. The rules of the General Medical Council in the Statutory Instrument which you approved say that when the Registrar receives a complaint which amounts to serious professional misconduct, he shall pass it on to the President. That is what the rule says, not "may" or "maybe he should think about it", but "he shall". The General Medical Council is knowingly and deliberately ignoring Parliamentary rules. The staff simply write to many of those complainants and tell them first to take their complaint to the hospital. It is not seen by the President, even though the allegation amounts to one of serious professional misconduct. By the time it eventually gets back to the General Medical Council, if it does, the doctor has gone or umpteen more babies may have been killed. We do not think that the General Medical Council is looking after public safety. I have been on the GMC for 12 years, Chairman, and I sit on the professional conduct committee and I have sat on preliminary proceedings committees.

1190. Do you not feel frustrated?

(*Mrs Robinson*) I have reached the point on a number of occasions where I have felt that I could not with honour remain a member. I have been talked out of resigning by my family and bodies like AIMS on a number of occasions.

Chairman: All I can say is that your evidence is now on record in black and white. Thank you for that very frank and full response.

Mr Hinchliffe: We are meeting the General Medical Council very shortly, I believe, are we not?

Chairman: Quite by coincidence. I was not going to reveal that! Yes, we are.

Mr Hinchliffe: It has been interesting to hear the witnesses today, because when we sit in this position, as we have done on many occasions, we can also see the reaction of people behind the witnesses and I have noticed your reactions on a number of occasions to comments made by witnesses at this table. I feel I have a fairly good idea of how you feel on a number of issues without asking you questions.

Alice Mahon

1191. On the issue of place of birth, which as you know is a contentious question which interests this Committee very much, in your evidence submitted to the Committee you give a table indicating that delivery in a GP unit or at home is safer than in hospital, even when the mother has a high risk pregnancy. But the data you give us were acquired more than 20 years ago when perinatal mortality was three times high than it is now. Do you still believe that it is safer for high risk mothers to be delivered in GP units or at home, rather than in hospital?

(*Ms Beech*) There is a question there, first of all, about the statistics. It is a pity that the statistics have not continued to be broken down in the way in which one can divide high risks and also that home birth has now gone to such a low rate that it really is of no statistical significance. A study has recently been produced by a midwife called Julia Allison, for the Royal College of Midwives, she looked at 15,000 births that took place in Nottingham delivered by community midwives between 1950 and 1960. Admittedly this is still some time ago, but it showed that midwives on completion of their training were confident and competent to deliver babies at home. By today's criteria, 50 per cent of those mothers would have been considered high risk. Yet the outcomes of those community midwives were better than the local hospital outcomes. So I suppose by going the long way round my answer to your question is that I feel that every case should be judged on its own merits. Furthermore, apportioning high risk to an individual is not helpful.

1192. In response are you saying that the existing criteria for high risk is wrong?

(*Ms Beech*) I merely observe that the criteria for high risk over the last 20 years or so has altered, depending on whether obstetricians have beds to fill or have too many beds or have full beds and need to be getting women out.

1193. Are you familiar with the criteria that apply in Holland, which we looked at in some detail when we were in Amsterdam? How would you regard that in the context of the comments you have just made about our criteria in this country?

(*Ms Rodgers*) I think it is difficult to see the Dutch example as being immediately comparable. In Holland there is a system whereby over 30 per cent of births take place at home, so within society you have women growing up with the expectation of giving birth at home. I do not think that will show up on any chart. I do not think that any chart that you can measure can put its finger on the confidence that a woman will feel if she sees her friends, her mother or her aunts giving birth at home. The other thing about the statistics you referred to—which I believe are Marjorie Tew's statistics which are 20 years out of date—is that we have to remember that Marjorie Tew looked at those statistics not from the point of view of proving a case that home birth was safer. She was simply looking at the evidence as a statistician with no particular specific interest. Her results are as valid now as they were then in that she said that once you sift out from home births those births that are obstetric emergencies, that are not planned for home birth—and births that were taking place in prison

[**Alice Mahon** *Cont*]
were included in that as well—you are then looking at the safety record of planned home confinements. That would still be statistically valid today.

(*Mrs Robinson*) Can I say something on this question of risk? Who defines risk and who decides what it is? One of the many women we deal with weekly who are wanting home confinement, and one I supported recently, was a woman who had had her first child at home quite successfully, then she had seven early miscarriages. After treatment she was able to conceive again and she was going through another pregnancy. It is very common for a woman having had many miscarriages to feel no affection whatsoever for the foetus she is carrying. We were able to assure her that that is absolutely normal. You cannot invest emotion in a foetus after this sort of thing. For her home confinement was important, because she knew that type of care was necessary for her to bond with that baby. Her priority category was not just survival of the baby—in fact that was something about which she was almost willing to say could go by the board—it was survival of the family as a unit. Women's criteria for risk and what is risk and morbidity is not the same as the criteria which obstetricians are using.

Mr Clarke: I was tempted, in view of Mrs Robinson's earlier comments, to ask whether she felt that last Monday's portrayal of the General Medical Council in *Rumpole of the Bailey* was accurate.

Chairman: She wrote it!

Mr Clarke

1194. The chairman was a Scot with a beard—a man I have seen on the Labour Front Bench these days. Anyway to be serious, Mr Chairman, because I am much impressed with the evidence. In earlier evidence you recognised the need for a specialist flying squad to support the midwives, comprising of an obstetrician, an anaesthetist and a paediatrician, if there was an increase in the number of home births. What would be the resource implication of establishing such a service?

(*Ms Rodgers*) We ought to nail the myth here and now that the flying squad is for home deliveries. It is not. The flying squad is the emergency obstetric services for any woman pregnant anywhere intending to deliver in a consultant unit, a GP unit, at home or wherever. In fact I know some research was done recently in Southampton which showed that postpartum haemorrhages were increased up to seven days for women who had been given oxytocin in labour in hospital. Those women having a postpartum haemorrhage at home, presumably after discharge from hospital, would be an obstetric emergency. There is no provision in that area for a flying squad, which that woman would need. I do not think it is a question of increased resources. I think the resources are there. We have midwives, we have obstetricians, we have paediatricians and we have anaesthetists. They are all there. In fact in *Maternity Care in Action*, which was the last investigation into maternity services published in 1984 suggested that consultant obstetricians should carry pagers, bleeps, and also carry an emergency pack in their cars so that they could be contacted at all times. It seems to me that in this age of technology, of all the technology that is applied to obstetrics, a little of it could be applied to communications with those experts whom we have expensively trained.

1195. Given the choice between putting women in hospital at risk by withdrawing the staff needed for a flying squad—in many ways this follows from what we have just heard—and discouraging home births because of their unavailability, which would you prioritise?

(*Ms Beech*) I do not think it is for us to prioritise that. What we are saying is that we have a service that at present is inappropriate to the needs of the majority of women. We do not believe that by reorganising that service we will necessarily be depriving or putting at risk high risk women who should appropriately be cared for in hospital. If we reorganise this service properly, if we use obstetricians in the way in which they ought to be used, they will have more time, they will have a greater opportunity for giving good continuity of care to women who need to be in hospital and their junior staff will also be available to do that. I do not think it is an either/or situation.

Chairman

1196. Do you know what proportion of all women really want home births? What is your evidence on this matter?

(*Ms Beech*) No, we do not know what proportion of women want a home birth because I do not think there has ever been a national survey on it. What we can say is that this is a very frequent question for us to be asked. We would also draw the Committee's attention to the home birth statistics. In the Torbay area home births are 12.5 per cent. In some areas in south London the home birth rate is less than 1 per cent. One needs to ask why. From our evidence and from the approaches we have, women are subjected to enormous amounts of intimidation and threats in order to persuade them into hospital. Equally, they are given the temptation of "Perhaps you would like to come into hospital because we have a domino system and you can have that instead and it is almost as good".

Mr Couchman

1197. Do you feel that the responsibility of an organisation such as yours with its considerable influence in these matters to be evangelical in proposing home births?

(*Ms Beech*) What our organisation should be doing is putting forward the views of women generally. In order to establish what the views of women are, one could do a whole national survey of that. Equally one could get the information in the way that we do about what care is wanted. We would not be promoting and campaigning for something that nobody really wanted because we would end up with our members telling us that this is really beyond the pale. What we are doing is putting forward the views of those who feel this way. There are many women who will ask for a type of care that they are persuaded is the best. For instance, women have been told that ultrasound is totally safe and that they are receiving good care if they have ultrasound. There are women who ask for ultrasound. Those who are informed about the risks of that technology would

[**Mr Couchman** *Cont*]
not be suggesting that ultrasound should be available to everyone.

Chairman

1198. Do you have any concerns expressed about any other form of intervention or screening procedure? You certainly talk about ultrasound, but do you have evidence about any other complaint or concern about medical interventions in pregnancy?

(*Ms Rodgers*) I want to reply to the question about home births, because what AIMS is doing—and the position it has always taken throughout its 26 or 28 years now—is that we are fighting to maintain women's choice. Kenneth Clarke as Secretary of State for Health is on record as saying that all women are offered the option of a home birth, a GP unit delivery or a consultant unit delivery. We know perfectly well they are not. We are pointing that out. The Committee has been to Holland and knows that there is a home birth rate there of 35 per cent. Here it is 1 per cent. Some 34 per cent of women who are wondering what to do when they give birth.

Mr Couchman

1199. Yes, but do you think that is the case? At the beginning of your evidence you said that we should not draw too many parallels with Holland.

(*Ms Rodgers*) You were asking me more about why women there are asking for it. I am saying that their systems encourages women to have confidence in their ability to give birth, which lies at the basis of the question.

(*Ms Beech*) Essentially what we have had is 30 years of women's confidence in their ability to give birth undermined by obstetric care, by the attitude that it is a very risky business and the only way that you can protect yourself from risk is to come into hospital.

Chairman

1200. Can you briefly respond to my question on other screening and interventions in pregnancy, other than ultrasound to which you have commented following Mr Couchman's question?

(*Mrs Robinson*) I think there is an assumption that screening of any kind is good and harmless. What people do not realise is that there is a substantial amount of sociological information showing that many screening procedures carry risk. Simply continually weighing women can cause anxiety, can be inaccurate and can lead to intervention which is unjustified. It is not necessarily high tech procedures which cause damage, but even low tech procedures like weighing the baby after every breast feed can cause anxiety and so on. I was very impressed with the Scandinavian study which showed that when people had been given information that a post natal check on their baby showed that it might be carrying a genetic disease—I think it was a thyroid abnormality. Subsequently some of those tests proved to be wrong. They went to the mother and said, "Terribly sorry, we thought your baby had this disease. It is all right. It is fine, it has not after all". They thought that there was no problem. Checks on those families years later showed that in some families the relationship with the child was still affected. By telling people that there may be a problem, even if it turns out not to be true, you can be doing untold damage. It is not just ultrasound that worries us.

1201. Can you name a number of the interventions or screening procedures to which you refer in the remarks that you are making?

(*Ms Beech*) Amniocentesis is an example of a procedure that is used. Women rarely have real information about whether amniocentesis is appropriate and what the risks of that procedure are. There is a study that shows that there is a 74 per cent chance of the woman feeling indifference towards her child following that procedure. That is quite a subtle effect of that procedure, yet it is looked upon by the profession as a means of screening the child—

(*Mrs Robinson*) I am sorry, that was amniotomy.

(*Ms Beech*) I am sorry. I beg your pardon. I am getting my amniocentesis confused with my amniotomy. We are talking about amniotomy. I make the point that it is a subtle effect of that particular screening. With amniocentesis what we found was that there was an increase in respiratory distress syndrome among the babies who were exposed to that. We have no idea of what the long term implications of that condition is. Obstetricians will say that we need not worry because we can deal with that when the baby is born. But what happens when the baby gets to 40, or 50 or 60? Does it still have breathing problems? Will that be a further drain on resources in dealing with and helping that individual? We do not know.

Audrey Wise

1202. Some of us who might accept many of the points which you make might also feel—I would like your comment on this because I suspect this would be my own view—that the opportunity to have an amniocentesis test in certain circumstances would be immeasurably valuable. Are you making a blanket condemnation or are you asking for more information? This part of your evidence, contrary to the earlier part, I find a bit less than clear.

(*Ms Beech*) My apologies for that. No, we are not making a blanket condemnation of any of the technologies that have been developed. Many of them have been developed for a specific reason and they have a very real value. For women with problems those technologies can be life-saving to them and their babies. We recognise that. Our difficulty with many of the technologies is that they have been used as a routine. When they are used as a routine there then follows that difficulties arise as a result of using it as a routine. It is the routine use of technology that we are questioning.

(*Mrs Robinson*) Can I make a point about amniocentesis, which is designed to detect as early as possible—although there are procedures which can do it even earlier—the abnormality of the child? One has to think of the relationship in which that information is communicated and how the family makes a decision. There have been reports from a number of areas where the mother has an early blood test showing that she may be carrying an abnormal child. She is told she can have amniocentesis, but only if she then goes on to have a termination. Women feel that it is too early for them to make that

[**Audrey Wise** *Cont*]
decision. They do not have enough information and so women call us for advice. We say to them, "Lie. Tell them that, yes, you will have a termination, because that is the only way you are going to get the test, if you want it. Then, after you have had the amniocentesis you will have time to think and no one is going to be able to force you to have an abortion you do not want. Say you are sorry, you've changed your mind". But how appalling that we have to advise people to be dishonest. We do not like doing it but there are certain health authorities where that was all people could do.

1203. So you are saying that in those circumstances that people were being deprived of having an amniocentesis test which they wanted to have?

(*Ms Beech*) Yes.

(*Mrs Robinson*) Yes, that is right. Of course one cannot assume that the termination of a pregnancy with an abnormal baby is the best outcome for that family. It may be, but if you are a health authority putting resources into amniocentesis and detection of abnormality, you are doing it on the assumption that it will reduce costs later on, either because it will reduce the perinatal mortality rate because the babies would have died when they were born, or it will reduce the costs of caring for an abnormal child. If you are looking at optimum health outcome from the family's point of view, the best emotional outcome for the family or for the woman may be to bear an abnormal child with a short expectation of life, care for it and grieve for a child that she knew. That is not right for everybody. That may be right for some people. The health authority's assumption of what is the right choice and the right way to use technology may not be the best way to make choices and use technology from the point of view of individual families.

Chairman

1204. Just a point of clarification and to return to the earlier answer you gave about the effect of mistaken diagnosis of thyroid damage. Perhaps Mrs. Robinson you would indicate to the Committee how you would weigh the effects against the benefit to those who were correctly diagnosed and saved from brain damage, that is those who did not have thyroid problem and therefore were fine, and the diagnosis where that diagnosis saved that baby from brain damage?

(*Mrs Robinson*) One has to realise that screening is never simplistic. It always will involve an element of counselling and if you are truly costing any procedure, outside maternity care for hypertension, AIDS or whatever, if it is being done properly there will be ongoing costs of support, counselling and so on. Therefore one should fully cost. You have to recognise that there will be false positives and false negatives with any test and therefore anybody who has that test should be fully informed beforehand and the need for support and information is recognised, and that there will be casualties.

Mr Clarke

1205. As representatives of users of the service would you welcome or oppose the introduction of paramedic staff for the emergency obstetric unit?

(*Ms Rodgers*) We would be very much opposed to that. The maternity services have very many well-trained staff. We do not need another layer, another category. We have midwives who work in the community who are trained in all aspects of normal childbirth. If we gave those midwives the full responsibility for taking care of the woman all through her pregnancy and referring that woman to hospital for any special care she might need, then I think we do not need emergency paramedics. We do not need to start training people to whiz round on motor bikes to women in labour. We have the staff.

Rev Martin Smyth

1206. I should like to go back to your illustration of 12.5 per cent of home confinements in Torbay and 1 per cent in London. Have you analysed those figures, because it is one of the largest percentages in the UK that we have come across? In that context did they come from the areas where they were closer to the hospital or were they more remote from the hospital, and what was the outcome?

(*Ms Beech*) I have only just received those figures. I was very surprised by them. I have done no analysis of them. I find them very interesting indeed and would urge the Committee to look at that. If Torbay can achieve that, I wonder why other areas cannot.

1207. It is a remarkably rural area too, with a lot of narrow roads and fast traffic?

(*Ms Beech*) It is. One of our groups quite some time ago—I am not sure whether I brought that chart—analysed the home birth rate in their area and they discovered that it was as high as it was because there were two specific midwives who were doing a great number of home births. There were a number of other midwives who did the occasional home birth and there were three or four other community midwives who did none at all.

(*Ms Rodgers*) Also you will find in those areas where there is a high home birth rate, there are a few very committed general practitioners.

Alice Mahon

1208. Given that 47 per cent of neonatal deaths occur in babies of very low birth weight, do you accept that these babies required skilled attention so that they can have the best possible chances of healthy survival?

(*Ms Beech*) Absolutely.

1209. Do you believe that mothers likely to deliver very low birth weight babies and other high risk babies should be transferred to appropriately staffed and equipped units? Or, failing that, the baby should, if necessary, be transferred after delivery?

(*Ms Beech*) We believe that that is an issue which should be dealt with by the professionals involved. Midwives are trained to identify women who are carrying babies of low birth weight and who have problems. We would expect them to take appropriate action. I think the question of how they organise the service for those low birth weight babies may perhaps be more appropriately addressed to NAWCH, which is more involved in that. From our organisation's point of view, we have comments from women who draw our attention to the difficulties of travelling long distances and perhaps having babies in one

[**Alice Mahon** *Cont*]
central unit which they cannot stay in, because they are not well enough to travel themselves or because it is too far away or because they have other children. That is a real problem for them.

1210. Do you think it would be safer for such babies to be born in GP units?
(*Ms Beech*) I would expect GPs and midwives carefully to be screening each individual case and deciding what is the most appropriate action for them.

1211. So you are not going to commit yourself?
(*Mrs Robinson*) Obviously a number of very small babies need a great deal of support and expert care from neonatal paediatricians and nurses. That is where they need to be. The safest way for them to travel is in utero, in the mother's tummy. Unfortunately we know of hospitals who are not transferring the women in labour early enough and then the mother and baby have to go separately. The emotional bond is also very important. The separation is very unfortunate.
Chairman: Thank you very much for that very full response. We shall move now to what I describe as resource allocation. Mrs Wise will be putting these questions.

Audrey Wise

1212. The general thrust of your evidence is that birth within the NHS is over-medicalised and too hospital centred. Are you prepared to support publicly a significant reallocation of resources away from high risk babies and mothers to maternity services for normal mothers?
(*Ms Beech*) No, we are not and that is not what we have ever said. What we are saying is that the resources are inappropriately used and I think my colleague, Chris Rodgers, could expand on that.
(*Ms Rodgers*) I think we are wasting resources in many ways. It is not a question of saying that there is a set amount and that it is going to be put all here or all there. What AIMS wants to do is to encourage women to see childbirth as a normal event. The Treasury can look at that and say that a normal event is cheaper than a high risk event. We have a staff of midwives throughout this country who are being underused. We are duplicating their efforts, very often, with the efforts of the general practitioners and then we are doing the same again in hospital. There is no doubt that low weight babies and high risk mothers are going to take the bulk of the resources, but that is not saying that we want to shift the emphasis. We do not want to take anything away from those women who need it. We just want to make sure that the provision—which I believe can be done at relatively low cost—is used properly.

1213. So you are saying that there is not a conflict of interest between the high risk babies and the more happy situations?
(*Ms Beech*) If you alter the structure of care as it is it will release resources. Those resources can then be appropriately used. The people who will then need perhaps more application of those resources would be the high risk women and the high risk babies who need the intensive care that obstetricians can give them.

1214. What in your view is the greatest amount of money wasted in the current organisation of NHS maternity units? You have hinted, but perhaps you could elaborate.
(*Mrs Robinson*) A very large number of normal women are allocated to care or funnelled into care by obstetricians which they do not need, using hospital beds which they do not need and technology which not only do they not need but which is positively harmful to them. I would say that this is where a great deal of money is wasted.

1215. You mentioned under-used midwives, but we are aware that a majority of women are delivered by midwives, so the midwives are being used. Will you elaborate on where you think the difference would be if they were being used properly?
(*Ms Beech*) Much of what midwives do is often a duplication of what other professionals do. An example of that would be the shared care with GPs and hospitals. There are midwives who share the care and the midwife will weigh the mother and do urine samples and then the GP will come in and palpate and the midwife has already done it. There is an enormous amount of duplication. There is an enormous amount of inappropriate use of midwives' skills in hospitals. If midwives were responsible for each individual woman right through her care, it then releases others to give care to those who appropriately need it.

1216. Often women are technically under the care of the obstetrician, but actually do not see that obstetrician. Does that fact that she is technically under the care of an obstetrician actually affect the care that she receives, even if that is from midwives?
(*Ms Beech*) Very much so. We are concerned. One can highlight that by the example of women who arrange a so-called domino birth and in areas where the community midwife will take a woman in, the community midwife will expect to look after that woman and deliver her in the way that she has been trained. But we have come across cases where the community midwives have been in conflict with the hospital either because the hospital has said, "Now you are in the hospital you will adhere to the labour ward protocol" or because of the views of the particular consultant to whom this woman has been allocated. There has been a lot of friction between community midwives and the hospital midwives and staff about the procedures.
(*Mrs Robinson*) When you say "under an obstetrician", many high risk women go through their pregnancies not seeing a consultant at all. What they are seeing is a series of entirely different junior doctors and sometimes very junior doctors. They lose out on continuity of care. You will see from the evidence we have put in that a survey was done by a midwife in London teaching hospitals. She found that the consultants went through the list of women coming in for ante-natal care and picked out who they wanted to look after and that was women in social class one, the lowest risk women. So they picked out lawyers' wives, doctors' wives and, doubtless, MPs' wives. Then the senior registrar went through and consulted whom he would personally look after and that was the next layer down, perhaps bank managers' wives and headmasters' wives and so on. By the time one got down the social scale to

[**Audrey Wise** *Cont*]
women in social classes four and five, the highest category risk group, they were being looked after in London teaching hospitals by the most junior staff which meant an ever changing staff. Interestingly enough the wives of social class one men did not necessarily do better because those who went for private care were booked for induction on their first antenatal visit. They got more intervention. They got more caesarian sections and when I last looked at maternal deaths by social class, women in social class one actually had a higher maternal death rate than women in social class two, the class below them, nearly as high as social class three. I suggest that that was because they had more unnecessary intervention, but the numbers were statistically very small and perhaps I am drawing more inference from those figures than the statistics would allow.

1217. Considering now the intensive care of babies after birth, or those perhaps transferred in utero as you have said, we have received much evidence that the present regionalised structure for perinatal and neonatal intensive care should be preserved following the NHS reforms because it is safer for the babies as well making the best use of resources. What are your views on that?

(*Ms Beech*) This is an issue, as I said earlier, that we do not get involved with particularly and therefore I suggest that this Committee should perhaps seek the views of NAWCH or the Maternity Alliance, which has looked into that particular area of care.

1218. We took evidence from specialists in neonatal care last week and neonatal nurses. The regionalised structure seems to have considerable professional support, although you may be interested to know that they did not feel that there was anything wrong at all in home confinements in other cases. One of them had his own baby born at home. We are concerned about the possible lack of cots and the possible lack of the highest skill and the best use of the highest skill which, in the case of the new ill baby, seems to be best done on a tiered basis. You would not have any quarrel with that?

(*Mrs Robinson*) Both of us have acted as lay advisers to the National Perinatal Trial Service, so we are involved in the discussions of these kinds of randomised trials. We are committed to well-designed scientific research in neonatal care. It is obvious that there are developments in this field which are extremely expensive and their effectiveness and costs must be properly studied. We are glad to see that they are being properly studied. We are asking for emotional problems and financial costs for the families of travel also to be embodied in the studies and that is being most sympathetically received. One of my concerns also is that there is a very high burn out rate for doctors and nurses who work in this kind of unit. It is extremely stressful. One of my long term interests has been occupational risks for those in caring professions. When we are costing those units and designing them we have to think of the problems of staff who are working with tiny babies, are in daily contact with very stressed families, and in areas where they know there is going to be a high mortality and morbidity rate. You really should not underestimate the difficulty of doing that job and how much support people need. They may also need extra study leave and other things, but we have to look at the needs of caring staff, not just do we put this unit here, there or everywhere.

Sir David Price

1219. Time is going on and a number of my colleagues have had to move on. Can we move quickly through a couple more subjects? One of these we have already touched on, which is the whole question of risk. You were answering some questions from my colleague, Audrey Wise, on risk. Do you believe that the fear of litigation may influence consultants in their choice of the women to whom they give more attention? This ties up a little with one of your earlier answers.

(*Mrs Robinson*) The obstetricians say that the fear of litigation does change their practice. I have to accept their word. I find that it is extraordinarily unethical that they are saying that they are giving caesarian sections to women who do not need them, simply for fear that they may be sued, even though they feel there is no medical need. Are we to counterbalance that and going to get women to sue if they were given unnecessary caesarian sections? If litigation influences them so much, then perhaps we have to use it in different directions. I started my involvement with looking at consumer obstetric care at the Patients Association in the 1970s when there was very little litigation. I have no doubt whatsoever, after 20 years' involvement in complaints, that the increase in litigation has been caused by peoples' dissatisfaction with complaints procedures. People do not want money for a dead baby. Sometimes they do not even want money for a damaged baby, although they may well need it. They wanted the truth and they did not get it and they were forced to turn to litigation. It was not what they wanted. We have cases that we are dealing with daily where people have gone to lawyers very reluctantly because the complaints procedures failed them and because they know people lied.

1220. I think you will be aware that increasing influence appears to be coming in the practice of obstetrics in this country from America, where I think both the substantial evidence and the anecdotal even more—and certainly our experience having been to America—is that the fear of litigation definitely influences clinical decisions.

(*Mrs Robinson*) It does, but it should not.

1221. How are we to prevent it?

(*Mrs Robinson*) I would like to see the education of doctors changed a great deal. One of the problems is that medical students and young doctors are not trained emotionally to deal with complaints. All of us in our lives make errors. None of us is perfect. But it is particularly dreadful if your error has led to injury or damage. You need the right kind of support from your colleagues in emotionally dealing with that, not the macho situation that we have at the moment. "Oh, well, all of us have made errors, old chap. Forget it and get on". You do not bury that deep inside you emotionally and forget it. You have to cope with it. You have to cope with it constructively and you have to be supported in the right way while you are doing it. That applies to both doctors and midwives. This is part of the reason why there is this *impasse*, why obstetricians and other doctors cannot

[**Sir David Price** *Cont*]
cope with what consumer groups are saying. That is one of the places we have to start.

1222. On a specific point with regard to risk, you describes the possible long term risks of ultrasound scanning as one of your major worries. Can you tell us very briefly on what evidence you made that judgment?

(*Mrs Robinson*) Two studies have shown an increase in miscarriage rate on women exposed to ultrasound. Neither of those is totally satisfactory. Nevertheless they are both randomised studies, one in Finland and one in the United States. What has not been satisfactorily explored is the short or long term possible adverse consequences. There is the Denver study in the United States which has come up with an increase in dyslexia with children exposed to ultrasound in uterus and that came up at three different hospitals. However, that is a very unsatisfactory study. It was not randomised and there are no data on how long they were exposed or how frequently or whatever. Nevertheless that possibility exists. I say no more than that. There is also the work on cells which has been done which shows that ultrasound does have an effect on cells and that can persist from generation to generation. What we are against is women being told categorically by obstetricians that exposure of the baby to ultrasound is safe. There are no studies which show that. The only studies which could show it are large scale randomised studies with long term follow up. We should not forget that when we are exposing, for example, a female foetus, the female foetus in the womb already carries her lifetime supply of eggs. That is exposure of the next generation as well as the current generation. We are not scaremongers. We have been very responsible in the things that we have said. We have not gone out frightening women, going to the tabloid press or whatever. We have been trying to have a debate with professionals. I wonder whether we have gone far enough in telling women how worried we are.

1223. Is there not a difficulty, as in so many matters affecting the human being, that unlike experiments one can do on laboratory animals, it takes a very long time to test on a purely randomised basis and where other factors are equal in order to identify the factor one is trying to study? It takes a very long time to discover the longer term effects, particularly in second and third generations, which is what you were implying in your answer just now.

(*Mrs Robinson*) One of the things that most worries us is the recommendations which the Department of Health recently put out on ethics committees. I was a long serving member of an ethics committee. What they have said is that in order to protect patient confidentiality the records of people involved in a scientific clinical trial should be destroyed. We think that is appalling because it means that long-term follow up is no longer possible. I can give you a specific example. When the long-term effects became known of young women who were exposed to stilboestrol in the uterus later developed clear cell carcinoma of the vagina when they grew up. Because their mothers had been given hormones when they were pregnant, the girls later on developed cancer when they were teenagers. This was published in the United States. Professor Martin Vessey in Oxford discovered that many years ago there had been a randomised study at a London teaching hospital where half the pregnant women had been given stilboestrol and half of them had not. The records still existed. He was able to go back to the records, see what had happened to those children in both groups who were now grown up. What he then discovered was that there was far more serious mental illness in the children who had been exposed to the hormones in the womb. We would never have discovered that more subtle and less obvious effect had those records not been kept. We sent a protest to the Department of Health at those recommendations. I know that the United Kingdom Central Council for Nursing and Midwifery also sent a protest, when the draft came out, but alas the Department of Health did not accept our protests. So records of research on unborn children will be destroyed and we shall have no means of identifying long term time bomb hazards.

1224. To get the record straight, you presumably accept that ultrasound has brought a good deal of good to quite a number of pregnant women, or do you deny it completely? It is trying to get the balance, is it not?

(*Ms Beech*) No. We would accept that ultrasound has a very valuable role to play in obstetric care where there are conditions that cannot be identified by other means and where the clinicians have a problem which could be resolved by ultrasound. What we are concerned about is the general publicity on ultrasound which says that it is totally safe. If I can add to Mrs Robinson's comments, some research has been done quite recently showing an increase in miscarriage among children who have been exposed in utero who are already at risk of miscarriage. The numbers of babies in the ultrasound group who died were double those who were palpated. The other issue that we have been chasing is this whole question of maintaining long term records. For the Committee I have brought a copy of the letter that we wrote to Gerard Vaughan in 1981 asking for there to be a proper trial of ultrasound. The response we had at that time was that they considered it unethical to do so because it was in general use. John Patten later, in 1986 I believe, said that it should not be used as a routine and yet ultrasound is used as a routine. Health Rights did a study of health authorities in London showing that 96 per cent of women in London were having routine ultrasound scans. It has a serious short term effect. We know of a case that was settled this year of a perfectly fit and healthy baby who was aborted because the parents were told that the baby was seriously hydrocephalic and needed to have an abortion and they agreed. There was nothing the matter with the baby. We have had other experiences of that and without a proper evaluation of this technology we have no idea how widespread this kind of misdiagnosis is. That is one extreme. The other extreme is women who are told they have a placenta praevia and they go back for an ultrasound one or two months later and they are told it has moved. I have spent time as we all have with women who were deeply distressed and upset about this diagnosis and having to reassure them and talk them through the implications of it. The diagnoses from this technology, indeed from all technologies,

[**Sir David Price** *Cont*]
as Jean said earlier, have implications for the emotional wellbeing of women. When there is a misdiagnosis the reaction to that can be traumatic. We are urging very strongly that there needs to be a proper trial of ultrasound. We still have not had it and we believe it is unethical for the profession to continue using this technology in the way that they do, when it is not properly assessed.

(*Ms Rodgers*) At enormous expense. The whole issue of ultrasound like electronic fetal monitoring, which occupies miles and miles of print out paper, is an extremely expensive technology which needs to be updated and it is also being used in different parts of the country by people who are not so skilled in the use of ultrasound. We know that at Kings, which is the centre of excellence for the use of ultrasound, the studies have shown that they have aborted healthy babies on a misdiagnosis.

Mr Sims

1225. You have indicated fairly clearly in the discussion we have had so far what you feel the role of the doctor should be. This, therefore, is reflected in your comments on training. You appear to be implying that training of GPs by obstetricians is inappropriate and that they really ought to be concentrating on normal deliveries. Have I interpreted that correctly? If you are saying that, how does this affect the role of the midwife?

(*Ms Rodgers*) GPs who did a six-month obstetric training are doing that training in a consultant unit. What they are seeing are abnormal births. They are seeing the births that the consultant is handling, the difficult ones. They are not seeing the 85 per cent of births where the delivery is managed by a midwife, where there are no problems. Their training should be much more aligned to that of the midwife. In fact I would go so far as to say that midwives should train those GPs who wish to be involved in maternity care. If a GP wants to be involved in maternity care he should be involved in the full range of care. He should be willing to be present at those deliveries where the mother wants him to be present. He should provide full antenatal care, full intrapartum care and full postnatal care in exactly the same way as a midwife does for normal births. The rest should be referred on to a consultant unit.

1226. So it is an either/or situation, is it? You are saying that either the doctor, the GP, should be involved all the way through, because you have said that you do not favour the idea of partial care, or the midwife should be involved all the way through, are you?

(*Mrs Robinson*) Yes.

(*Ms Beech*) Yes.

1227. But it follows that the doctor who does that should have had some kind of training in this field and you feel that it should be ideally by the midwife rather than as happens at present?

(*Ms Rodgers*) Yes, because that GP will not be doing a caesarian section. He should be trained by the midwife.

(*Mrs Robinson*) It is not just initial training. It is refresher training. One of the differences which we note is that a midwife cannot stay in practice as a midwife unless she takes a statutory refresher course every five years. That is not so for the general practitioner. He had some training perhaps many years ago and is now continuing to be responsible for pregnant women, but may not be up to date. Once those doctors are on the obstetric list—and therefore being paid at a higher rate for giving antenatal care and postnatal care—we cannot get them off. We have tried and tried with general practitioners where we have had very serious proven complaints before the Family Practitioner Committee, as it then was, of errors resulting perhaps in the death of a baby or something of that kind. We cannot get them removed from the obstetric list, even though we believe them to be incompetent.

(*Ms Beech*) Perhaps I should add that there is an editorial in the British Journal of General Practice that says: "Home births require no special facilities, yet the family doctor is the most likely obstacle to a woman achieving her desire for home delivery. The most potent effect of the six months' senior house officer experience in obstetrics is to frighten the general practitioner trainee; a bizarre result rivalled only by the effect parachute training has on its trainees". We are saying that we very much welcome general practitioners who are very keen on doing home births and being involved in maternity care and offering that full service. They do exist. They are around the country. We do know of them.

(*Ms Rodgers*) They are treasured.

(*Ms Beech*) Very much treasured, but the main bulk of general practitioners are not particularly sympathetic to it and they are the source, very often, of some very serious problems and intimidation and threats that women have to endure to get the kind of birth that they want.

1228. So you are really saying that they should either not be involved or be fully involved and be fully trained before they are involved?

(*Ms Beech*) Absolutely. We expect them to be of a standard that is required of midwives. At the moment we do not perceive that the bulk of general practitioners are.

1229. Are you satisfied that the training of midwives is adequate?

(*Ms Beech*) There are a number of issues about the training of midwives. Certainly we hear from midwives who are coming out of training, the new midwife students, that they learn and they feel confident in delivering babies and looking after women completely. But they find when they get down on to the labour wards that they are not able to implement the practice for which they have been trained and that they have this difficulty there.

1230. Why are they not allowed to?

(*Ms Beech*) Because many labour wards have protocols which they require the midwives to adhere to and many consultants lay down criteria and conditions that again they require the midwives to adhere to. While midwives do not have total responsibility for individual women, we do not see that situation resolving itself. Many student midwives have been thoroughly depressed by coming from their training and finding that they are not able to put it into practice. Perhaps I may lead on: there are some issues in midwifery care that we are very worried about. We particularly want to draw your

[**Mr Sims** *Cont*]
attention to the three issues. The first issue is the education changes that are now coming in. The second is the changes that have taken place at board level and the third is the changes that have taken place in district and hospital levels and the changes with trusts. On the educational changes, while midwifery is a research based profession it is also a skill based profession, and one wonders how lecturers in institutes of higher education by professors of nursing prepare modern midwives for the role they should be taking. It is increasingly causing anxiety within the profession. What has happened with the changes that are taking place at board level is that the Act presently requires the boards to consult the midwifery committee on matters of midwifery and the midwifery committee that makes a recommendation. There have been a number of instances where the midwifery committee has unanimously made a recommendation concerning midwifery practice and they have been overruled by the board, which is predominantly nursing of course. The third issue are the changes that are taking place at district level. We are concerned to find that in some hospitals the highest level of practising midwife in hospital has been a senior sister in the labour ward. The midwifery managers are being moved to one side so that the managers are becoming nurse managers who do not understand the issues and the problems of midwifery. When there is a confusion or a dispute on the labour ward concerning practice, the midwives do not have a senior manager, a midwifery manager, whom they can go to. They are going to nursing managers and they are going to the administration. We consider that this is a very serious problem that is emerging.

Audrey Wise

1231. You suggest that a doctor's first experience of stitching should not be on a woman's perineum?
(*Ms Beech*) Absolutely.

1232. You think that it sometimes is?
(*Mrs Robinson*) Indeed. The subject of medical students being allowed to stitch was something that I raised frequently on the General Medical Council. This I understand is less likely to happen, but very often it is a very junior doctor. The long term damage to women from a bad repair in that area is significant. Would a man who had an injury to his penis or his testicles be happy to feel that the most junior medical staff or a medical student with no experience of stitching was allocated that task? The problems that we see of women who have long term difficulties and cannot enjoy sex and so on because of injuries to that area and failure to suture properly are very common.
(*Ms Beech*) Yes, episiotomy problems make up a fair proportion of the complaints that we have and they are very difficult problems to resolve.

1233. What about the trainee midwife? Where would she get her stitching experience?
(*Ms Beech*) One would hope that it would not be on the perineum of a woman. However, midwives, I would suggest, are dealing with women all the way through their labour and we hope they would be looking after them right through their whole experience, but I think that is an issue that you should address to the midwifery profession to see how they deal with it. There are very few midwives that cause us problems with stitching.
(*Ms Rodgers*) Many have trained as nurses first, so they do at least have some idea of the issues involved. A medical student may only be two years out of sixth form.
(*Ms Beech*) Also I think women usually have some experience of needlework, and very often the men have none at all.

1234. And, of course, they would be conscious of the sensitivities of the area. Do you think there might be fewer episiotomies anyway, if midwives had more control?
(*Ms Beech*) Yes, that is a very good point. The problems with episiotomies and the rate of episiotomies have certainly gone down, because the research has shown—contrary to what obstetricians have told women over the last 20 years—that there is no evidence for routinely carrying out episiotomies. The midwifery profession have very much taken that on and the episiotomy rates are dropping quite considerably.
Audrey Wise: Is there any briefly you can say about this? You have pointed out the need for more women consultant obstetricians. A very small percentage are women. Can you suggest ways of improving recruitment of women into obstetrics?
Mr Sims: Or male midwives.

1235. That is a different question and has a lot of other connotations, if you do not mind.
(*Mrs Robinson*) My understanding from women doctors is that one of the problems has been resistance by the Royal College of Obstetricians to part-time training. We need to have provisions for part-time training. That would assist. Also, I am afraid, that the atmosphere of labour wards and the whole ethos of the way maternity care has been conducted has put off some of the most sensitive people who would otherwise have gone into obstetrics. If you look at complaints from Susan Bewley in the journal of the Royal College of Obstetricians and Gynaecologists, which we quote in our evidence, there are very serious complaints about the quality of medical training that they are receiving. Alternative specialties are more attractive.

1236. Pursuing this question of part time, which I feel is a very valid point, do you think that part of the problem is not simply the lack of part time training opportunities, but that the training might itself involve not simply full time but excessive time and excessively long hours, that makes it perhaps harder for women?
(*Ms Rodgers*) Excessive hours can be a problem across the board. One of the other suggestions that has been made and which we support is that perhaps we should be separating obstetrics from gynaecology. We might be able to persuade young women doctors coming in to specialise in obstetrics or in gynaecology, one or the other.

1237. Presumably you would like to see more women in gynaecology as well?
(*Ms Beech*) Of course, yes. We would like to see many more women.
Sir David Price: Talking about excessive hours, we do not wish to keep you here, or ourselves, so I think that is a very good note to finish on. Thank you very

[**Audrey Wise** *Cont*]
much. I resist the temptation, as one whose first experience of surgery was as a soldier in World War Two, to tell you about stitching! Thank you very much indeed.

WEDNESDAY 4 DECEMBER 1991

Members present:
Mr Nicholas Winterton, in the Chair

Mr James Couchman
Mr David Hinchliffe
Alice Mahon
Sir David Price
Mr Roger Sims
Rev Martin Smyth
Audrey Wise

Memorandum submitted by Professor Jonathan Wigglesworth

SERVICES IN PERINATAL PATHOLOGY

Introduction

Perinatal pathology is mainly concerned with postmortem investigation of the fetus and infant.

Such investigation may take place following spontaneous abortion or deliberate termination of pregnancy for medical reasons before the period of viability, or following stillbirth or neonatal death of any viable fetus or infant.

The procedure represents an important form of audit on a variety of aspects of human reproduction:

(a) Providing diagnosis of the cause or causes of fetal or perinatal death, or of abnormalities which caused the pregnancy to be terminated. The procedure is readily linked to specific diagnostic techniques such as radiology, microbiology, enzyme biochemistry or DNA studies. Determination of causes allows assessment of recurrence risks and strategies for early detection in subsequent pregnancies.

(b) Assessment of the accuracy of prenatal diagnostic techniques such as real time ultrasound.

(c) Expanding, and complementing, the gross observations of dysmorphology; thus aiding regional clinical geneticists.

(d) Recognition of unexpected hazards of new forms of investigation or treatment and providing a check on the ability of obstetricians and paediatricians to avoid known hazards of standard forms of treatment.

(e) Providing a basis for conducting audit into perinatal mortality at local or regional level, for recognising changing patterns of disease incidence and diagnosing new conditions.

The consultant perinatal pathologist, as a specialist in disease processes affecting the fetus and newborn, may provide expert advice on likely pathology underlying unexpected findings on imaging in live fetuses in utero or ill newborn infants inspecial care. He can assist diagnosis in such cases by reviewing pathological reports and histological slides of previous pregnancies. He has an important role in aiding less experienced general pathologists who may be faced with problems in performing perinatal autopsies. He can provide expert advice on causation in cases of alleged negligence in obstetric and neonatal care.

A good perinatal pathology service should clearly form part of any efficient and responsive maternity service.

Relevance to Terms of Current Health Committee Enquiry

The service impinges on each of the 5 themes considered in the current Health Committee enquiry.

a. Pre-conception care

Perinatal pathology is relevant to this if a previous pregnancy has ended in fetal or neonatal loss. Genetic or general counselling on the basis of pathological findings may be of importance at this stage.

b. Antenatal care

Pathological findings following a previous death may be important in determining the appropriate pattern of antenatal care. Thus findings of a particular genetic disease may indicate the need for chorion villous sampling or amniocentesis to allow early rcognition or exclusion of recurrence. Findings of a particular pattern of anoxic damage may indicate the stage of pregnancy at which monitoring is most critical.

c. Delivery/birth

Findings after a previous death may indicate an appropriate mode or timing of delivery to avoid recurrence.

d. Post-natal care

Following fetal or infant death explanation of the pathological mechanism may be an important aid to bereavement counselling.

e. Paediatric care

Explanation of a previous neonatal death may be an important aid to management of a subsequent infant.

Perinatal Pathology Services in the UK

The need for regional specialists in perinatal pathology was recognised by the House of Commons Social Services Committee in their report on Perinatal and Neonatal mortality in 1980.[1] At that time it was suggested that there should be at least one specialist per region. The role of such a specialist was defined in a document produced at a DHSS seminar at Harrogate in 1980[2] and has recently been further defined by a working party on Paediatric and Perinatal Pathology set up by the Royal College of Pathologists.[3] Although there has been a considerable fall in perinatal mortality since 1980 the increasing scope of prenatal diagnosis and genetic diagnostic methods has resulted in a large increase in referrals of fetuses for pathological confirmation of diagnosis, or definitive diagnosis. There has in fact been a considerable net increase in the work of perinatal pathologists. The concept of the regional perinatal pathology unit has been generally accepted although a minority of regions have a functional unit which can serve the region as a whole.

Components of a Regional Perinatal Pathology Unit

Personnel. The RCPath Working Party suggested that 1.5-2 whole time equivalent consultants would be needed, supported by dedicated MLSOs, and a full time secretary.

Facilities. Facilities for photography and radiology (Faxitron cabinet) need to be provided adjacent to the area where postmortems are performed and fetuses examined. Appropriate weighing scales for small organs and small sized dissecting instruments are necessary. Small group teaching facilities such as multihead microscopes are essential and there should be office space for junior staff rotating through the unit and for visiting pathologists. Precise requirements may vary according to whether the unit is to form part of a main histology department or is separately sited in relation to obstetric and neonatal departments.

Current Perinatal Pathology Services in England and Wales

In order to ascertain the current status of perinatal pathology services in England and Wales a simple questionnaire was sent out to 21 consultant pathologist members of the British Paediatric Pathology Association who were known to work in fetal and perinatal pathology. 19 questionnaires were completed.

The information received revealed the following data:—

Consultant Sessions per Region

No of Sessions	*No. of Regions*
0	4
1-4	0
3-6	3
7-10	3
11-15	2
16-20	3

Senior Registrar Posts

Whole time	3
Part time rotation	2

Regional Support for Salaries

Consultants (whole)	3
Consultants (half)	2
Senior Registrars	2
Secretaries	1½
MLSOs*	2

* Medical laboratory scientific officers

Regional Support for Capital cost of Equipment

Faxitron	4 regions

Photographic equipment	2
Other capital costs	2
(5 regions involved)	

Regional Support for Recurrent Costs

1 Region only

In addition, at time of writing (April 1991) 2 new consultant posts are being advertised in Regions which currently have no consultant, 1 specifically for regional perinatal pathology and the other an academic senior lecturer post in paediatric pathology. An increase in consultant sessions is planned in at least 3 regions.

It is clear from this survey that perinatal pathology has attracted very little specific Regional funding although there has been a significant increase in the posts which have a whole time or part time commitment to the subspeciality. The lack of earmarked funding means that the work is mainly carried out on general funds allocated to histopathology departments. The regional perinatal pathology unit as envisaged by the RCPath Working Party hardly yet exists. One question asked in the survey was what difference NHS reorganisation was making, or expected to make, on the fetal and perinatal pathology service in the Region concerned. Those pathologists whose work merely involved fetuses and infants from their own hospitals did not expect much change. The majority, involved in examination of fetuses and infants referred for examination from a dozen or more other hospitals, were concerned that the advent of contract arrangements would have a deleterious effect, as discussed below.

Effects of NHS Reorganisation on Perinatal Pathology

Changes in the method of financing perinatal pathology will inevitably have a deleterious effect on the provision of the service unless special arrangements are made to protect it.

If the cost of providing a perinatal pathology service were divided by the number of fetal and perinatal autopsy examinations performed annually the cost of each examination would be extremely high, probably £300–£400. If the costs of additional tests performed by other departments, virology, cytogenetics etc., were added, the cost would be even higher, possibly £600 or more.

Any purchaser of services faced with such a cost is likely to query the need for examination or to suggest that it be performed by the local district general hospital pathologist at a lower price.

Budgetholders in general pathology departments are likely to prefer, as an initial measure, to absorb the costs of the perinatal pathology service into the general budget. As the pressure on such departments to become "economically viable" increases, there will be pressure on perinatal pathologists to abandon their time-consuming and uneconomic work on dead fetuses and neonates in favour of surgical pathology, cytology etc. which are low cost, high turnover activities. This pressure will be least where a Region already has a good perinatal pathology service and the paediatricians, obstetricians and geneticists are convinced of its value. The pressures will be most severe in those regions where a perinatal pathologist has only recently been appointed and has not yet shown the value of the service.

An alternative to a "cost per item" method of funding the perinatal pathology service would be for each maternity unit to "subscribe" to it annually at a cost which could be adjusted within broad limits according to the use made of the service. This method is planned in at least one region.

Costs of setting up and running a Regional Perinatal Pathology Service (1991 prices).

Capital equipment	Faxitron	£15,000
	Microscopes	£15,000
	Photographic equipment	£2,000
	Office equipment (word processors etc)	£8,000
	Capital Costs Total	*£40,000*
Salary costs:		
1.5 consultants		£80,000
2 MLSOs		£40,000
1 secretary		£18,000
	Salary Total	*£138,000*
Consumables:		
X-ray and photographic films, processing materials, stationary, postage, service of equipment, heating, lighting etc.		£12,000
	Recurrent Costs Total	*£150,000*

Basically the main recurrent costs are salaries, write down costs of equipment and the costs of running office and laboratory space. Consumable costs in histopathology are relatively low.

Some investigations such as immunocytochemistry and electronmicroscopy, appropriate to only a minority of cases, will usually be performed in the associated general histopathology department with absorption of costs into those of the main department.

Specimens referred by perinatal pathologists to other laboratories for ancillary tests (cytogenetics, DNA studies, haematology, microbiology) will however generate significant costs.

REFERENCES

1. House of Commons second report from Social Services Committee, 1979–80, London HMSO, (1980). R. Short, Chairman.

2. Organisation of Perinatal Pathology Services. Harrogate Seminar Reports 6. (1981)

3. Report of RCPath working party on paediatric and perinatal pathology. Bulletin of the Royal College of Pathologists 1990; 69: 10–13.

Examination of Witnesses

DR IAN RUSHTON, President, and PROFESSOR JONATHAN WIGGLESWORTH, British Paediatric Pathology Association, examined.

Chairman: Can I welcome the British Paediatric Pathology Association to our Committee meeting and thank you very much for coming to help us as part of our inquiry into maternity services. I see we have Professor Jonathan Wigglesworth, you are well-known to us, Sir, and we are very grateful to you for coming; and, of course, as President of your Association, Dr Ian Rushton, we believe the evidence that you and your colleague will be giving will be very valuable to our inquiry. Without further ado, can I pass the first questions across to Jim Couchman.

Mr Couchman

1238. Good afternoon. Could I ask you what distinguishes perinatal pathology from any other brand?

(*Professor Wigglesworth*) I think that one of the major distinguishing differences really between perinatal pathology and other areas of pathology is that it does involve a considerable knowledge of the background clinical medicine and associations from these practitioners. In the perinatal period there is not a long period of history to go on, usually, because, obviously, there may have been a relatively short gestation or a very short time after birth when the baby may die and, therefore, any possible clinical information that is available needs to be understood by the pathologist; that is one aspect. Another aspect, of course, is that it is an area of pathology where the results of the findings are of direct importance for the family concerned. If one of us departs suddenly, from a coronary, or something, that is very sad but the actual cause of our demise may not be of great significance to our family, apart from the actual fact of the loss, whereas in the perinatal period the precise diagnosis may be of critical importance for managing future pregnancies, for giving an assessment of the likelihood of a recurrence of this particular event.

1239. You take me into my second question, Professor, which is that I should like to ask you what part perinatal pathology can play in the further reduction of the levels of perinatal mortality and morbidity?

(*Professor Wigglesworth*) Clearly, one can answer that at a superficial level, because the problem is that perinatal mortality is itself a very restrictive term because we define it from the 28th week of pregnancy to one week past birth and we look at these figures of, you know, we are getting it down to sort of 8 per 1,000, can we get it down to 7 per 1,000, and so on. Of course, perinatal pathology can help to lower that particular figure because we may diagnose the cause of death in one particular case which has died in the perinatal period and say that this particular condition needs to be looked out for by specific techniques early in the following pregnancy and if a recurrence is recognised then the pregnancy can be terminated and it will not come into our figures.

1240. Can you take a more positive view?

(*Professor Wigglesworth*) As to a more positive view, clearly, what one is interested in, obviously, is lowering the whole range of perinatal loss.

1241. But you were at pains to say that perinatal mortality may well have a great relevance to the family concerned, where our deaths might not have?

(*Professor Wigglesworth*) Yes.

1242. What about the relevance for a subsequent pregnancy?

(*Professor Wigglesworth*) That is certainly an important point, that in the individual case the recognition of precisely what went wrong, the time at which some problem developed, say, in a case of a stillborn infant one may recognise that this was either a chronic, prolonged process which had gone on for some weeks or months and, therefore, problems earlier in pregnancy should be looked for during a subsequent occasion; or one may find that there is evidence of some rather sudden event, perhaps round about term, and that the pregnancy should perhaps be completed earlier in the following pregnancy, possibly.

[**Mr Couchman** *Cont*]

1243. The relevance, perhaps, for the mother's health?

(*Professor Wigglesworth*) Certainly, there may be relevance for the mother's health. I think why we are complaining, in a way, about the question is that I think that explaining the cause of a particular death may have much more important effects than just reducing mortality, the explanation of the mechanism of death may be very important in helping in the bereavement process in general. Even if it does not lower mortality rates, in a way, it must help in general terms to improve the quality of life; it may improve the quality of life subsequently for that particular family and help them to come to terms with exactly what went wrong on this occasion, whether or not you can prevent it occurring subsequently.

Chairman

1244. Could I come to Dr Ian Rushton, as President of the Association, and put this question to you. You have recently sent us, as you know, I think some very important evidence about the quality of perinatal autopsies. Can you please summarise your findings for us, briefly; i.e. what can be done to improve matters?

(*Dr Rushton*) What we did was survey the West Midlands Region, which is the largest health authority region, and we surveyed half of it and we looked at all the autopsy reports from that half, which came to 300 autopsies, and we scored these and set a minimum standard and, having set the minimum standard, we then found that just under half of these failed to reach that standard; in fact, if you take out the ones that were referred centrally then about almost exactly half of the post mortems we considered to be inadequate. The reasons for this were very varied but we came to the conclusion, firstly, that there is no point in doing a post mortem if it is inadequate; you are distressing the parents unnecessarily, you are not satisfying your clinical colleagues, who have asked specific questions of you about the death and you do not give them the answers, and this means that they will not ask for post mortems in future deaths because they feel they are not getting the right service from the pathologists. The way forward, as far as improving the pathology service, really there are several ways of doing this. One, which is really the basic one, is to improve the training of all pathologists in this field and the Royal College is attempting to do that but, at the end of the day, particularly the more obscure deaths, one will almost certainly have to increase, one *will* have to increase the number of specialist perinatal pathologists in the country.

1245. On that very point, Dr Rushton, as a layman, and on this Committee we are all laymen, can you just tell us, are perinatal pathologists paediatric pathologists or are they separate?

(*Dr Rushton*) They may be either, really. A lot of paediatric pathologists do perinatal pathology and a lot of perinatal pathologists do paediatric and there are few of us who do entirely paediatric or entirely perinatal. Basically, I do not think we would have any problem in finding that the standards of post mortems in perinatal deaths done by paediatric pathologists would be inadequate, they might even perform better than us, I do not know, we have not looked at that, but they would be included in the overall pool of pathologists who could provide a service. Because a lot of perinatal, certainly the neonatal deaths, that is the babies born alive but who die, many of them die in children's hospitals so they are, therefore, actually, if they have an autopsy, it may well be done by a "paediatric" pathologist rather than the perinatal pathologist.

1246. You talked about additional pathologists, Dr Rushton. Are you prepared, in front of this Committee, which is inevitably concerned with resources, to indicate the numbers which, from your experience, you feel might be necessary to provide the quality of service that you would wish to see provided?

(*Dr Rushton*) I can certainly speak for the West Midlands Region because I have been involved in establishing, or attempting to establish, a programme where we will increase the number and on the basis of the figures that the Royal College of Pathologists has produced, which they consider a reasonable workload for a perinatal pathologist, we have identified the need for four extra posts in the West Midlands Region and we are, in fact, well advanced already in the establishment of one of these posts. We have, in fact, had backing from the regional health authority in this programme and certainly there is the money waiting to be spent on one of these posts but we anticipate that it will take four or five years, if it does reach completion, before they would all be in post.

Rev Smyth

1247. I was thinking, Mr Chairman, that the answers we were getting there confirm that view that we live in an age where specialists are those who know more and more about less and less and it makes life more difficult. Can we, therefore, probe a little bit, Professor Wigglesworth, on your own particular view. We all welcome the fact that there has been a significant fall in perinatal mortality in recent years. Have you a particular opinion as to the reasons behind that fall?

(*Professor Wigglesworth*) I think, like anything, Sir, there are a number of reasons. One reason will be that a higher proportion of pregnancies which proceed towards term are wanted pregnancies now and, for instance, the relatively easy availability of social termination will have allowed that, so that more of those pregnancies which proceed are going to be wanted pregnancies and there will be positive incentives for people to turn up for antenatal care and to follow medical advice, as it were. Clearly, there have been very significant advances in obstetric care and there are continuing advances in obstetric care, in perinatal care and in neonatology, these are continual processes, and I think it is extremely difficult to dig out precise causes for falls of this type which have been relatively continuous; a lot of these factors have played a role.

1248. Would you agree, for example, that smaller family sizes, better education and better nutrition could also have played a significant part?

(*Professor Wigglesworth*) Yes, indeed.

[**Rev Smyth** *Cont*]

1249. Can I probe a little bit. When we think of reducing the number of perinatal deaths, there is no cause for congratulation, is there, in terminating earlier, that we have actually solved a problem?

(*Professor Wigglesworth*) None whatever, no.

1250. When you refer to "social" reasons, that would be absolutely distinct from the genetic reasons which have been advanced for termination in other cases; is that right?

(*Professor Wigglesworth*) Yes.

1251. Do you honestly believe that we should be solving the problem of perinatal mortality by "social" termination? Do you think we perhaps understand a little about the genetic manipulation and improving the quality of life, but really one would find it difficult if we are looking for the care of the unborn and the perinatal provision that we should underscore social reasons as a reason for improvement?

(*Professor Wigglesworth*) I am not advocating that, I am just saying this may well be a fact that those situations where young women who become pregnant may wish to have termination may be, say, the same situations which in the past gave rise to very high mortality rates: unmarried, young girls, we know that these were the things associated with very high mortality rates in the past. Although nobody is suggesting that this is would be a good reason, or would wish to promote social termination as a cause of reduction in perinatal mortality, it may still play some role.

1252. Yes, I can understand that. Can I ask is there any statistical evidence, from your own field of pathology, which confirms that a high percentage of perinatal deaths in the past came from single, young mothers?

(*Professor Wigglesworth*) Yes. I think that all statistics have shown that particular association.

1253. Was that the association or was it a health factor or was it a question of nutritional factors, that is what I am trying to probe?

(*Professor Wigglesworth*) It will be a mixture which will be very difficult to sort out in which health will be involved, nutrition, as you say, will be involved, there will be a whole number of reasons for this but, really, the whole question of causation of falls in mortality, although we are sure that improved medical care is important, clearly, is an extremely complex area and it is not one in which, as a practising pathologist, I would claim particular expertise.

1254. In the light and space of Dr Rushton's earlier answers, there would be questions over some of the evidence presented, in that 50 per cent of the evidence which was presented fell short of the minimum standard that was set in the West Midlands?

(*Dr Rushton*) In the autopsies, yes. It depends what you want to use an autopsy report for, once you have done the autopsy, and there are various uses to which they are put; obviously, the main one is to attempt to explain to the parents why they have lost a particular baby but by no means all such deaths are explained. There is then, of course, a need to provide answers to the people who have actually looked after the baby, the obstetricians or the paediatricians who have been concerned with the care of the baby, not only to give them an answer to a cause of death. I think there is a danger in dwelling on causes of death. We are much more interested these days in actually delineating the disease processes these babies have because often when a baby dies it has a whole host of conditions which might have killed it and when you fill in a death certificate you often have to fill it in, "Well, I will choose A today" and another day "I might choose B" as the actual cause of death.

1255. For adults, as well?

(*Dr Rushton*) The same is true for adults as well, yes, but I think it is more so with babies because the very sick, for instance, premature baby may well die with a whole host of lethal conditions which you have to arbitrarily choose and the trouble is that these are the statistics which the OPCS use to provide incidences and causes of death. I would much prefer that we could actually say, "Well, 29 per cent of babies have disease process X and another 20 per cent have disease process Y" and then try to determine the causes and the methods of prevention of each of these individual processes.

Sir David Price

1256. Following that up and going to a different aspect of causation, how successful do you reckon perinatal pathology has been in providing assessments of new diagnostic techniques, and one thinks immediately of ultrasound, in checking efficacy and safety?

(*Dr Rushton*) Again, one has to assume that the standard of autopsy is high enough to do this, but I think it is absolutely critical because with many of the disorders which are diagnosed antenatally by ultrasound the only proof that the diagnosis is correct is an adequate autopsy. With other techniques, for instance cytogenetics, you can prove that a baby has a chromosomal abnormality without doing an autopsy, you will not know what malformations that baby has, but I think it is absolutely critical, in monitoring the outcome of tests, it is an essential part of audit that you must follow up what you do, otherwise, and I know from my own experience that errors are made, unless these are brought to the notice of the clinicians they will think, "I am doing fine" but once you are told that a pregnancy has been terminated which was normal which was believed to be abnormal it makes people think. In later stages, for instance with the neonate, then you are into the question of the neonatologist with his armamentarium of clinical apparatus is very good at producing disease in these babies while he is trying to cure them of the disease that they have got and I think one of the crucial things that perinatal pathology has done is it has identified these disease processes and, as a result, the treatment of babies has changed because we have said, "Look, you are producing damage", oxygen was one of the prime factors of damaging the lungs, so that you can monitor clinical care as well.

1257. Following that line of thought, can you pick up inadequate nutrition, for instance, or wrong nutrition?

(*Dr Rushton*) You can certainly see if the baby is poorly nourished. It may not be inadequate, in the

[**Sir David Price** *Cont*]
sense that everything has been done to give it adequate nutrition and we just do not have the facilities or the knowhow actually to nourish babies adequately. Certainly, in certain areas, for instance in bone disease in babies which are on prolonged intensive care, the incidence of brittle bones, not brittle-bone disease but brittle bones, in these babies was noted and then the biochemists got to work and noticed that these babies had abnormalities in their calcium and phosphorous metabolism and now this is treated, or attempts are made to prevent this happening, so that you can identify things which are treatable and also things which are produced by treatment.

1258. Going back to my original question, are you able to identify whether a diagnostic technique, like ultrasound, has had a detrimental affect, to produce the pictures, as it were, the clinician wanted?
(*Dr Rushton*) You mean the actual technique is having a detrimental effect?

1259. Yes. I do not take this question out of the blue because it was suggested by one lot of witnesses?
(*Dr Rushton*) I think that the evidence that ultrasound, *per se*, produces any damage is very minimal in the doses in which it is given, but certainly you can identify that other things which are done cause damage, not necessarily ultrasound. In the past, people have identified the dangers of using radiation, x-rays, during the pregnancy and I have already mentioned the use of high levels of oxygen in babies and it may well be that with some of the newer treatments, for instance the use of artificial surfactant, we do not know yet what effects this may have in the long term on babies.

Mr Couchman

1260. What about amniocentesis; suggestions have been made to us that this was not always benign?
(*Dr Rushton*) I think any interventional procedure must carry a risk, whatever happens. Recently, there has been the problem of babies who have limb reduction malformations, where they have parts of limbs missing, which may be related to amniocentesis; certainly in the experimental situation you can produce the equivalent abnormalities in animals by doing amniocentesis.

Chairman

1261. Could I ask you then, Dr Rushton, whether the perinatal autopsy really also assesses the standard of work of the relevant health professionals, because you have implied that just now? Therefore, could it be used to assess the standard of work of other health professionals, such as paediatricians, obstetricians, and if so would it, therefore, appear in the autopsy report, so that this might—and I am not being provocative—well be evidence which could form part of litigation at a later stage, if the parents felt that some of the care which had been given to the baby had not been up to standard?
(*Dr Rushton*) I think that is certainly true, that you can provide evidence. In fact, I think both of us have been involved in cases of litigation where the pathology found in the baby has been of crucial importance in the case. Certainly, some of the pathology which is associated with the severely brain-damaged baby, that obviously had first to be described and it was described by perinatal pathologists, on the whole.

1262. Do you think that that might prevent a perinatal pathologist from doing a full and honest report?
(*Dr Rushton*) I would hope not.

1263. Professor Wigglesworth, you shook your head.
(*Professor Wigglesworth*) I will tell you why. I think the point about this is that it can cut both ways. I get asked to provide reports for medico-legal cases relating to alleged brain damage or, very often, nowadays, in cases where the baby has actually died and the parents are prepared to go to court, even though they know that there will not be huge sums of money to be gained by so doing; the pathology can quite often indicate that damage occurred before the questionable period of, say, round about birth. It may be alleged that the obstetrician should have carried out a Caesarean section when the cardiotocograph had shown particular dips in the fetal heart rate or there was meconium in the liquor, but if the pathology demonstrates established damage in the brain or in other organs which had clearly preceded that event then this will put a totally different complexion on the case. We are specifically investigating the brains of babies even who die *in utero*, before labour has occurred, to see how often it is that we find evidence of damage in the brain which has fully developed before the final event which led to death, so we are getting a lot of information about this. I think it is always useful and important to have a good autopsy in such cases and the litigation process is a very good reason for ensuring that one does get good autopsies, because I think that although on some occasions they provide the evidence which may help the plaintiff and establish that something clearly did go wrong with the management, on other cases they do quite the opposite.

1264. So they are objective?
(*Professor Wigglesworth*) They are objective.

1265. Do you think, either of you, that the right to such an autopsy should be given to parents or should be available for parents in the Patient's Charter?
(*Dr Rushton*) Yes, I would have thought so.
(*Professor Wigglesworth*) Yes, definitely.

Mr Hinchliffe

1266. In your evidence you have argued strongly for the preservation/establishment of regionally-based services for perinatal pathology and we know that the Government have taken certain steps on this. The Department of Health asked all regions to have one such pathologist in post by April of this year and review for the requirements during the next year, during 1992. What have the regions actually done, from your experience, what is the position in the regions at the present time on this issue?
(*Professor Wigglesworth*) I think there is quite a lot of variation. At the time that I presented my document we found that there were four regions which did not have any pathologists, that had

[**Mr Hinchliffe** *Cont*]
sessions devoted purely to perinatal pathology. Now, there is some fluctuation and I think there have been further posts since then, which was in April of this year.

Alice Mahon

1267. Which were the regions?
(*Professor Wigglesworth*) I cannot tell you, off-hand.

Mr Hinchliffe

1268. Do we know why there were these variations; do you have any reasons why there are these differences? In other words, what were the reasons why those regions did not act, despite the information from Government?
(*Professor Wigglesworth*) I think there is probably a whole variety of reasons, this is not something that has been specifically investigated by our pathologists. From knowledge of the regions in which perinatal pathologists now work, it has usually taken pressures from several different directions to get posts established. There has to be interest from the pathology departments themselves to have a post, there has to be interest from the obstetricians and the paediatricians and then there has to be goodwill on the part of regional administration and I think some regions probably have been dragging their heels on this. The other point is, certainly, that it has not been particularly easy to get trained people to appoint in some instances.
(*Dr Rushton*) Could I just add a point to that. In fact, regretfully I say this but I think a lot of the hold-up has actually been as a result of the activities of other pathologists, because when money is produced for a new pathology job it tends to go to those jobs, or the incumbent pathologists have applied for posts to take the workload off what might be termed the front-end of pathology, i.e. surgical pathology or cytology, where there has to be a rapid turn round and the patients are still alive. Perinatal pathology is, largely, almost entirely, an autopsy-based service. Certainly, when I trained I was given babies to practise on before I went on to do adults. I think this practice has largely died out but it was very common when I was a trainee pathologist.

Chairman

1269. If I were you, I should define and qualify that, otherwise it might be misreported?
(*Dr Rushton*) When you did your first pathology job, your consultant, for whom you were working, told you that you could go and do a post mortem on a baby and when you had done some babies you would then, if you like, move up the ladder, so that, in fact, perinatal pathology, in essence, really is a relatively young specialist branch of the subject and where limited funds have been available the pathologists, on the whole, have preferred to ensure that the surgical pathology service is running properly, the cytology screening, etc., etc., and deaths are not, perhaps, as important. The message that we have been trying to get over is the need that the perinatal pathology is different and it does affect the future reproductive behaviour of families, it is not simply your elderly relative dropping dead.

Mr Hinchliffe

1270. Can I pursue this point in a slightly different direction. I had correspondence with the Home Office and a local coroner some time ago on the issue of the role of the coroners in the investigation of perinatal deaths. Can you describe, from your own point of view, how you view the role of the coroner in the investigation of perinatal deaths and say whether you feel perhaps the information available to coroners at the local level is adequate for them to fulfil their duties in the way they would be expected to fulfil them in respect of the death, say, of an adult or an older child?
(*Professor Wigglesworth*) Clearly, they are involved in some perinatal deaths; clearly, if the baby is found dead unexpectedly in the neonatal period or if there is a very rapid death. Clearly, the role that they have been granted and have had traditionally is that of determining whether deaths were due to natural causes or not. In the perinatal period the problem is that that is not usually the question. If a baby is found unexpectedly dead, shall we say, having apparently been healthy at birth, and is found dead in the cot, say, two days after birth, as happens, unfortunately, every now and again, clearly, the real question should be what was the cause of death in this case and what processes have been going on, in the same way as in any other perinatal death. If such a case gets referred to the coroner, clearly, his only mechanism of investigating it is to whether this is a natural death or not. Coroners have been advised to refer perinatal deaths and sudden infant deaths to specialist paediatric pathologists wherever possible and many of them do. In our own area, my coroner actually sends in to me problem cases from other hospitals and even if we get a problem case in our own hospital, where he might have thought there would be a conflict of interest, he would rather that we investigate the death than somebody who is more used to dealing with deaths due to a knife in the back, as it were. That does not apply to all coroners and I think that is where the problem lies, that the role that the coroner has is not really, in such cases, the role that we would like to see for many of these deaths, where the question is not as to whether it is a natural death or no, because we usually are pretty certain it is a natural death, but precisely what has gone on.

1271. Going back to my original question, which related to the regional variations in the ability to perhaps undertake the appropriate investigations, is it not fair to say then, from the answers that you have given, that perhaps the ability of the coroner to fully investigate a cause of death varies from area to area, depending on the back-up support of the services available in that particular area?
(*Professor Wigglesworth*) That is perfectly true, I would agree with that entirely; although I would say that even in areas where such facilities and expertise is available there are coroners who will not refer cases to specialist paediatric pathologists. Certainly, there are hospitals not too far from where I work where if it is a normal perinatal death which is not referred to the coroner we will do the investigation; if it is an unexpected death then the coroner gets somebody who is not a skilled paediatric pathologist to do the work and that is certainly an additional problem.

[**Mr Hinchliffe** *Cont*]

1272. Do you feel that there is a need, bearing in mind the comment you have just made, for further guidance to be issued by the Home Office to coroners about the way they handle the investigation of such deaths?

(*Professor Wigglesworth*) I would be happy to see such advice given, yes.

Chairman: In order to give you an opportunity perhaps to qualify what you have just said, if you would like to send us a short paper on the sort of advice you would like to see given, please send us a note, Professor Wigglesworth*.

Audrey Wise

1273. Professor Wigglesworth, in your memorandum you said: "Changes in the method of financing perinatal pathology will inevitably have a deleterious effect on the provision of the service unless special arrangements are made to protect it." Are you saying there that if there has to be a "fee for service" approach, with the new contracting system your speciality will be squeezed by purchasers?

(*Professor Wigglesworth*) Yes, I would say that is a very great danger and it is one which, as I explained in the document, many of our colleagues are concerned about because, clearly, the true costs of doing a complex autopsy examination, with subsidiary cytogenetics and virology and radiology, photography, a whole range of investigations which may be absolutely essential to investigate the case, the true cost, if one had a "fee for service" basis, might be many hundreds of pounds. Clearly, any hospital administrators faced with such a bill from, say, a regional specialist service would say, "We have got a perfectly good pathologist in our hospital, why cannot he do the post mortem; he is not going to charge this sort of sum?" and that is the real problem. I think that the other problem is that in the pathology departments themselves, where a decision may have been made to try to absorb such costs, somebody who was appointed to do perinatal pathology, may, when it is seen that big bills cannot be sent out for perinatal autopsies, then be directed into doing cytology, or something, where a lot of money can be produced by sending out a very large number of very small bills for cytology reports and so it is much easier to get money in for a large number of small items than for a few large ones.

1274. You are saying really, I think, that a market approach to your particular speciality is likely to produce distortions which are not going to be beneficial to babies and parents; is that right?

(*Professor Wigglesworth*) Yes. That is if it is done on a "fee for service" basis. What has been suggested to get round this, and I think this is true, probably, for other, what you might call small area specialities, such as clinical genetics and a number of other areas, is that those who are likely to use the service should fund it by a "fee per patient" basis, such as would be a cost per maternity patient delivered, rather than per perinatal death. So that a maternity hospital with so many thousand births per year would pay a certain sum for each birth towards the provision of perinatal pathology services and this could be part of the quality scheme relating to the provision of the maternity services; you would expect there to be good perinatal pathology services provided as part of maternity care.

1275. If I can refer back to a question that you were answering, Dr Rushton, when you were talking about statistics and death certificates, do I understand that you would like there to be some different arrangement for collecting statistics about causes of death in infants, or would you think that should be examined?

(*Dr Rushton*) I think it is not necessarily that we want to collect the actual causes of death because, as I indicated, there may be multiple causes; what we really want to know is the incidence of particular diseases in babies which die and this is a different question.

1276. What I meant was, do you think that you should have an opportunity of inputting that to the OPCS statistics, instead of having to choose today A, tomorrow B?

(*Dr Rushton*) Yes, providing then it is used appropriately. I still will have the fear that somebody, somewhere, will pick one out of that list and produce it in a statistical table and ignore the others.

Audrey Wise: I think it would be interesting to have a note on this particular thing, because we are interested in statistics.

Chairman

1277. Dr Rushton, are you prepared to drop us a short note if you feel you would like to expand on what you have said to the Committee?

(*Dr Rushton*) Yes*.

Alice Mahon

1278. Will the service be able to cope with the work involved in the confidential inquiry announced recently into stillbirths and deaths in infancy, as the Minister of Health claimed it would at the inquiry's launch?

(*Professor Wigglesworth*) I think the problems there are, firstly, it may depend on exactly how the inquiry is managed and I am not quite certain what is happening. It would, clearly, also depend very much on work load in individual regions but, having said that, I think that most of us will find it fairly difficult to undertake additional responsibilities without additional assistance and, certainly, in the regions where there is no perinatal pathologist I do not see how they can possibly do it, they may have to drop perinatal pathology from their area of the inquiry, which would be very sad.

(*Dr Rushton*) I think the other thing which has caused us great concern is that the inquiry was announced and we, as pathologists, have not been approached about the inquiry and, also, when I attended a meeting of the British Association of Perinatal Medicine, hoping that I would find out more about the inquiry, nobody there knew anything about it and I think that the problem is that the right people have not been approached and, certainly, we would have felt that if there were going to be another inquiry into perinatal mortality one of the groups which should have been approached was our own.

*See page 520

[**Alice Mahon** *Cont*]

Alice Mahon: Perhaps we could ask for some more information on the progress of the inquiry?

Chairman: Indeed, we certainly could and, of course, as you know, this Committee has done inquiries into perinatal and neonatal mortality and, from time to time, we do follow up inquiries. No doubt, your views, Dr Rushton, will be taken fully into account by us even if not by the Department of Health. Can I thank you, Dr Rushton and Professor Wigglesworth, for coming to give us your views in answer to our questions. Thank you very much for the helpful evidence that you have given to us.

Supplementary memorandum submitted by Professor Jonathan Wigglesworth

CORONERS AUTOPSIES ON YOUNG INFANTS

Deaths of young infants which are referred for investigation to the coroner include many where there is an overwhelming probability that death was due to natural causes. These will include the majority of cases where an infant of a few weeks to several months of age is found unexpectedly dead at home and almost all cases where an infant is found dead in hospital.

A particularly important group comprises those infants who die very early in the neonatal period after an apparently normal birth.

A full investigation into the causes and mechanisms of each such death is of major importance for the parents and their advisors. The investigations required are often more extensive and costly than those required by the coroner in order to perform his statutory duty of determining that death was due to "natural causes". They may include radiology, cytogenetics, bacteriology, virology and biochemical studies as well as extensive histology including neuropathology.

Coroners should be urged to call on the services of Regional perinatal or paediatric pathologists to assist in investigating such cases, particularly the early neonatal deaths in which a genetic cause is most likely to be discovered.

Memorandum submitted by Dr Ian Rushton

EVIDENCE TO HEALTH COMMITTEE—4.12.91

Further to the above meeting the following written evidence expands the points I was making relating to the inadequacy of data collected on perinatal deaths for the purpose of certification of these deaths.

As I indicated in my oral evidence many very sick babies may die with several lethal or potentially lethal diseases. The death certificate makes it necessary to prioritise these conditions. Such prioritisation may be done differently by different doctors who complete such certificates and is also almost certainly not done consistently over a period of time by any individual doctor. It is therefore my contention that it would be more valuable, particularly when considering methods of reducing the perinatal mortality rate if the disease processes were recorded so that the overall incidence of these diseases could be determined. Though often interlinked the causes of these diseases in an individual baby may be different and will therefore require different measures to treat or prevent them. If the true incidence of these diseases is recorded then not only the relative frequency will be known but also it will enable a clearer view of areas for research to be obtained. I would however add the proviso that accurate diagnosis of these disorders is often dependent on an adequate perinatal autopsy. Thus if such data is to be obtained it can only be done so with an adequate autopsy service. This is dependent not only on the availability of the appropriate expertise but also on the willingness of the health authorities to purchase the service. As we emphasised at the oral hearing we and our colleagues have major concerns that health authorities will prefer to spend such monies as they have on the living rather than the dead. This approach will inevitably result in the decline of perinatal pathology services and the accuracy of data on perinatal deaths.

December 1991

Memorandum submitted by Support After Termination for Abnormality (SATFA)

SUMMARY AND RECOMMENDATIONS

1. More than 2,000 women each year undergo a termination of pregnancy because of fetal abnormality.

2. There is a growing literature showing that terminations of pregnancy for fetal abnormality should be likened to any other perinatal bereavement, but very little evidence to show that this happens consistently.

3. It is essential that women are referred quickly for confirmation or refutation of a diagnosis with the minimum of conflicting advice.

4. It is important to give couples full and clear information about the specific abnormality to enable them to reach a decision.

5. All parents should be given the SATFA Parents' Handbook.

6. If a couple do decide to have a termination of pregnancy the whole process of labour and all medical procedures should be explained in as much detail as they require.

7. Consideration should be given to the relief of pain and the use of epidural analgesia where appropriate.

8. Couples should be given a separate room of their own and full consideration given to the woman's partner.

9. The midwife should discuss with the parents the possibility of seeing and holding their baby.

10. A photograph should be taken and either given to the couple or kept on file for the future.

11. The nature of the post mortem and burial of the baby should be discussed with parents. And, if requested, help given in organising a private funeral.

12. Thorough medical and genetic follow up for the family should be carried out.

13. There should be routine follow up by a midwife as women experience the physical changes which accompany any birth as well as possible psychological problems. One home visit is essential and then as many as the midwife thinks is necessary.

14. Consideration should be given to the support needs of staff who participate in terminations of pregnancy. A review of their training should be undertaken to include bereavement support and counselling.

1.1 Support After Termination for Abnormality (SATFA) is a registered charity run by women and couples who have experienced a termination of pregnancy because an abnormality was diagnosed in their baby. As well as offering individual and group support to other parents, SATFA aims to raise public and professional awareness of the physical and psychological needs of parents during this sad and difficult time and in their future pregnancies.

1.2 The emotional consequences of a termination of pregnancy for abnormality and the need for continued support have been well documented[1,2]. SATFA hopes that by working with health professionals we will encourage good practice and a greater understanding of the individual needs of parents. We hope that services and support to women during their prenatal screening, their time in hospital, and especially on discharge into the community will be enhanced.

1.3 The detection of an abnormality in their unborn baby is usually unexpected, and always, devastating for parents. The hopes and expectations of a healthy baby/child are shattered and, whilst in a state of shock, parents have to make difficult and painful decisions about the future of the pregnancy. More than 2,000 parents each year, make the decison to undergo a termination of pregnancy because of fetal abnormality. "Terminations of pregnancy for fetal abnormality, and infants born with 'birth defects' are officially notifiable, but there is reason to suspect considerable under-reporting."[3]

1.4 "It is important to recognise that parents who have lost a pregnancy by natural miscarriage or by termination of pregnancy may feel as much grief as after a stillbirth or neonatal death, and the period of grief may be prolonged."[3]

1.5 SAFTA has produced a Handbook which should be given to parents at the time of diagnosis of fetal abnormality. The Handbook deals with the practical, physical and psychological aspects of a termination for fetal abnormality. It considers such issues as the means of termination, seeing and holding the baby, funerals remembrance, grief, family life, future pregnancies and so on. The Handbook will be available, free for parents, in all hospitals throughout the country. It has been distributed to all consultant obstetricians and managers of maternity services.[4]

1.6 SAFTA would like the Health Committee to consider the needs of parents who undergo a termination for fetal abnormality within the inquiry into Maternity Services. As the experience of diagnosis, termination and after care takes place within the ante natal period we have addressed all issues in this report. The Committee may choose to consider some aspects of the report at a later stage.

Pre-conception care

2.1 Most infants with congenital malformations and chromosomal disorders are born to healthy young women with no previously identifiable risk factors. It seems unlikely that these sporadic disorders can be prevented, and neither diagnosis nor intervention is possible before the woman becomes pregnant.[5]

2.2 There are those couples who are carriers of inherited disorders. In this circumstance when a genetic risk is known the necessary investigations need to be carried out before a pregnancy occurs so that testing can be offered as a planned procedure. "Screening and counselling for inherited disorders need to be offered at the pre-conception stage, ie these services should become part of family planning. This is starting to happen.

Education about reproductive risk should begin in schools, and be reinforced in primary health care prior to conception, particularly in family planning clinics."[5]

2.3 Any parent who has had a termination of pregnancy for fetal abnormality should be referred for genetic counselling before they consider future pregnancies. This will provide the opportunity for consideration of personal or family history of genetic disease or fetal abnormality. Parents can be given information on the probability and possibility of recurrence and information about any risks that other children may have. Suggested questions which parents might ask are in the SATFA Handbook.[4]

Ante natal care

3.1 An important component of ante natal care is prenatal screening. A very large part of the responsibility for delivering these services falls on the primary health care and maternal and child health services. "Identification of high risk factors usually occurs when a patient presents to her family doctor, midwife or obstetrician for ante natal care. Careful ante natal history taking, including family history and past obstetric history noting the patient's age and any medical conditions, will identify many of those at higher risk of having a baby with problems."[1]

3.2 The majority of women are subject to some form of routine screening during pregnancy. For example it could be through maternal serum AFP screening or ultrasound anomaly scanning. Most parents see screening as a confirmation of the health of their baby. Few expect to be told that their baby has a severe abnormality and are therefore unprepared for the consequences of such screening. It is therefore important that parents are fully informed of the nature of the tests and their implications. Many ante natal clinics have written information so that parents can absorb the information in their own time.

3.3 It is essential that all screening methods should be reliable. They should have a high detection rate and a low false positive rate. When a test result indicates that a repeat test or further action is required, this result should be communicated quickly to the mother by a professional person familiar with the test and its interpretation in order to answer the inevitable questions and to provide appropriate information and support.

3.4 The way information is communicated can vary greatly. Many staff do not feel comfortable in giving "bad news" and are given little training in counselling in this area. For example, staff need to consider what happens when a mother is telephoned at home; it may be that her partner is not present and he should be called before the information is given. Should confirmation of test results be sent through the post? In some areas the community midwife is the person who will visit and take the results to the parents spending time with them discussing the implications and offering support. Follow up can then be arranged with the consultant obstetrician, paediatrician or whoever else is needed for parents to make an informed decision on the future of the pregnancy.

3.5 Particular problems arise in tests where the results are immediately available, such as in ultrasound scanning, but where the full implications of the observed anomaly may not be apparent. Each centre needs to have an agreement between the obstetric and radiology staff on the management of these difficult situations in terms of communication with the parent if fear and anxiety are not to be increased. Inevitably, when an abnormality is suspected the mother perceives that something is wrong. The non verbal communication of body language alerts parents. "Full information, advice and support, rapid obstetric back-up and expert counselling should be available on the spot. Obstetric ultrasound scanning requires appropriate training, a high standard of supervision and a clear code of practice."[5]

3.6 It is essential in such situations parents are not left to go home alone. The partner should be present, if possible, when the diagnosis is given. If this is not possible or desired a friend or relative should be called to allow for a safe journey home. In SATFA's experience mothers have left the clinic in a state of extreme distress and have been allowed to drive home risking their life and the lives of others.

3.7 Many parents will seek further information before reaching their decision. They may seek information from their GP, paediatricians, disability and other support organisations. It may be that they will require several visits to the hospital to have information repeated to them. For when people are in a state of shock they do not always absorb all that is said. Hospital staff should be prepared for this and be sympathetic to the needs of parents.

The decision

4.1 The decision to terminate a wanted pregnancy because of fetal abnormality is one made out of care for the unborn child and in consideration of existing family. It is not a decision taken easily or lightly and will remain with the family forever. Once parents reach the decision to terminate the pregnancy who discusses the process with them? Are they informed of the procedures that will be used; have they had enough time to think, not necessarily to doubt, but to prepare themselves for a process that the woman's body will naturally want to resist? Have they had any help in starting the grief process. It is at this stage that the SATFA Handbook may be useful for parents. It addresses many of the questions they will need to consider such as seeing and holding the baby, funerals and so on.

Admission and delivery

5.1 Until recently, the psychological implications of abortion for fetal abnormality were sadly neglected by comparison with technical aspects of prenatal diagnosis. Mothers undergoing this procedure at any stage of pregnancy require constant expert and sensitive physical care, and psychological support and bereavement counselling should be readily available to them.[5]

5.2 Terminations of pregnancy take place on both labour wards and gynaecology wards according to the policy of the hospital. Within SATFA parents have different views as to the most appropriate place for a termination of pregnancy to take place. Some have found being on a labour ward with other pregnant women giving birth very distressing. Others have found that being on a gynaecology ward can add to their sense of isolation and failure in motherhood. In order to address this parents should be given a side room.

5.3 Wherever a termination of pregnancy takes place sensitive and aware handling is essential. No one can take away the pain, anger, sadness and loss. But how the parents come to terms with the loss of their baby can be helped by sensitive and thoughtful practice. Each parent's circumstances are different and this will affect how they cope with the experience. For some it may be their first pregnancy, others may have experienced previous miscarriage and so on.

5.4 Co-ordination of information is necessary on the ward. All staff need to know why the pregnancy is ending in this way. Continuity of care is important also so that information given to parents is consistent and a relationship can be established between the woman, her partner, and those caring for her. It is important for staff to discuss again with parents the actual procedures used on the ward to induce the pregnancy and a birth plan if appropriate.

5.5 Once the labour has been induced pain relief should be available to the mother, e.g. pethidine and morphine derivatives, epidurals etc. It is important to give the mother a warning that some women find the haze and loss of control induced by pethidine is worse than the pain it is supposed to stop. If the mother has been too heavily drugged she may feel detached from the labour and not properly able to see, hold and experience her baby after delivery.

5.6 It is at this stage that staff will be able to discuss with parents the issues of whether they wish to see and hold their baby and their requirements for a funeral. Many parents are ambivalent about seeing and holding their baby. Their fears and fantasies of a monster can be extreme. It can be helpful to discuss it during the labour giving parents a chance to change their minds. Sensitive encouragement can help. In the experience of SATFA no parent has regretted seeing their baby but many have regretted not seeing him or her. Many parents have found that holding the baby, although dead, has made her or him more real and has helped in coming to terms with their loss.

5.7 The delivery of the baby needs to be handled with dignity as for any birth. To deliver a baby into a bedpan can cause distress and humiliation. Sometimes it may not be possible to avoid this but continuity of care by experienced staff can help in monitoring the labour and birth. And in this the special skills of the midwife can be invaluable.

5.8 Some hospitals routinely photograph all babies. Others will do so if asked. This is a recognised part of support in stillbirth and neonatal death and needs to become accepted practice in all forms of loss in pregnancy. The quality of the photograph and the way the baby is laid out is important to parents. This will be one of their most cherished memories of their baby so the need for care and respect cannot be exaggerated. If a parent does not want a photograph a copy must be kept on file.

5.9 Remembrance of a formal kind can seem quite strange to some people. For many parents, even those not especially religious, a church service or blessing can be helpful. Ward staff can help parents understand that these ceremonies and memories are available and perhaps arrange a visit from the hospital chaplain or social worker.

5.10 As there are no legal requirements to bury or cremate a baby born dead before 28 weeks often such babies are cremated by the hospital following post mortem examination. However, there is no reason why a baby, whatever her or his age, should not have a funeral and/or burial service if that is the wish of the parents. Many parents are often unaware of their rights and it would be helpful if the hospital chaplain or administrator were available to discuss this.

5.11 After delivery the placenta is often retained. In such cases a D&C is necessary. Some hospitals routinely do this to prevent possible infection. In SATFA's experience many mothers who have not had a D&C experience prolonged bleeding which requires admission at a later date for a D&C and this adds to their distress. This issue needs to be given further consideration.

5.12 A detailed post mortem will need to be carried out to confirm the abnormality and to determine the condition which affected the baby as accurate information is essential for future genetic counselling. If the parents wish to have the baby buried staff need to inform anyone who will be involved in the post mortem.

5.13 The needs and feelings of staff involved in terminations for abnormality need to be taken into consideration. It is a difficult and demanding task to be involved in and all those staff who have objections

based on moral grounds should be allowed to invoke the conscience clause. Support and training needs to be built into the system for those staff who do participate in terminations of pregnancy. It has become obvious to us from the many seminars and training sessions in which we have participated that staff need time to reflect upon the powerful feelings which are evoked within them. They also have fears about how an abnormal fetus will look, and many younger members of staff experience some difficulty in holding the fetus and giving support to parents who are experiencing great distress. For example in one hospital the manager of maternity services has requested that SATFA offer direct support to any of the staff, for whom she is responsible, if they experience difficulty in this area of work.

5.14 "Abortion for fetal abnormality should be carried out in a unit with specially trained staff. Most prenatal diagnosis is still done at 16 to 20 weeks' gestation, and the decision to terminate a pregnancy because of fetal abnormality is usually made at about 20 weeks' gestation. Mid-trimester abortion of a wanted pregnancy is psychologically painful and distressing both for the mother and for attendant staff."[5]

After Care

6.1 Many women do not realise that they will lactate and this can be devastating for the mother. All parents should be forewarned and given drugs to prevent the milk forming if that is their wish.

6.2 There is no statutory requirement for the primary health care team to offer any support to parents when they have been discharged from hospital. All that is left for the parents is their grief. She has given birth to a baby she knew would die. She has been through labour, no less than had she reached 40 weeks of pregnancy, when she would have had a midwife visiting and a health visitor allocated.

6.3 In a recent survey of 112 SATFA members regarding after care only 36 per cent received a visit from a midwife and of those 85 per cent found the visit helpful. 94 per cent of those who received no visit stated that they would have liked one.

Advice was needed on

Lactation	61 per cent
Bleeding	72 per cent
Future pregnancies	83 per cent
Emotional/spiritual	22 per cent
Genetics	18 per cent

The timing of the visit

1st day	11 per cent
2-4 days	31 per cent
1st week	42 per cent
2nd week	11 per cent
More than one visit	26 per cent

Obviously many women feel that they would have benefited from a visit from a midwife on discharge. It is important in giving recognition to the fact that the woman has been pregnant and has given birth to a baby. The skills of the midwife are needed to ensure that the woman's body is coping with the after effects of giving birth and that she is also coping emotionally with the consequences of the termination of pregnancy.

6.4 Six weeks after the termination the woman should be given a check up either by the GP or obstetrician. It is important to consider where this happens. Does it have to be in a post natal clinic or ante natal clinic? Being around other pregnant women and young babies can be extremely distressing. It is at this time parents are often given the post mortem results. Referral to a genetics clinic should always be considered. All information given to parents should be in words they understand. It may be helpful to give parents written information so they can consider it at a less stressful time. At this stage consideration should again be given to the emotional needs of the parent and access to bereavement counselling if this is necessary.

REFERENCES

1. Donnai (1987) The management of the patient having fetal diagnosis. Bailliere's Clinical Obstetrics and Gynaecology Vol 1 No 3:737-745

2. Lloyd J & Laurence KM (1985). Sequelea and support after termination of pregnancy for fetal malformation. British Medical Journal 290:907-909

3. Royal College of Obstetricians and Gynaecologists (1985). Report of the RCOG Working Party on the Management of Perinatal Deaths

4. Support After Termination for Abnormality (1991). A Parents' Handbook

5. The Royal College of Physicians (1989). Prenatal Diagnosis and Genetic Screening. Community and service implications

Examination of Witnesses

Ms Joanie Dimavicius, Director, and Ms Helen Statham, Vice-Chair, Support After Termination for Abnormality (SATFA), examined.

Chairman

1279. Ms Dimavicius and Ms Statham, thank you very much for coming to give evidence to us. I apologise for Members having to go but there are important other meetings going on in the Palace today, but as long as we retain a quorum your evidence will be as valuable, whether or not there are many here or perhaps only the select quality few. Perhaps you could both state exactly who you are, for the purpose of the record?

(*Ms Dimavicius*) Thank you. I am Joanie Dimavicius and I am the Director of SATFA.

(*Ms Statham*) I am Helen Statham and I am the Vice-Chair.

1280. We are concerned about your evidence of the under-reporting of terminations for fetal abnormality; how big a problem do you think this is and what effects does it have?

(*Ms Dimavicius*) We commented in our evidence on a report by the Royal College of Physicians on genetic screening and prenatal diagnosis, where they themselves suggested under-reporting and we thought that was important information for the Committee. In recent discussion with one of our advisers, Dr Bernadette Modell, of University College Hospital, she herself is a specialist in the haemoglobinopathies and, looking through work which she did with patients who had thalassaemia, she went back through their case notes in 1988 and 1989 and the forms which should have been sent to the Department of Health, notifying that there had been a termination of pregnancy, in one year there were 20 per cent of those forms still on file and in another year there were 40 per cent of those forms still on file; therefore, no notification had gone to the Department of Health and, subsequently, to OPCS. What Dr Modell believes is that if that happens in her hospital and that particular grouping of patients then perhaps it is also happening elsewhere.

(*Ms Statham*) There is additional evidence: a recent paper in the British Medical Journal earlier this month, from Dr Lyn Chitty, who is now at Guys, who reviewed all the ultrasound scans done at a district general hospital, the Luton and Dunstable, over a two-year period, 1988-89: 52 pregnancies were terminated because of fetal abnormality there from just under 9,000 births. This gives an incidence of 1 in 168 and if you multiply up for the whole country, assuming about 700,000 live births, it gives about 4,300 terminations a year. Similar sort of data has come from another of our advisers, Dr Shirley, from Hillingdon Hospital, who showed 29 terminations for abnormality out of just 6,500 live births and that gives a national rate of 3,200 per year. These figures are different from each other but we feel that they are both substantially higher than the 1,812 that OPCS cited for 1988 and 1,735 that they cited for 1989. We have no more recent figures for that.

1281. In short, it is a big problem?

(*Ms Statham*) I think it is a big problem.

(*Ms Dimavicius*) It is one which needs investigation.

1282. Do you feel that prenatal screening, as is currently offered to pregnant women, is an efficient and appropriate service?

(*Ms Statham*) One of the things that I do is, it is my job, I am working on a study of women's attitudes to antenatal care, following a large, unselected group of women through their prenatal care, focusing on screening. If you ask women early in pregnancy how worried they are that something is wrong with their baby then on a scale of 0 to 5 more than 50 per cent of them score 3, 4 or 5; by the time you get to 22 weeks of pregnancy you are actually talking about just over 30 per cent score 3, 4 or 5, so something has happened between 12-14 weeks of pregnancy and 22 weeks of pregnancy which says that a lot of women become a lot less anxious that something is wrong with their baby. That is one way of looking at it. In terms of whether women get what they want and what is right for them, there are many variations in availability of screening, that varies with the region, it varies within districts, we have got evidence that it varies even within one hospital, with one consultant having one particular policy and the other two consultants doing something totally different. The sort of examples where different sorts of things happen are things like the age at which amniocentesis is offered; it can be 35 in one region, 37 in another, there are suggestions that in one region it is the lab. analysing the amniocentesis cultures which actually dictates the age at which they will accept routine amnios, depending on how busy they are.

1283. Is that service, or facility, offered or encouraged?

(*Ms Statham*) Less than half of the women in our study who discussed amniocentesis had it; most of the women are happy with the decision which was made as to whether or not they had it.

Mr Couchman

1284. Can I take this up from precisely that point. Do you feel that all pregnant women should be offered prenatal screening with biochemical tests, such as alpha-fetoprotein, triple test for Down's syndrome and routine ultrasound?

(*Ms Statham*) I would think that all pregnant women should be given the information available to make an informed decision about whether or not they wish to partake of these tests.

1285. Having made that informed decision, should they be offered it on the NHS?

(*Ms Statham*) I think that that should be their right but we recognise that there are resource implications for that.

1286. Do you think that all such innovations are adequately evaluated and assessed, and if not do you believe that, in fact, their use may lead to unnecessary anxiety amongst mothers?

(*Ms Statham*) I think there is evidence now that people are likely to do better evaluations and I think

[**Mr Couchman** *Cont*]
we have seen that in detailed comparisons between chorionic villus sampling and amniocentesis, where they have been subjected to randomised control trials. There is talk now that the possibility of early amniocentesis versus amniocentesis at the more normal time of 16 weeks will also be subjected to a properly conducted randomised control trial and I think we would recommend that and hope that that happened with new innovations. We recognise that in the past such trials have not happened and I feel sure that what you are referring to is ultrasound.

1287. Do you think, in fact, that most, or all prenatal screening tests could be carried out in the community by the GPs or midwives and the results directly obtained by them and would that be more reassuring?

(*Ms Dimavicius*) I think that Gps and midwives could conduct some of the prenatal screening; for example, age, family history, a basic screening process to determine whether a woman is at risk or not. I think there are great resource implications and standards implications if GPs and midwives were to undertake alpha-fetoprotein testing or ultrasound; I do not know if that is necessarily appropriate. I think that there would need to be much greater training and almost a national policy to ensure that all women had access to services.

Mr Sims

1288. Just carrying on that point, would it be more appropriate for positive results of abnormality screening to be communicated by specialist counsellors?

(*Ms Dimavicius*) I think it is essential that they should be. I think that all results, actually, should be communicated to parents because at the moment in many hospitals the policy is, "If you do not hear from us within three to five weeks, assume that everything is okay". That, I think, can greatly raise maternal anxiety and I think that there should be, as I say, a specified date when information will be communicated, the means by which it will be communicated, whether it will be a letter, a telephone call or a pre-arranged visit to the hospital. In cases where there is an indication that the baby may have a fetal abnormality then I think specialist counsellors should be available to actually talk to the parents, someone who understands the tests, understands the implications of the tests, understands the prognosis for what may or may not be available and can actually answer the questions of the parents—in some hospitals they have an antenatal midwife who is trained as a counsellor—and also, I think, who has some understanding of the grief process, as well, because if you are telling parents that "your baby has a lethal malformation" then it is at that point that the grief process, their bereavement, will start for them and I think health professionals need to understand that as well.

(*Ms Statham*) I think that reaction of the grief process will occur, regardless of what decision the parents make with regard to termination, because not all parents terminate pregnancies when abnormalities are detected.

1289. That suggests really that the results should invariably be given in hospital.

(*Ms Dimavicius*) I think, in some areas, the community midwife will do that, she will arrange to go and visit the parent and actually talk to the parents, perhaps in their own home as well, where they can absorb the news more easily, because I think hospitals are places of anxiety, for most of us, whatever we are going for, so I think that for some it may be better in the home but I do think that whoever gives that information needs to be trained in communication skills and counselling skills. In some hospitals it may be some obstetricians; as I say, it may be a midwife or it may be senior radiographers if the diagnosis is immediate, as through ultrasound.

1290. They will make sure it will be a clear arrangement, a clear understanding, otherwise there is a risk that the mother may not actually be told the result if she does not go to the hospital regularly?

(*Ms Dimavicius*) That is right. I think every hospital should determine its own protocol.

Audrey Wise

1291. Do you think that there are adequate prenatal diagnostic services for ethnic minorities who are at risk from conditions such as sickle-cell disease and thalassaemia?

(*Ms Dimavicius*) I think that there are other organisations which are better able to answer the details of that question than us, the specialists in the haemoglobinopathies, but I do know that in some work that Dr Bernadette Modell—again, who is a specialist in those areas—did, for some communities in the south of England, particularly the Cypriot community, and so on, who may be carriers of thalassaemia, there is access to adequate services for them. For other communities, such as the Pakistani community in the Midlands, they do not have the uptake of prenatal diagnosis or access to appropriate services and I do think there is a working group, which Dr Modell is the Secretary to, the North London Working Group on Haemoglobinopathies, and I think they would be able to give you very detailed information, they have collected a lot of data on that.

(*Ms Statham*) Some work which is coming from an adjunct to the Cambridge screening study, part of the study is being carried out in the West Midlands where there is a large proportion of the women at risk for sickle-cell, and what the researcher there, Merry France-Dawson, is finding is that though Afro-Caribbean women go to their GPs at the same stage of pregnancy as non-Afro-Caribbean women there seems to be a reluctance by GPs to refer those women to hospitals at the same time, based on some belief that Afro-Caribbean women do not wish to be at the hospital as much as non-Afro-Caribbean women do, although she finds no evidence that the women feel that, so this means that they actually get to hospital less soon for sickle-cell testing. In that population, in terms of making decisions about pregnancy, it is perhaps not an issue because many women there would continue with the pregnancy after sickle-cell diagnosis. What it does mean for these women is that they are possibly being denied access to other tests for other conditions for which they are just as at risk as anybody else in the population.

Chairman

1292. Who do you blame for that: the doctors, the GPs?

(*Ms Statham*) The GPs have this idea that this is what women want, apparently, and this is something that she is looking into.

1293. Are they not qualified to decide? Are you saying they are not, or they are misguided?

(*Ms Dimavicius*) Or it is an attitude.

1294. Or it is an attitude, indeed?

(*Ms Statham*) I cannot interpret doctors' actions in the West Midlands. I think perhaps Merry France-Dawson would be happy to supply you with information on that.

Audrey Wise

1295. Do you think that, this kind of thing, what is needed is for people to listen to the women, ask the women and listen to what they say?

(*Ms Statham*) I think there is a need to listen to what they say. I think there is very much a need to accept that, often, pregnant women are very informed and know what they want, they know what tests their friend has had and they know where it is available and I think there is evidence that in the primary care team, "If I do not know about it, it cannot be worth knowing about" so, yes, listening is very important.

1296. Can I just refer back briefly to some of your evidence and follow what Roger Sims was asking. In your evidence, in paragraph 3.4, you talk about mothers being telephoned at home when they may be completely alone and about things being sent through the post and you talk about, in paragraph 3.6, mothers being allowed to just leave in distress and actually drive just after being given this kind of news. Are those things common or rare?

(*Ms Dimavicius*) I would say they are fairly common, in our experience. Very few hospitals have a clear protocol on how they communicate information. I think amniocentesis results, in one sense, are easier to communicate because there is a period of time, but I think that quite often for parents who go along for routine screening and the majority of abnormalities, fetal abnormality,—and I am careful of that word because I do not like concepts of normal and abnormal at all but that is the medical language that we use—that they occur in people with no previous history, so it is often younger women going through routine care, routine ultrasound, and suddenly the woman is being told, "There is a problem with your baby's spine", "Your baby has anencephaly" (the brain is not there); very crude terms in which that information is given to the woman. Many women are there on their own because they just turn up for their 18-week check, or whatever, and they are unprepared for that news. Quite often they are asked to wait until someone else can come along and confirm the diagnosis, quite often their partner or a friend is not there and they are not asked if they want someone to be there, they may be asked to go to different parts of the hospital to different sites and so they are walking round the hospital, by themselves, knowing that there is "something wrong" with their baby, very unsupported in that way. Quite often, again, I can think of several parents who have just driven home in floods of tears and they have actually risked their own life and the lives of others because arrangements have not been made for them to be escorted home.

1297. Really, your organisation, which is for Support After Termination for Abnormality, in a sense you would go further and say that women need more support as soon as there is any diagnosis and that that support should then be followed through, presumably with whatever decision they make about termination or not?

(*Ms Dimavicius*) I think SATFA originated out of professional concern that the parents were given a diagnosis and for those parents who elected to terminate their pregnancy there was no aftercare support or anything, so that was when the professional concern for SATFA arose and the charity was formed. I think we are very clear, as an organisation, that there are options available to parents. Once a diagnosis has been given there are three options available to parents: one is to continue to term, knowing that the baby will die; another is to continue, perhaps with the prospect of treatment for their child, to have a baby with a disability who may or may not need treatment; or to terminate a pregnancy and that parents should make informed decisions about that pregnancy, they should be given as much information and as much time as they want. I think that, yes, more and more parents are coming to us having been given a suspected diagnosis, so I think that we become more involved in that aspect, that we are very much a non-directive charity, I would like to state that.

(*Ms Statham*) I think, in a way, the issue which prompted that question from you was we are talking about what goes on in hospitals and while we see our primary role as supporting parents we believe we do that in two ways, we give them direct support, either by talking to them or sending them newsletters, but we know that many women will not contact a perfect stranger on the end of a telephone. The way we support most women is by working with health professionals, talking about areas of good practice, and health professionals are desperate to be informed about good practice in this area, we get endless requests from hospitals, maternity units, all sorts of people, to talk.

Chairman

1298. Does your organisation receive any financial or other assistance from the Department of Health?

(*Ms Dimavicius*) We received a three-year core grant of £5,000 per annum, which expired this year, and we have just received £5,000 towards the establishment of a national self-help network from the Department.

Rev Smith

1299. The Royal College of Midwives have shown some concern at the growing increase in screening for genetic disorders, identifying congenital malformation *in utero* and a development of *in utero* surgery. Would your organisation share that concern, or have you an opinion on it?

[**Rev Smith** *Cont*]

(*Ms Statham*) I think really it is an area which has, so far, not affected any of our members and it is an area on which I do not think we are particularly qualified to talk. I think we probably have seen as much in the media as other people and my concern would be parents thinking that it is more widely available for a wider range of conditions than perhaps it is.

Mr Couchman

1300. In your opinion, is the follow-up care provided for mothers who have had a termination for fetal abnormality currently sufficient and if not how could it be improved? Is there a role for the GP or the midwife, for example, in providing continuing counselling for bereaved parents in the community?

(*Ms Dimavicius*) There is no statutory requirement for any follow-up aftercare for anybody whose baby has died before 28 weeks of pregnancy and in a survey we did of 112 of our members 64 per cent received no follow-up visit by a GP, a midwife, or anyone, and of those I think it was something like 94, 98 per cent would have liked a visit. I think that the need is there, there is no requirement by any authority to provide and we actually believe it is essential.

1301. Is it best provided by the GP or the midwife, or should there be some specialist, in fact?

(*Ms Dimavicius*) When we asked parents, I think the majority would have preferred a midwife, because they have gone through labour, they have given birth to a baby, they actually need to have their body checked, their body needs to be checked to see that it is returning to normal. Also, the emotional after-effects of the termination for abnormality need support and I think parents believe that the midwife will give, for them, recognition, actually, that they have had a baby, that it was a wanted baby, it may or may not have been a planned pregnancy but by that stage it was a wanted baby and that they themselves have experienced a perinatal bereavement.

(*Ms Statham*) I think the other visit that most parents will wish to avoid will be the visit a couple of months before the expected date of delivery by the community midwife to see if everything is going alright with the pregnancy. This does not happen often but when it does happen to parents it is very distressing when news of the termination has not been communicated to appropriate people, the community midwife does not know that a woman has terminated.

(*Ms Dimavicius*) We recently had an example where the community midwife turned up two days after the expected date of delivery, with a student in tow, to actually see the baby, weigh the baby and see how 'mum' was getting on and I think that is basically unacceptable.

Chairman

1302. How does that happen?

(*Ms Dimavicius*) Poor communication.

1303. With all the information technology, kit, that we have got these days?

(*Ms Dimavicius*) Quite often GPs are not informed, the community midwives are not informed, even in the same hospital; we have had many parents who have actually received letters saying, "Why did you not turn up for your last antenatal check-up?" and the mother has had the termination of pregnancy in that hospital.

(*Ms Statham*) Part of it is possibly that no-one is responsible; some take place on gynae. wards, some take place on labour wards. Nobody has got overall responsibility for what is going on, is the only reason.

1304. You do not think that the Sister in the delivery suite is responsible for reporting?

(*Ms Statham*) Not at all. It seems that that falls down, as I say, not often but sufficiently often that when it does happen it is very distressing and it seems an unnecessary cause of distress to women who are already going through enough.

Chairman: Your point is now in black and white.

Alice Mahon

1305. You say in your evidence, and I have some experience of this and I will give my opinion in a minute, that in your experience no parent regretted seeing their baby but many regretted not seeing him or her. I was discouraged quite firmly from seeing my son, in a similar situation, and I was very pleased that I stuck out and said I insisted. Is that still the case? I am talking now 26 years ago, to my lost son, who died, and it was very, very important to me, it was part of me, it was part of our family. Is that still the case, that women are discouraged from seeing their babies?

(*Ms Dimavicius*) The work that SANDS has done, as an organisation, has actually improved greatly the management of stillbirth and neonatal death and, in some ways, obviously, we are trying to actually get those standards applied to terminations for abnormality. I think that if health professionals perceive it as a perinatal bereavement then, obviously, the attendant services should follow but I think that many health professionals have seen the issue of termination for abnormality as taking the problem away and also they themselves have great fears of what a baby will look like, what does an 18-week baby look like with anencephaly or which has other severe congenital deformities? I think the staff are often frightened and it is misguided, their protection, in saying to the parents, "No, you do not want to see this, this is so awful" and I think what that does for many parents is actually to compound their own fantasies of what the baby looks like. Their fears and fantasies of the "monster"—and I use that word guardedly because that is one of the words which parents have used—can be extreme and if the hospital staff are saying to you, "No, no, no, you do not want to see this baby, this baby is awful" then many parents are left with unresolved feelings, unresolved grief and many, many go through terrible fears and nightmares, and so on, so I think that we would ask that it becomes hospital policy.

Chairman

1306. On this matter, how far is such a termination seen by the medical profession as an operation rather than a bereavement?

(*Ms Statham*) If we think back to when terminations first became available for abnormality, the conditions then, as now, were more severe, there

[**Chairman** *Cont*]
was no treatment, as is the situation now. There was some evidence, with the introduction of legal abortion for non-medical reasons, that women generally fared quite well as a result of an early termination of an unplanned pregnancy and not always but counselling was available for those women. The next logical step was, "These women are quite happy about losing a completely normal baby so if the one we are taking away is a not very good one they probably feel even better about it". I think that each time there has been a report in the literature from a group of health workers who have looked at how women feel following the termination of pregnancy for abnormality there seems to be a bit of surprise that, "Oh dear, they are depressed; oh dear, they are still thinking about this baby at the time the baby should have been born". This, rather than saying that what is happening to these women is that they have gone through the difficulties of knowing they have conceived an abnormal child, which I think happens to all parents at whatever stage they discover their child has a handicap, be that at term or be it something which occurs later in life, they have then gone through that sort of emotional loss of the normal baby that they and everybody else had thought they were expecting. They have then actually gone through a physical loss of a baby, they have actually delivered a dead baby and they have actually had to be the ones to make the decision about that and that is something which parents do find difficult and I think it is only slowly that all those aspects of this particular bereavement are starting to register with the health professionals. To be fair, many are thinking in that way but there are still pockets where it is not thought of.

Alice Mahon

1307. I just want to go on a bit now, if you do not mind; I just thought that point needed to be made. Do you think the law regarding the registration of births should be changed and would this help with the problems relating to burial?

(*Ms Dimavicius*) I think that the majority of terminations for abnormality take place at 16 to 20 weeks, or 18 to 20 weeks, so, in a sense, reduction of the law to 24 weeks would not directly affect many of our members but I am sure that SANDS has much to say on that, in terms of the effect upon their members, but I do believe that all babies, whatever their gestational age, should have a respectful disposal. What that respectful disposal means will vary with the needs of the parents. For some, they may be happy that the hospital takes over and cremates the baby with dignity, others may want a funeral, others may want a cremation, others may simply want a blessing by the hospital chaplain, the baby's name put in the Book of Remembrance in the hospital, or a service in the hospital chapel. There are many forms that remembrance can take for the parents but I think the essence of it is that all babies should be disposed of with dignity. I do not like the word disposal, but ...

Chairman

1308. What special problems, in your experience, arise with a termination for fetal abnormality which perhaps do not arise with miscarriage or stillbirth, or even neonatal death?

(*Ms Statham*) It is possibly what I was getting at before. First of all, parents have had to cope with this medical attitude that "Really, we are helping you out of a problem", which in one way is true but it is not a nice, neat, tidy answer to a problem which does not have its own resultant problems. I think, secondly, and this also applies to miscarriages and stillbirths, it is almost always unexpected. Thirdly, for many women it remains a hidden loss, they feel able to talk about it to very few, all but their closest friends, because there is a fear that they will be stigmatised by a moralising society. I think that combination of unexpectedness, of the slight stigma, is possibly the greatest problem that they carry when they have terminated the pregnancy and they are problems which I think sensitive and aware handling, through from the time of diagnosis for as long afterwards as it takes, can actually alleviate, I think they are not insuperable.

(*Ms Dimavicius*) I think there is also, for many parents, the problem of guilt; they are the ones who actually had to make the decision to terminate that pregnancy. I think in miscarriages, I do not want to get into any pecking order of loss either, I would not like to make any comments on that, but in miscarriages and stillbirth I believe the reasons for the guilt attached to that would be different because those occurrences happen "naturally", or spontaneously, whereas in a termination for abnormality parents have to make that decision about the future of their pregnancy. I can think of one parent whose baby would have been born stillborn or would perhaps not even have gone to term, the baby would have died before term, but she said that she was left with the power to actually determine when her baby would die and I think that is very profound; she was given that information, she said it could happen any time up to 36, 40 weeks, but she was told that at 20 weeks of pregnancy and *she* had to decide and I think that is a very special aspect of the work that we do and the support needs of parents.

Chairman: On behalf of all the members of the Committee, we are most grateful to you for coming to give your evidence and we perhaps ended on a very moving but a very real issue. Thank you very much indeed.

Supplementary memorandum submitted by SATFA

We recognise from some of the questions addressed to the Association of Paediatric Pathologists, and other organisations such as AIMS, that the Committee is concerned about the possible misdiagnosis of fetal anomalies.

This is an area of particular interest and importance to SATFA. The decision to terminate a pregnancy because of fetal abnormality is a particularly hard one; to do so and then to discover that a misdiagnosis has been made will contribute enormously to the grief experienced by parents. But we do believe that it is essential that parents are informed of a misdiagnosis. It will affect their perception of their own reproductive ability and, as discussed by Professor Wigglesworth, their risks in future pregnancies. The medico-legal consequences of such an error need consideration.

Although such diagnoses are particularly tragic, there would seem to be little evidence to suggest that they are frequent. We would like to draw your attention to some recent data on ultrasound diagnosis.

It is important to recognise that ultrasound is still a developing technology, both in terms of equipment used and the personnel who use the equipment and interpret the data. More sensitive machinery and more experienced operators result in the detection of more anomalies than previously; in some circumstances the consequences of the anomaly are unknown or uncertain; in other circumstances they may be transient. Three recent large studies show that no pregnancy was terminated as a result of a misdiagnosis or error.

Saari-Kemppainen et al (1990) suspected 30 malformations following ultrasound examination of 4,073 women. In 10 cases the suspected anomaly had disappeared in follow up examinations; 9 pregnancies continued to term with variable outcomes and 11 pregnancies were terminated.

Chitty et al (1991) suspected major abnormality in 93 of the 8,432 women scanned in the second trimester. Of these, 52 pregnancies were terminated, and the abnormalities confirmed; in 2 cases subsequent scans did not confirm the abnormality and apparently normal infants were born at term. Abnormalities were confirmed in those pregnancies that continued to term. These authors comment separately on the less serious anomalies detected, which constituted the 10 "false positives" referred to by Saari-Kemppainen et al which had disappeared in subsequent scans.

Dr I M Shirley from Hillingdon Hospital presented data at the British Medical Ultrasound Society Meeting (Dec 1991) and made this available to us. Of 6,412 women who were scanned, 58 major abnormalities were suspected; 29 women terminated the pregnancies. Abnormalities were confirmed in these fetuses and in those that continued to term; in one case a suspected anomaly was not found at a subsequent scan at a tertiary referral centre and the pregnancy continued to term.

These comments refer primarily to the issue of the reliability of diagnosis of anomaly by ultrasound prior to the decision to terminate a pregnancy. It is of interest that in all of the studies described above, many women continued pregnancies following the detection of an anomaly, even when either lethal or severely disabling. This discredits a popularly held belief that prenatal diagnosis is, by definition a "seek and destroy" service. Such a view belittles the integrity of parents. The evidence from the studies shows that parents are able to make the decision to continue their pregnancy. It is hoped that they are well supported throughout the remainder of the pregnancy.

False positives

The impact of false positives and of the detection of anomalies where the outcome is uncertain is an area of concern to SATFA and to all who scan pregnant women. The emotional and practical needs of women in such circumstances must be considered and met, and Dr Chitty addresses some of these issues in her paper.

All screening procedures will give rise to false positives; anxiety is known to be associated with initially positive results following mammography, cervical cytology, hypertension screening etc. This is not surprising considering the possible implications of such findings. Recognition of such anxiety and subsequent support should be encouraged for all health screening programmes.

False negatives

All screening procedures will also give rise to false negatives, that is existing cases which are not detected. We have not presented evidence concerning the sensitivity of ultrasound but this is again discussed by Dr Chitty. There will always be anomalies that cannot be detected, but, accepting that limitation, the sensitivity will also be affected by the quality of the machine used and the skill of the operator. It would seem unethical to offer women anomaly scans if either the machinery or operator was inadequate.

Ultrasound is not solely concerned with the detection of anomalies. We have not discussed its safety or its use in the detection of twin pregnancies, placenta praevia, intra uterine growth retardation or in estimating the date of delivery. There are other organisations which can comment on these areas with more authority.

Saari-Kemppainen et al, (1991) Lancet 336: 387–391

Chitty et al, (1991) British Medical Journal 303: 1165–1169

Shirley, (1991) Personal Communication also BMUS 1991

The Training Needs of Health Professionals

We were pleased that SANDS gave evidence on the needs of staff who deal with parents bereaved in the perinatal period. SATFA has always believed that the way in which most parents will receive much of the support they need is through health professionals who are trained in, and understand, grief work relating to perinatal bereavement.

Whilst a formal training for relevant staff in grief and communication is necessary. There are also other ways in which their training and support needs can be met.

SATFA has run a series of training days for members which have focussed on befriending, telephone support, listening skills, the grief process and group work.

Not only parents benefited from the workshops and training days. Health professionals also participated and found them useful in focussing attention on their own needs and difficulties associated with their work in this area. Midwives, nurses, health visitors, radiographers, genetic counsellors and social workers, at both junior and senior levels, attended. Evaluation showed that the professionals involved felt that they had benefited and they had been given ideas for improving their own practice.

Such days are invaluable as they provide an opportunity for each party to learn from the other and provide a special insight into the support needs of parents. The low cost of the training days allows access for professionals who may have to pay for themselves, due to restricted health service training budgets.

As a result of such days SATFA is often asked to attend seminars either within specific hospitals or particular disciplines to discuss issues of practice, their emotional implications for staff, and the particular support needs of that staff group. Such days provide a safe forum for staff to talk about their own needs. Staff can often feel more able to talk about their difficulties with an outside agency as they believe it will not "threaten" their professional status. Whilst we see this as an important area of work, it is one which we cannot develop or respond to as we would wish due to both time and financial restrictions. We would be willing to contribute to, and participate in, any initiative which trained and supported health care staff and thus improved the care given to parents bereaved in the perinatal period.

Memorandum submitted by the Stillbirth and Neonatal Death Society (SANDS)

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

1. The needs of parents who do not deliver a live baby or whose baby dies during the early weeks of life should be included in the planning of maternity services.

2. SANDS believes that there is still a great need for professionals to understand the experiences of families who experience miscarriage, stillbirth and neonatal death and to formulate sensitive policies to address these needs.

3. SANDS believes that indicators of pregnancy outcomes should also include more accurate figures of loss before 28 weeks.

4. SANDS recommends that the current definition of stillbirth be changed to 24 weeks.

5. SANDS believes that all pregnancy loss should be treated with respect and in line with parents' wishes, regardless of gestational age.

6. An essential element of maternity services is an adequate level of Department funding for the voluntary organisations that complement this work.

7. Extra care should be offered and given to bereaved parents ante-natally. Their special anxieties should be recognised, extra tests discussed, and reassurance and time made available. All health records should identify parents' experience of loss.

8. Strategies for communicating scan information should be developed.

9. SANDS believes that there is an urgent need for guidance to enable professionals to understand and manage all pregnancy loss in a way that meets parents' needs.

10. SANDS strongly recommends that all professionals caring for parents during and after the loss of a baby be given appropriate support and training.

11. SANDS recommends a certificate be offered for all babies born dead before the legal age of viability. In addition, burial or cremation should be offered where appropriate and the cost, if requested, covered by the hospital in line with arrangements for stillborn babies.

12. SANDS believes that hospitals making arrangements for the disposal of babies born dead before 28 weeks gestation should ensure that these arrangements are respectful and not likely to cause shock and distress to parents.

1 Introduction

1.1 The Stillbirth and Neonatal Death Society (SANDS) has been established since 1978. It has four main aims:

- To develop self help support for families bereaved by stillbirth or neonatal death
- To improve professional management of stillbirth and neonatal death
- To develop a comprehensive information service
- To promote research into the cause and effects of stillbirth and neonatal death.

Over the past 13 years SANDS has gained a great deal of expertise from listening and talking to families and professionals about the experience and management of stillbirth and neonatal death.

Over the past 12 months alone the SANDS office has responded to 20,500 letters and phone calls, directing many families to our national self help network of over 200 groups and contacts.

In recent years SANDS has been approached by an increasing number of families who have lost a baby before the 28th week of pregnancy. (The current definition of a stillbirth.) It has become evident that the distress and grief experienced when a pregnancy ends before the 28th week can be as great as when a baby is stillborn or dies in the early weeks of life. It was because of this perceived need that SANDS established a working party to look at the management of pregnancy loss before 28 weeks in 1988. We worked collaboratively with representatives of all the relevant professional and voluntary organisations. The conclusions and recommendations of this working party have recently been published by SANDS[1] (already circulated to the Committee).

We welcome the invitation to submit evidence to the Health Committee and believe we have sound knowledge of the needs of families that use the maternity services but unfortunately do not take a live baby home.

2 General Issues

2.1 *Full spectrum of Maternity Care*

SANDS welcomes the Health Committee's inquiry into Maternity Services and is particularly pleased to see that the terms of reference cover the whole spectrum of maternity care, including what happens when things go wrong. The management of straightforward pregnancy and birth must of course be central but not, as in the past, in a way that diverts focus from the very real needs of women and their families when things go wrong.

SANDS believes that there is still a great need for professionals to understand the experience of families who experience miscarriage, stillbirth or neonatal death and to formulate sensitive policies to address these needs.

2.2 *The effect of miscarriage, stillbirth and neonatal death*

Many people underestimate the depth of this experience: the effects can last forever.

> "The death of a baby, whether at birth or in the weeks and months immediately afterwards is no less a death than any other. It is no less significant, no less important, no less heartbreaking than the death of an older child or an adult. It is certainly different but it is not a lesser event.
>
> "The loss of a baby is the loss of a person. All parents who are positive about their pregnancy include their baby not just in their plans for the future but in their present lives too, so that even before birth, a baby is being considered, loved and cared for. A baby's death is also the death of a person who would have been. It means the ending of dreams and hopes and plans, the loss of a future. Even a baby lost in the earliest stages of pregnancy may have this sort of significance for the parents. Parents may also have invested so much of themselves in their baby that when the baby dies, a part of them dies too."

Extracts from SANDS' book for parents, "When a Baby Dies", written by Nancy Kohner and Alix Henley, to be published autumn 1991.

With other bereavements there is much to remember, but when babies are lost in this way the only memories are the ones created at the time. The management of this loss is therefore particularly important and can turn a devastating event into an event that at least carries some positive memories. This can greatly help the grieving process.

2.3 *The management of pregnancy loss before 28 weeks gestation*

There is much confusion around the management of pregnancies that end before the 28th week.

Many hospitals and community units lack clear policies, which causes distress to parents and professionals alike. A letter SANDS received recently from a mother whose baby died at 21 weeks gestation demonstrates this: "I am confused as to what my baby is classed as. A Bereavement Officer called her an inviable fetus, my GP says she is a potential baby. But she is my baby, fully formed. I did not miscarry her, I had to go through an induced, very painful labour. But because she was 21 weeks and not 28 she was not stillborn. Lucy is my baby. How can anyone class her as anything else?"

2.4 *Statistics of pregnancy outcomes*

Although there has been a significant improvement in perinatal and neonatal deaths there are still a large number of families affected by this bereavement. One in 100 babies will die at birth or in the first 4 weeks of life—7,364 families in the UK in 1989. However, the unrecorded figures of pregnancies that are lost before 28 weeks are just as significant. Data from Scotland[2] suggests that the number of miscarriages between 20-27 weeks are roughly equal to the number of registered stillbirths that are delivered after 28 weeks. There are no accurate figures that SANDS knows of collected for pregnancy loss before 28 weeks.

The implications of this are enormous. In order to plan Maternity Services to meet women's needs it is vital to know not only the ratio of midwives to deliveries and cots available for babies requiring special and intensive care, but also what resoruces are required in gynaecological wards, maternity units and the community to manage pregnancies that end before 28 weeks.

SANDS believes that indicators of pregnancy outcomes should also include more accurate figures on loss before 28 weeks.

2.5 *The legal position*

The definition and management of stillborn babies arise from the Infant Life (Preservation) Act 1929 which set 28 weeks as the limit of viability. The Births and Deaths Registrations Act 1953 defines stillbirth and provisions relating to registration and the Crematorium Regulations 51 1930 No 1016, Reg 3, states it is an offence to burn the body of a stillborn baby, other than in an authorised crematorium.

In short, stillborn babies have to be registered, and the baby's body must either be buried or cremated.

There is no legislation relating to pregnancy which ends before the 28th week except the Human Fertilisation and Embryology Bill which permits abortion up to 24 weeks, accepting viability after that date. There is an urgent need to redefine stillbirth to at least 24 weeks.

2.6 *The special status of the fetus*

The Review of the Guidance on the Research Use of Fetuses and Fetal Material, The Polkinghorne Report (1989), provides a code of practice. It builds on the Warnock Committee's assertion that "the embryo of the human species ought to have a 'special status'." The Polkinghorne Report clarifies this thinking further: "Central to our understanding is the acceptance of a special status of the living human fetus at every stage of its development which we wish to characterise as a profound respect based on its potential for development into a fully formed human being...That respect carries over in a modified fashion to the dead fetus, in a way analogous to the respect afforded to a human cadaver on the basis of its having been the body of a human person."

SANDS is deeply concerned that the fetus/baby lost before the 28th week of pregnancy is frequently not treated with this respect. This will be dealt with in more detail in our evidence on ante-natal care.

We believe this is an issue that should be of concern to those planning services for pregnant women.

SANDS believes that all pregnancy loss should be treated with respect and in accordance with parents' wishes, regardless of gestational age.

2.7 *The role of the voluntary sector*

SANDS believes that it offers a unique service to families and professionals involved in stillbirth and neonatal death. The recent SANDS' publication "Miscarriage, Stillbirth, Neonatal Death—Guidelines for Professionals" is an excellent example of collaborative working, resulting in guidance based on parents' needs using examples of good practice from around the country.

We believe the services SANDS offers are an essential complement to statutory maternity services. We would like to develop training to support the Guidelines in practice. We could offer guidance to purchasers looking for criteria to include in contracts and together with others in the voluntary sector provide valuable feedback on that elusive aspect of care—quality. Our work is extremely cost effective, 4.6 staff and an extensive network of volunteers were contacted by approximately 5,000 bereaved parents last year. We have

spread our funding base. However, financial support from the Department of Health has fallen from 56 per cent to 11 per cent of our core costs. This means a very high percentage of time is spent raising money instead of developing services.

SANDS believes that an essential element of maternity services is an adequate level of Department funding for the voluntary organisations that complement this work.

3 Pre-Conception Care

3.1 *The next pregnancy*

For parents who have lost a baby during pregnancy or shortly afterwards there are special considerations in preparation for any future conception. It is essential to understand that a future pregnancy will not replace the baby that was lost.

3.2 *The timing of a future pregnancy*

"Parents need to be aware that before conceiving again they will first need to grieve for the baby who has died. They also need to know that the anniversary of their babies' death is likely to be a difficult time. If their next baby is born at about that time, they may find the pregnancy and the birth itself very distressing. For most parents it is helpful if the timing of their next pregnancy is totally different to the one which has just ended unhappily. All parents need to make their own informed decision. If appropriate, parents should be given information about how they can obtain genetic counselling and/or advice on pre-conception care." "Miscarriage, Stillbirth and Neonatal Death—Guidelines for Professionals" SANDS, 1991, p. 31.

3.3 *Causes of miscarriage, stillbirth and neonatal death*

Most parents feel a strong need to understand why their baby died or their pregnancy failed. An opportunity to discuss any known causes, the implications for future pregnancies and to accept the absence of a known cause without assuming they caused the death/loss, is an essential part of pre-conception care.

4 Ante-Natal Care

4.1 *The aim of ante-natal care*

The aim of ante-natal care must be to ensure as far as possible the health and well-being of the woman and the unborn child. Pregnancy and childbirth represent physical, psychological and social change for the prospective parents, particularly the woman, and ante-natal care should provide support and guidance at this time and help them prepare for parenthood[3]. This extract from the Maternity Services Advisory Committee Report stops short of an additional aim, which is to support women and their partners when pregnancy fails, or the baby dies. SANDS believes this is a serious omission. Estimates of miscarriage are between 1 in 3 and 1 in 5. 1 in 100 babies are stillborn or die in the neonatal period.

4.2 *Ante-natal preparation*

Almost all parents live with the knowledge and anxiety that babies can die from cot death. However, many parents and indeed professionals are unaware of the frequency of stillbirth and neonatal deaths—four times more likely to happen than cot death. Parents frequently say that the devastation they experience at the time of such a loss is deepened because they did not realise babies can, and do, die at this stage. This in turn makes them feel isolated and alone. Sensitive education both before and during the ante-natal period that admits and acknowledges that things can go wrong would be invaluable. Although SANDS recognises the difficulties professionals may experience in this, for parents is an essential part of their information about pregnancy. The Health Education Authority's pregnancy book has a section on perinatal loss which SANDS welcomes.

4.3 *The needs of parents who have experienced the loss of a baby*

SANDS has evidence to suggest that a future pregnancy is a time of extreme anxiety for any parent who has experienced the loss of a baby. It is not a relief, and in no way replaces the baby who was lost. This needs to be acknowledged in their ante-natal care.

SANDS believes that extra care should be offered and given to bereaved parents ante-natally. Their special anxieties should be recognised, extra tests discussed and reassurance and time made available at ante-natal visits. All health records and requests should identify this previous experience.

4.4 *Scans*

SANDS would like to highlight one particular area of ante-natal care that appears to be problematic for both parents and professionals. SANDS' 'Guidelines for Professionals' make specific recommendations about the management of scans on page 16. The immense significance of a scan needs to be fully understood. It can confirm worst fears that the baby has died, or unexpectedly discover that something is wrong.

SANDS believes that strategies for communicating information obtained from scans need to be developed to overcome problems experienced both by professionals and parents.

This is particularly relevant when an intrauterine death has occurred, or an abnormality that may lead to termination discovered.

4.5 *Management of loss before 28 weeks*

Current practice regarding loss before 28 weeks is very variable. The care given to women/parents is often determined by the stage of pregnancy at which the loss occurs. However, as SANDS states in its 'Guidelines for Professionals': "Most women, from the beginning, think of their pregnancy in terms of a baby. If their pregnancy fails it means, for them, the loss of that baby and all that that baby meant to them. This is true whether the loss occurs early or late in pregnancy." SANDS believes that it is the significance of the loss to the parent, not the gestational age of the baby, that should dictate management practice.

Perhaps the most difficult aspect for professionals is the intellectual leap that is required in order to see pregnancy loss through parents' eyes, ie acknowledging that a miscarriage can have potentially the same impact as a stillbith or neonatal death. It is even more difficult to put this intellectual understanding into practice.

SANDS believes that there is an urgent need for guidance to enable professionals to understand and manage all pregnancy loss in a way that meets parents' needs.

The details of this are contained in SANDS' 'Guidelines for Professionals'. We would be willing to give more detailed evidence on this subject if required. For the purpose of written evidence we have selected a few examples:

(i) *Respect and flexibility*

The overriding need is for parents to be treated with respect and flexibility. Professionals need to be able to respond to individual parent's needs.

(ii) *Place of delivery*

Women should be admitted to a ward where the management of loss is part of the planned work of that ward. Women should never be left to miscarry in an Accident and Emergency Department.

(iii) *Seeing what is lost*

Parents may wish or need to see what they have lost, even if there is no recognisable body. If they do not see it, they may later become anxious and upset and may imagine something worse than reality. When there is a body, no matter how small, parents may wish to hold, spend time with, and care for their baby.

(iv) *Permission*

In line with the recommendations of the Polkinghorne Report, SANDS believes that parents' consent should be asked before any pathological investigation is carried out or a baby/fetus is used for research.

(v) *Disposal*

SANDS knows from parents and professionals that what happens to many babies/fetuses lost before 28 weeks is not always respectful. In some hospitals, all pregnancy loss of any gestation is treated in the same way as stillbirth, provided there is an identifiable body. However, other practices include incineration with hospital waste, removed with hospital rubbish and disposal down waste disposal units. In a recent survey, two hospitals reported using these methods for babies of 26 and 28 weeks gestation. This is clearly totally unacceptable.

SANDS believes that hospitals making arrangements for the disposal of babies born dead before 28 weeks gestation should ensure that these arrangements are respectful and not likely to cause shock and distress to parents.

(vi) *Certification, burial, cremation*

For many parents a piece of paper that acknowledges their baby existed is an absolute minimum, yet we know that very few hospitals give certificates of any kind before 28 weeks.

SANDS recommends a certificate be offered for all babies born dead before the legal age of viability. In addition a burial or cremation should be offered where appropriate and the cost, if requested, covered by the hospital in line with arrangements for stillborn babies.

(vii) *Follow up/community care*

Notification and communication between hospital and the community needs to be improved. Many parents report GPs and midwives not knowing they have lost their baby. Continuing support from community professionals can be vital to parents. In addition all parents whose pregnancies fail need to be offered a follow up appointment, not only to check their physical well being but also, and equally important, to offer an opportunity to discuss what happened, to give the results of pathological investigation, to answer questions, and to talk about a future pregnancy if parents wish.

4.6 *Professional support*

This is a very challenging area for professionals to work in. Individualising care demands a great deal of understanding and sharing pain with parents can be stressful and difficult. Special knowledge and skills are needed, and professionals whose job it is to support parents should also be supported themselves. In recognition of this, **SANDS strongly recommends that all professionals caring for parents during and after the loss of their baby be given appropriate support and training.**

March 1991

REFERENCES

[1] "Miscarriage, Stillbirth and Neonatal Death: Guidelines for Professionals" SANDS, 1991

[2] Scottish Stillbirth and Neonatal Death Report 1989—Scottish Health Service

[3] Maternity Care in Action—Common Services Agency. Part 1—Ante-natal Care—Maternity Services Advisory Committee 1982.

Supplementary memorandum submitted by SANDS

1 INTRODUCTION:

1.1 This second submission from the Stillbirth and Neonatal Death Society (SANDS) covers issues to do with miscarriage, stillbirth and neonatal death which fall under the headings of delivery, postnatal care and paediatric (or neonatal) care.

1.2 SANDS wishes to emphasise, however, that there is a need to consider the subject of pregnancy/neonatal loss (including early miscarriage) as a whole. The development of appropriate services to meet the needs of bereaved parents requires a high degree of co-operation and co-ordination. Within any single hospital, staff in the gynaecological ward, maternity ward, pathology department and the mortuary, administrative and counselling/support staff are all involved, at some stage and in some way, with the management of pregnancy/neonatal loss. The community services also have a vital role to play.

1.3 SANDS is aware that at present services are not coherent. Within hospitals, practice in different wards or departments may be very different and is often inconsistent. Hospital and community services are often ill co-ordinated.

1.4 SANDS therefore urges the Health Committee to give some exclusive consideration to the entire spectrum of pregnancy and neonatal loss, and to review every aspect of the services provided for all parents who lose a baby.

2 PRESENT MANAGEMENT OF MISCARRIAGE, STILLBIRTH AND NEONATAL DEATH

2.1 Over recent years there have been great improvements in the care given to parents whose baby dies at birth or neonatally. There is now better professional understanding of the significance of the loss to parents, and of parents' needs both at the time and afterwards. It is vital that these improvements are maintained and developed.

2.2 SANDS has had thirteen years' experience of listening to the needs of parents whose babies have died. Throughout that time SANDS has also worked closely with professionals from many different disciplines. In the last two and a half years, this work has been intensified in order to develop, in consultation with professionals and bereaved parents, guidelines for the management of miscarriage, stillbirth and neonatal death. Many different issues were researched and discussed in depth. SANDS has also carried out a preliminary survey of hospital practice in the management of pre-28 week loss and has obtained information on specific aspects from gynaecological wards, maternity wards, pathology departments and mortuaries. The expertise and experience gained in the course of this work informs this evidence and references are made throughout to the relevant sections of SANDS' publication **Miscarriage, Stillbirth and Neonatal Death: Guidelines for Professionals**[1]. The Committee are asked to consider the **Guidelines** and the recommendations they contain as part of this evidence.

2.3 We cannot emphasise too strongly the need to consider pregnancy/neonatal loss as a continuum. In this submission we have highlighted as a major concern the management of pre-28 week loss. We wish to stress that we include in this **all** pregnancy loss occurring before 28 weeks, the vast proportion of which are admitted to gynaecological wards not maternity units.

3 Delivery after a Death in Utero

3.1 When a baby is known to have died in utero, no matter at what stage of pregnancy the death occurs, sensitive management of labour and delivery is essential. Parents retain vivid memories of their baby's birth and all that happens around if. Good care can give them some positive memories among their many sad ones, and this can help them to grieve.

3.2 SANDS has set out detailed recommendations for the management of labour and delivery after death in utero in its **Guidelines for Professionals**[1], pages 18-20.

3.3 *Pre-28 week loss*

These recommendations apply equally to the management of labour and delivery before 28 weeks gestation. A professional tendency to categorise miscarriage a "lesser loss" sometimes leads to insensitive management of what is often, to individual parents, an overwhelming loss. It is appropriate to offer the same kind of care and consideration to all parents, regardless of their baby's gestational age or even of the physical reality of what is lost. At present this kind of care is not widespread.

4 Postnatal Care

4.1 The time immediately after a baby's death is a crucial time for creating the memories which will help parents to grieve over the months and years to come. Detailed recommendations on all aspects of postnatal care are set out in SANDS' **Guidelines for Professionals**[1], pages 21-32. It is again stressed that the same principles of good practice, and often the same practical recommendations apply in the case of loss before 28 weeks gestation.

4.2 *Care following pre-28 week loss*

Ten years ago, it was not uncommon for parents of a stillborn baby to be deprived of holding or perhaps even of seeing their baby. It is now universal practice for parents to be offered the chance (and if appropriate to be encouraged) to see, hold and spend time with their stillborn baby. However, not all parents who lose babies at early gestations are given the same opportunities to get to know their baby and so to begin to understand their loss. There is a need, therefore, to extend policies and appropriate staff training from the maternity to the gynaecological wards, so that equally sensitive and understanding care is given to all parents.

(The management of pre-28 week loss is also covered in Part One of SANDS' submission to the Health Committee, para 4.5.)

4.3 *Flexibility in management*

SANDS is also aware that there is not always sufficient flexibility in the way postnatal care is managed. All parents respond in individual ways to the death of their baby and most need time, as well as information and support, before they can feel clear about what they need or want to do. It is essential that staff are able to accommodate parents' different needs, and that they can accommodate those needs at the time that they are felt. Thus, for example, parents who do not want to spend time with their baby immediately after the birth should know that they can ask to see their baby again at a later time. Bodies (including the bodies of very tiny babies) should be stored in such a way that parents can see their baby at a later time without distress. Parents in contact with SANDS frequently mention that they were not given enough time to make decisions about what to do after their baby's death, or the freedom to change their minds.

Parents' cultural and religious beliefs will often influence the response to the loss of their baby and their needs. It is vital that staff can respond sensitively and with understanding to parents of all cultures and faiths and that hospital procedures take this variety of need into account. Consultation with parents is essential and staff should avoid assumptions about the needs of any parent/family.

4.4 *Pro-active care*

SANDS' recent survey of hospital practice, as well as the experiences of recently bereaved parents, suggests that although staff are anxious to accommodate parents' wishes, many assume a passive role and do not offer what is not asked for. Yet parents may find it very difficult to ask for what they want, and may indeed not know what they want unless suggestions and offers are made. Many only discover too late what they could have done for their baby or for themselves if only they had asked. It is therefore important that, without

pressurising or encroaching on parents' privacy, staff inform parents about the options open to them, suggest what they may wish to do with and for their baby and for themselves, and help them to understand and express their own individual needs. The onus should not be placed on parents to make requests.

4.5 *The need of fathers*

It is important that postnatal care takes account of the need of the father of the baby. The management of earlier loss especially tends to focus on the needs of the mother.

4.6 *Parental consent for pathological investigations*

It is essential that parents' consent is asked before a post mortem or any kind of pathological examination is carried out, regardless of the gestational age of the baby/fetus. There is frequently a mismatch between parents' strong feelings that their baby, fetus or even fetal remains are theirs and hospital procedures which assume that the baby/fetus has become hospital property. SANDS is aware that parental consent is often not asked before the pathological examination of pre-28 week fetuses, and also that the professionals involved are sometime themselves unaware of what happens to babies/fetuses once they have left the ward.

The Polkinghorne Report, **Review of the Guidance on the Research Use of Fetuses and Fetal Material 2,** states that the mothers' consent should always be obtained before an embryo, fetus or fetal material is used for research and that consent should be explicit and positive. It is a matter of concern to SANDS that the guidance contained in the Polkinghorne Report has not been adopted in practice and we strongly recommend that its recommendations are backed by appropriate legislation.

4.7 *Consultation with parents about disposal*

All parents should be consulted about the kind of funeral or other ceremony they would like to hold for their baby and how their baby's body should be disposed of. This applies equally to parents of babies lost at early gestations. Results of a recent survey carried out by SANDS suggest that many hospitals do not consult parents of pre-28 week babies about how the body should be disposed of, and that some use methods of disposal which are unacceptable not only to parents but also in moral terms. In a few hospitals, however, practice is excellent: all fetuses and fetal remains are disposed of with respect and in accordance with parents' wishes.

4.8 *Communication between hospital and community*

Parents and professionals report that GPs and community nursing staff are not always informed, or not informed properly, about a miscarriage or stillbirth in hospital. This can cause distress to bereaved parents and embarrassment to the professionals concerned, and means that parents are deprived of immediate support from community professionals on discharge from hospitals. It is vital that community staff are promptly informed about any miscarriage or stillbirth—by telephone immediately, and then by confirmatory letter. Further information, including a full history and if possible the results of any pathological investigation, should follow as soon as possible, as this will enable community staff to support the parents concerned. For more detailed recommendations concerning communication between hospital and community, see SANDS' **Guidelines for Professionals,**[1] page 26.

4.9 *Follow up*

It is essential that a follow-up appointment of some kind is offered to all women who have lost a baby, however early in pregnancy the loss has occurred. In many cases, it is appropriate and helpful for the father to attend the follow-up appointment as well. Both parents are likely to need information, and the chance to talk and ask questions about every aspect of what has happened to them. Many also have a pressing need to talk about a possible future pregnancy.

For more detailed recommendations concerning follow up, see SANDS' **Guidelines for Professionals**[1], pages 37-8.

4.10 *Bereavement support and counselling*

Some hospitals now employ bereavement counsellors who work solely with parents whose babies have died. Elsewhere, staff such as hospital chaplains or social workers, or ward staff themselves, are specially trained in the support of parents after the loss of a baby. SANDS welcomes these appointments. It is particularly valuable to parents when support is continued after discharge from hospital.

SANDS recommends that every maternity unit, and every gynaecological ward, should have (or should have access to) staff who have been specially trained to give support after the loss of a baby.

5 AFTERCARE IN THE COMMUNITY

5.1 While great progress has been made in the care given to bereaved parents in hospital, SANDS feels that comparable progress has yet to be achieved in the community. Community professionals, particularly the GP, community midwife and health visitor, should be able to offer bereaved parents the longer term support which many need. However, many parents find that, once discharged from hospital, their continuing needs are unmet, or that the support which is given is badly co-ordinated or haphazard.

5.2 SANDS recommends that community professionals in each area should develop a clear policy in order to ensure that all parents who have had a miscarriage, stillbirth or neonatal death receive the care and support they need.

5.3 For more detailed recommendations concerning care and support for bereaved parents in the community, see SANDS' **Guidelines for Professionals**[1], pages 55-9.

6 PAEDIATRIC (NEONATAL) CARE

6.1 Accounts from bereaved parents suggest that the care given to both dying babies and to parents after their baby's death is generally good—and in many hospitals excellent. Detailed recommendations for the management of neonatal loss are set out in SANDS' **Guidelines for Professionals**[1], pages 33-6.

6.2 *Taking a dying baby home*

In some cases, it may be possible for parents to take their baby home to die. Some will not want to do this, but for others it will be extremely helpful. Some parents may want to take their baby home, but will be unable to do so without support.

It is important that staff recognise that the hospital is a 'foreign' and inhibiting environment for the majority of parents. Many whose baby die in hospital regret that they were never able to be with their baby in the privacy of their own home. Whenever appropriate and possible, therefore, staff should suggest that a baby might be taken home, perhaps at least for a short time, and arrangements should be made for the support that parents need to make this possible.

Some parents value the chance to take their baby home after he or she has died. It can be helpful for them to have time with their baby's body in their own private and familiar surroundings.

7 TRAINING AND SUPPORT FOR PROFESSIONALS

7.1 All professionals who care for bereaved parents need appropriate training and access to support for themselves. Detailed recommendations are given in SANDS' **Guidelines for Professionals**[1], page 75.

7.2 It is especially important to recognise that staff of gynaecological wards have an equal need for training and support.

8 RESEARCH

8.1 At present, the cause of 50 per cent of stillbirths is unknown. Parents are frequently given inadequate or misleading explanations as to why their baby died, although for many this is the single most burning question that they have.

8.2 The total number of stillbirths in 1989 in the UK was 3,688, and it is generally accepted that if the definition of stillbirth is amended to include babies born dead from 24 weeks gestation onwards, this figure will be substantially increased. It is essential that priority is given to research into the causes and circumstances of these deaths.

9 THE CONFIDENTIAL ENQUIRY INTO INFANT DEATHS

9.1 The Confidential Enquiry into Infant Deaths recommended by the Social Services Committee on Infant Mortality[3] in 1988-89 has still not been established. Subsequent reports, including the Government's reply to the Select Committee[4], the National Audit Office report[5] and the Committee of Public Accounts 35th Report on Maternity Services[6] have all urged speed in activating this recommendation.

9.2 SANDS urges that this Enquiry be estabished without further delay, with consumer representation; and that the action recommended is speedily incorporated into practice.

10 CONCLUSIONS AND RECOMMENDATIONS

Throughout this submission reference has been made to the recommendations contained in SANDS' **Guidelines for Professionals**[1]. While every aspect of practice to do with the management of miscarriage, stillbirth and neonatal death is of concern to SANDS, our work in developing the **Guidelines** has highlighted some areas of particular concern. These are:

(i) **The need for training and support for all professionals involved in the management of miscarriage, stillbirth and neonatal death.**

(ii) **The need to develop clear, detailed and appropriate policies for the management of loss before 28 weeks gestation.**

(iii) **Informed parental consent should be obtained before any pathological investigation is carried out. This applies to all babies/fetuses regardless of gestational age.**

(iv) **The urgent need to improve practice concerning the disposal of babies/fetuses/fetal remains lost before 28 weeks gestation so that it is acceptable to parents and respectful in moral terms.**

(v) **The need for improved communication between hospital and community staff following a miscarriage, stillbirth or neonatal death.**

(vi) **The need to provide adequate and appropriate follow up after a miscarriage, stillbirth or neonatal death.**

(vii) **The need for better care for bereaved parents in the community both immediately and, if appropriate, longer term.**

(viii) **The need for research into the causes of stillbirth.**

(ix) **The need to establish the Confidential Enquiry into Infant Deaths without further delay.**

(x) **The need for the Polkinghorne Report to be backed by appropriate legislation.**

SANDS requests that these issues are given serious consideration by the Committee with a view to reducing the distress which inappropriate and inadequate care can cause to parents who have lost a baby.

April 1991

REFERENCES

[1] Miscarriage, Stillbirth and Neonatal Death: Guidelines for Professionals, SANDS 1991.

[2] Review of the Guidance on the Research Use of Fetuses and Fetal Material, HMSO July 1989.

[3] Social Services Committee First Report on Perinatal, Neonatal and Infant Mortality, HMSO November 1988.

[4] Perinatal, Neonatal and Infant Mortality: Government reply to the First Report from the Social Services Committee, HMSO July 1989.

[5] National Audit Office Report by the Comptroller and Auditor General on Maternity Services, HMSO March 1990.

[6] Committee of Public Accounts Thirty-fifth Report on Maternity Services, HMSO July 1990.

Supplementary memorandum submitted by SANDS

THE DISPOSAL OF BABIES BORN DEAD BEFORE 28 WEEKS GESTATION

THE ISSUE

The present legal date of viability is 28 weeks' gestation*. Babies born dead after this time are classed as stillbirths, while babies born dead at an earlier gestation are classed as miscarriages.

Stillborn babies are recognised by the law: they must be registered and a stillbirth certificate issued, and their bodies must be either buried or cremated. But babies born dead before 28 weeks' gestation have no legal status. There is no registration procedure, and no legal requirements for disposal of the body or remains. In this way the law may almost be said to define miscarriage as a "lesser loss", and this has perhaps encouraged a similar notion among professionals. There has, without doubt, been a tendency among professionals to think that the earlier a baby is lost, the less it is loved, and the less need there is for their care and support.

Sadly, neither the law nor such professional attitudes reflect the reality of parents' experience. Many parents who lose a baby before the date of viability feel their loss very deeply. They do not see themselves as having "miscarried" but as having lost their baby. Many need others to acknowledge their baby's existence and the significance of their loss, and many need to find ways of commemorating and mourning their baby. This can be true for parents who lose babies very early in pregnancy as well as those whose babies die at a gestation when they might, if born alive, have stood a chance of survival.

SANDS has recently developed guidelines for the management of miscarriage, stillbirth and neonatal death** which seek to break down some of the artificial barriers created by the legal and professional

* The Government is now committed to legislation, at a future date, which will bring down the age of viability to 24 weeks' gestation.

** Miscarriage Stillbirth and Neonatal Death: Guidelines for Professionals, The Stillbirth and Neonatal Death Society, 1991.

categorisation of loss. The guidelines describe a kind of care which responds to parents as individuals and which takes account of the meaning parents themselves attach to their loss, no matter when that loss occurs.

However, during the development of these guidelines, SANDS became increasingly aware that in one particular area of hospital practice—the disposal of the bodies of pre-28 week babies—there were special difficulties. Both professionals and parents expressed distress and concern about practice in this area—yet there was no clear picture available of what disposal arrangements are usually made. It was felt that separate attention needed to be given to such a sensitive and problematic area of practice and so, as a basis for planning future work, a preliminary survey of hospital practice was carried out.

The Survey

During 1990, SANDS sent out 235 sets of questionnaires to district health authorities (or their equivalent) in England, Wales, Scotland and Northern Ireland. The aim was to obtain information about current practice in the disposal of bodies of babies born dead before 28 weeks' gestation.

Each health authority received five questionnaires, for completion by—

- the District General Manager
- gynaecological wards
- maternity wards
- pathology laboratories
- mortuaries

The response rate suggests that disposal is a matter of current concern for many professionals:

72 replies were received from District General Managers (31 per cent)

119 from gynaecological wards (51 per cent)

125 from maternity wards (53 per cent)

95 from pathology laboratories (40 per cent)

105 from mortuaries (45 per cent).

Findings

1 The responses show that disposal practices are extremely varied. A few hospitals emerge as outstanding, but in the majority there is a need for improvement, and in some, practice is clearly unacceptable.

2 It is clear that the implementation of good practice is complicated by the necessary involvement of a number of different hospital departments and a number of different professionals, and perhaps impeded by lack of co-ordination. Some respondents, answering the questionnaire on behalf of their own department, were apparently unaware of practice in other departments within the same hospital.

3 Although some respondents expressed concern and sometimes anxiety about the disposal of babies lost before 28 weeks, the majority stated that they were satisfied with their arrangements. Yet arrangements in a considerable number of hospitals are certainly not satisfactory from parents' point of view, nor even, in some cases, satisfactory in moral terms.

4 The survey records some disposal practices which are unacceptable:

- 28 mortuaries (27 per cent of respondents) incinerate at least some pre-28 week babies with hospital waste, (22 of these 28 state that they are satisfied with their arrangements.)
- 20 pathology laboratories (21 per cent of respondents) use the waste disposal unit to dispose of at least some pre-28 week babies. Some of these only use the waste disposal for the very smallest babies (eg under 5 cms), after dissection. A few, however, appear to use the waste disposal unit for all pre-28 week babies sent for pathological investigation. A few have no access to an incinerator.

5 The questionnaires did not directly ask whether parents were consulted about what should happen to their baby's body. However, a large number of respondents recorded procedures which were offered "if requested by parents". In particular, cremation or burial is provided by a number of hospitals for babies lost at early gestations *if the parents wish*. It is probable that in a considerable number of hospitals parents' wishes are complied with if they are expressed, but that parents are not explicitly asked what they would like to be done with their baby's body.

6 There was no correlation between the size of hospital and the acceptability of practice. Nor was there always consistency between departments within the same hospital. While practice on, say, a hospital's maternity ward may be very good, practice on the gynaecological ward of the same hospital may be poor.

SANDS' FUTURE WORK

On the basis of these findings, SANDS is now carrying out a small piece of qualitative research in order to find out more about hospital policy and practice and to gain some understanding of the practical and other problems which professionals may face.

The outcome of this work will be recommendations for good practice. These recommendations will include:

— guidance about methods of respectful disposal for all babies lost before 28 weeks' gestation

— the recommendation that parents should know (and feel satisfied about) what is done with their baby's body and should, if appropriate, be offered choices.

June 1991

Examination of Witnesses

MS ROMA ISKANDER, Director, and MS NANCY KOHNER, Stillbirth and Neonatal Death Society (SANDS), examined.

Chairman

1309. On behalf of the Committee, can I thank you for coming. If you could identify yourselves to us I would be most grateful.

(*Ms Iskander*) I am Roma Iskander, the Director of SANDS, Stillbirth and Neonatal Death Society. I came to SANDS from a previous background of being a nurse, midwife and health visitor and working as Professional Officer for the Health Visitors' Association. I have been with SANDS, as its Director, for the last two years and I think the combination of professional background and voluntary sector background has, for me, been interesting.

1310. Thank you very much, and your colleague?

(*Ms Kohner*) My name is Nancy Kohner, I work as an adviser to SANDS and, as a freelance writer/researcher, I specialise in health and social issues, particularly in pregnancy and parenthood.

Mr Sims

1311. The title of your organisation indicates your area of interest but I wonder if you could tell us a little bit more about the structure of it and what your aims and objects are?

(*Ms Iskander*) Certainly. The overriding aim of SANDS is to support bereaved parents. It was established in 1978 and registered as a charity in 1981. It really has four basic aims. The first one is to support parents through a self-help network, so the primary aim is to put parents in touch with other parents who have lost a baby in this way. The second one is to work with professionals, really to feed back the experience, what it feels like from the parents' point of view and so to work with the professionals to develop management of pregnancy and baby loss. Thirdly, to develop an information base which actually gives us a sound base in which to do that; and, fourthly, to promote research. We certainly do not consider ourselves big enough to do research but there is a very urgent need for research in this area to be done so we would like to do everything we can to promote it. We have the equivalent of eight full-time staff, our budget at the moment is about £250,000 a year. We have 211 self-help groups around the country which are autonomous groups so they fund themselves and we refer to them or else local hospitals' contacts will get in touch with groups directly but they are volunteers in the groups, the only paid staff are in the London office.

1312. The budget you refer to is for your paid staff?

(*Ms Iskander*) Yes.

1313. That comes from?

(*Ms Iskander*) It comes from a variety of sources. We have a Department of Health project grant of £22,000 for core money; sorry, the core grant is £22,000, they give us a project grant of £8,000, for the last three years, which has been to raise our profile, primarily to get at more bereaved parents. The Department of Health in England, Section 64 grant is at present 11 per cent of our total expected income for this financial year. This has fallen from 24 per cent of our income when this grant was first awarded in 1988/89. The bulk of the funding, about 58 per cent, comes from trusts and companies and really, at the beginning of the year, that is keep your fingers crossed and hope it comes in; we have, particularly in the last 12 months, had a much better income from publications, really because we have been working on publications which have come up for sale, in this year in particular, but we know that that is going to be a hiccup, that the sales of that will also drop off, so most of it from trusts and companies.

Rev Smyth

1314. What particular organisational difficulties militate against the provision of a focused service for parents who may have been bereaved?

(*Ms Kohner*) When you say "organisational", do you mean within hospitals?

1315. Yes, or within the community?

(*Ms Kohner*) I think there are a number of problems which act as obstacles to the provision of a high-quality service and the most fundamental of those is that, obviously, this is a very difficult area, that bereavement and loss, and, most particularly, bereavement and loss to do with the loss of a baby is a very difficult area for professionals to work in and that applies to a whole range, all the professionals who are involved. I think there is a further general difficulty which affects the quality of provision, which is to do with the fact that, on the whole, the maternity services are geared to successful, healthy outcomes and loss is not generally recognised as an

[Rev Smyth *Cont*]
essential, integral feature of what their services are about. The result of that may be that in both the hospital and the community there is an absence of recognition of the need for policy and the development of good practice and that obviously affects individual professionals. Lastly, I think the main difficulty which individual professionals are coping with is the fact that their training for managing and caring for bereaved parents is, on the whole, insufficient.

1316. Certainly, your own organisation, despite some 10 years of existence, is only reaching a small number, would you say, to do with that?
(*Ms Kohner*) Of professionals?

1317. Yes, when you are scattered throughout the whole country?
(*Ms Kohner*) The number of professionals that we reach has, without doubt, I would say, increased dramatically this year with the publication of our guidelines which you have, I think, seen.

Chairman

1318. From what to what: you can go from one to 10 and that is a dramatic increase but from what base are you starting?
(*Ms Iskander*) Within the office, we monitor 'phone calls and letters which come in and out and at the moment it is running at something above 5,000 a year professionals contact just the office; that is something like a 70 per cent increase over the last two years. The second side of it is less accurate, in terms of monitoring, it is asking the groups exactly what they are doing and, certainly, the figures we have recently are that a very high proportion of those groups go into hospitals, are asked to go into hospitals, to talk about their experience.

Mr Couchman

1319. Could I just clarify something you said earlier; you said, I think, that there was an urgent need for research. Could you tell us what particular research projects you would like to see taking place?
(*Ms Iskander*) I think it is true to say that for a very large number of parents the question about why their baby has died is absolutely burning, because in the absence of reasonable explanations it must be your fault. I think there are other questions around why, but there is a very real need to know that. There are also estimates of about 50 per cent of stillborn babies for which there is no known cause—we have a briefing paper if you want any more information about that—because the complexities of how the death certificate is recorded about maternal causes and fetal causes, and there are lots of each, make it very difficult to interpret and, certainly, things like hypoxia, which simply means not enough oxygen, are not sufficient in terms of an explanation as to why that baby died.

1320. Can I then turn to how you monitor improvements, or lack of them, in the services which are offered and, indeed, the impact of your own work, such as the publication of "Miscarriage, Stillbirth and Neonatal Death"?
(*Ms Iskander*) How SANDS monitors its own work?

1321. Yes, and monitors other improvements in the services provided?
(*Ms Iskander*) I think that the mechanisms for monitoring our own work are certainly to have quite tight plans on a three-year basis and on an annual basis and to look at whether those targets have been reached and, certainly, we have been, I think, very successful in reaching those and can demonstrate that. I think the figures that we collect within the office, certainly over the last 12 months the contacts in and out of the office have gone up from 18,000 to 30,000, that is from a mixture of parents, professionals, media and increased administration, we are sending out publications, so I think that is partly indicative of how much the work has increased and how much the interest has increased. From the groups' point of view, we ask them on an annual basis, though we have only just started to do that so, as I say, I think that is fairly tenuous; we did it fairly comprehensively in 1987 and certainly the number of parents contacting the local groups has doubled, from about 1,500—this is new parents contacting the groups—to 3,000 last year. We have not done any evaluation of the guidelines, as such, and at the moment our plans for next year are not to evaluate the guidelines other than to look at what is clearly an increase in interest from professionals, because we think next year's focus must be on developing the self-help network and, obviously, with a staff of eight one has to prioritise fairly tightly. However, in the past eleven months we have distributed 7,000 copies of these Guidelines for Professionals.

Chairman

1322. Has the provision of care across the three groups, that is miscarriage, stillbirth and neonatal deaths, been uniformly good or uniformly bad?
(*Ms Kohner*) That is quite a difficult question to answer. There is not really any uniformity and there is a sense in which there should be no uniformity, because a fundamental principle of good care is that it responds to the individual needs of the parents and this means that, on the whole, therefore, a good quality service will be a very variable and certainly a very flexible one. To answer you more directly, it is true to say, I think, and our experience is that whilst the quality of care given to bereaved parents who have lost a baby through stillbirth or neonatal death is now of a much improved standard and the last 10 years have seen dramatic improvements, as I am sure you know, nonetheless, there is still a great deal of work to be done in loss before 28 weeks gestation and perhaps even increasingly, as one moves backwards down the gestational ages; that is our experience both through parents and through our contact with professionals.

Alice Mahon

1323. Do you think all health professionals who potentially will be caring for people who have lost their babies should receive some kind of special training in bereavement counselling and if you do think that which profession do you think is best placed and best able to perform the function?
(*Ms Iskander*) I think the need for training professionals is massive. I think there are a number

[**Alice Mahon** *Cont*]
of things. I think if you look at the figures of something like estimates of, and there are no reliable figures of pregnancy loss under 28 weeks that SANDS can find but there are guestimates of 20 to 25 per cent of pregnancies confirmed medically will end before the 28th week; that is a very high figure. If you add to that stillbirth and neonatal death, which is about 1 in 100 babies will die from stillbirth or neonatal death, there is a staggering lack of provision in both planning the policies for the service and training the professionals who are within it for them to be able to respond well to this group of parents. I think, for us, there is a very keen need for professionals to really understand what it is like, what it means to lose a baby at this stage and during pregnancy, I mean stillbirth, neonatal death and during pregnancy. Nancy might like to say a little bit more about that.

(*Ms Kohner*) Just picking up, I think you said training in counselling skills and I think that, possibly, there is a sort of hiccup around professional training at the moment in this field, in that it is always associated with training in counselling whereas, in fact, our experience tells us that it is training involving different components and not necessarily always counselling with a big C. For example, professionals need to, both for the sake of their own confidence and for the sake of the parents, have a very sound knowledge of the procedures which relate to different kinds of loss and be skilled enough to communicate about those procedures to parents. That goes alongside understanding enough about the experience to be able to deal sensitively with parents and respond to their individual needs, which may or may not involve counselling skills, if you understand what I mean.

1324. I think it is a very important area. If I could just move on because, there again, personal experience, the first baby I lost, the woman's body is operating as if she still has a baby and milk is being produced and I found that one of the most painful experiences and yet nobody seemed to have any time to explain and I think you need somebody to talk, as well, because that is the other thing, people think that you do not want talk about it and, of course, women do want to talk about it?

(*Ms Iskander*) I think one of the things which is staggering to us, and certainly would be enormously helpful to both parents and professionals, is the lack of policies. You have just heard SATFA say that communication between hospital and the community does not always happen. I think that if there are some policies in place, so that the staff know what to do, it certainly helps from a training point of view but it also helps because this is a very difficult area of work for professionals to work in so there is also a need for the professionals to be supported in order to deliver care.

Chairman

1325. On this special aspect, if I may come in here, Alice, is it not true that sometimes intensive care has to be withdrawn from a baby where there is an absolutely hopeless prognosis; I think you will agree that that does happen? Do you agree that this is a situation which needs what I would describe as especially careful management and handling and how well, from your point of view as an organisation, do you think that this is managed, because it is really very much along the lines that Mrs Mahon has just been putting questions to you?

(*Ms Kohner*) I cannot comment on that specific situation with any specific information about the quality of care that is given. I agree absolutely that that situation, as with every other one which occurs within this whole range of loss, needs to be very sensitively and carefully managed and our experience of the way in which that care is given is that it is very patchy and in every aspect of care for every story of excellence one can match a story of incompetence. All those stories reflect the need for policies and work on improving practice, very largely through training.

Alice Mahon

1326. Is the pressure on staffing for post-natal care a source of inflexibility suffered by some bereaved couples?

(*Ms Kohner*) A staffing problem in neonatal units?

1327. No, in post-natal care?

(*Ms Kohner*) I would say that our experience is much more that the pressures on staff have a harmful effect on the quality of care that is given on the gynaecological wards more than on the post-natal wards and there are, I think, special problems for the gynaecological nurses in dealing with this kind of work; we are certainly less conscious of that post-natally.

Audrey Wise

1328. You indicate that SANDS should have a role in the training of professionals. Have you put any proposals to the Department of Health to get funding for specific projects, such as particular training packages?

(*Ms Iskander*) No. We have had meetings with the Department and tried to explore with them the best areas of project grants to put in and training for professionals was not, apparently, one of them.

1329. Do you mean that they did not think that training for professionals was appropriate?

(*Ms Iskander*) This was a completely informal discussion. As with any sort of funding, you move around, we have got these ideas for things, which ones might it be worthwhile us putting applications in on; so, no. I think that the expertise SANDS now has, both from working with parents and working with professionals over a period of time, does give us exactly that, a lot of expertise and things that we think would be very valuable to the Health Service in all sorts of ways, in policy advice, in workshops, in training. We are looking at that as an initiative for next year and, obviously, the funding of it will be important and it is also a potential source of income, we would certainly not do it in a way which was not also very supportive to the organisation as a whole.

1330. You mention various publications, guidelines for professionals, and is your feeling that you should have a hand in training professionals; would you want to be able to build on the written material that you have provided as guidelines in a more face-to-face way?

[**Audrey Wise** *Cont*]

(*Ms Iskander*) I think, if you spend a lot of time when you produce a publication which the professionals and everybody are acclaiming then, yes, the logical side of it is that we would like to support that becoming practice because, I think Nancy will probably like to say a little bit more, it is not just about following guidelines, it is also about understanding what is behind them. I think it is also true to say that, as an organisation, there is a debate about how appropriate it is for a small, voluntary organisation to be spending such a lot of time, energy and resources on policy development and I think if we had felt confident that that would be done well by other people it is probably not an area that we would have focused on as much as we have done, particularly around disposal and the management of pre-28-week loss. SANDS is currently looking at the possibility of offering training to health professionals to follow up our written material during 1992/93. No funding has yet been obtained.

1331. You obviously have not felt that it would be done as properly if you did not focus on it?

(*Ms Iskander*) We have not seen any evidence of anybody else doing it or being interested in doing it and there was a very urgent need, from the parents' perception.

1332. One of the things which you talk about in your evidence, in paragraphs 3.1 and 3.2, is delivery after death *in utero* and you have, apparently, produced guidelines in relation to that particular topic. Why do you think that that is important; do you think that the handling of such a difficult delivery situation might affect a woman's attitude to future births or have you got experience of the sorts of problems which can arise in other ways?

(*Ms Kohner*) The answer to that is yes, but I think in a way you may have misinterpreted the reason why that was included in our evidence; we were attempting, I suppose, to respond to the topics with which the Committee were concerned at that time. The guidelines for professionals, which is referred to in those paragraphs, are, in fact, comprehensive guidelines which cover not only the management of delivery after death *in utero* but every aspect of care for parents who have suffered a miscarriage, stillbirth or neonatal death and I think we would want to emphasise very much both the role of that publication and its relevance to all that you are considering, in relation to professional practice after loss. To pick up on what Roma was saying, I think our experience of developing those guidelines and of distributing them to hospitals has demonstrated to us very forcefully just how needed they were and are and how they only take us really one stage along the road of improving practice and, in fact, what the distribution of those guidelines has brought about is a demand for the next stage.

1333. How have you arrived at the guidelines; does it come from the knowledge that you get from women who have gone through the experience, or quite how?

(*Ms Kohner*) The guidelines were developed over quite a lengthy period of time, they originated from and the development was informed by the experiences of parents that were known to SANDS and also to the other parent support organisations which were involved. The guidelines were developed by means of a working party which—and you will find it actually listed in the book—consisted of representatives from all the interested organisations, the professional organisations, which met regularly in order to debate some of these very difficult points about the management of miscarriage, stillbirth and neonatal death. Within the forum of that working party, over this period of time, a great many difficulties to do with management were, in fact, I think, progressed in a way in which they had not been ever before.

1334. You have indicated that sometimes there is a professional tendency to categorise miscarriages a lesser loss and that that can cause insensitive management. Have you come across worries and frustrated feelings in women who have suffered a miscarriage and have felt desperate to know if there was any reason for it which could be found and have been told, "Oh, you have to have several miscarriages before anybody will do any investigation or anything", which makes them feel really as if, I think it is obvious how it would make them feel? Is it just that I have come across this or does it happen in your experience as well?

(*Ms Iskander*) I think some of SANDS' primary experience has been with people who have had stillbirth and neonatal death. I think what we have found is an increasing number of people who have lost babies before 28 weeks have been coming to us but I think an organisation which has been going for a similar length of time is the Miscarriage Association and, certainly, I think the early, repeated losses, that is probably the organisation which would be able to give you the information, in answer to that question.

1335. Lastly, you talk about the needs of fathers and I have noticed in your oral evidence you have constantly talked about "parents". What kind of needs do you think fathers have which might not be being met at the moment?

(*Ms Iskander*) I think that the sort of crucial need which fathers have is to be recognised; I think that the loss is often not sufficiently recognised and if you amplify that for the men concerned they will certainly tell you very clearly that they feel very deeply, very frequently, if not always, in the case of stillbirth, that this was their baby, too. I think the whole process of how not only professionals manage them but also the general public is that they are underestimated in terms of their feelings. I think anything we say about professionals I think it is SANDS' experience that the professionals desperately want to get it right and all the evidence we have of working together is exactly that, so I think it is not about any sort of malicious oversight, it really is about understanding and taking different needs into account.

Audrey Wise: I think the Committee would understand that.

Chairman

1336. You recommend that burial costs for all babies born dead before a viable age should be met if the parent/parents request it. Do you recommend this regardless of the length of pregnancy?

(*Ms Kohner*) Yes.

[**Chairman** *Cont*]

1337. Could you expand very briefly on your recommendation for a follow-up appointment for women who have lost a baby and, particularly in relation to this matter, do you feel that perhaps the community midwife is the ideal person who should have the responsibility for counselling the parent/parents when a tragic death has occurred?

(*Ms Kohner*) I do not think that the community midwife is necessarily the only professional who should take on that role. The needs of parents for follow-up will, for example, relate to needing a great deal of information, following perhaps a post mortem, and it may be, therefore, that the appointment at the hospital is a vital part of that follow-up; in other words, all parents should be offered some kind of appointment which will give them the information they are seeking about their loss.

1338. You do not think it is better to give that information in the secure surroundings of a home, where you feel more relaxed, rather than in the rather clinical, tense atmosphere of a hospital and, therefore, the midwife, who is, of course, clinically qualified, as well as perhaps having many social attributes as well and abilities, is one of the more reasonable people to look to for this sort of very sensitive counselling?

(*Ms Kohner*) As indeed the GP may be also. I think that there is a connected issue, which is follow-up care, where I think the role of the community midwife and her home visits is vital. I cannot say whether parents would actually prefer to receive information about the results of a post mortem from the obstetrician or paediatrician within the hospital but my guess is that that may be so in many cases.

1339. You made a number of excellent recommendations at the end of your April memorandum: to which one would you, in fact, attach the highest priority?

(*Ms Iskander*) We had four actually.

1340. Put them to us, briefly?

(*Ms Iskander*) We did this independently and together and came up with the same priorities, which was reassuring. I think the first one is very definitely, from SANDS' point of view, number two, which was to develop clear, detailed and appropriate policies for the management of loss before 28 weeks; that would resolve the communication between the hospital and the community, it would take in the whole issue of disposal, which is such a big one, it would help staff in terms of training and support and is clearly the biggest area of need from both the professionals' and parents' point of view. That would definitely be number one. I think number two is about research and the lack of research, particularly when you look at the figures in comparison with other areas which are researched. The third one would be the training and support of staff, I think that is very, very necessary, in the whole range of loss, because actually understanding it is quite complex. The fourth one is, as I say, the need for increased communication between hospitals and communities and, possibly, named people to do that.

Chairman: Can I say I am delighted that you have given those as priorities, it is very helpful to our inquiry. Thank you very much to SANDS for coming and giving us such valuable evidence. Thank you.

WEDNESDAY 11 DECEMBER 1991

Members present:
Mr Nicholas Winterton, in the Chair

Mr David Hinchliffe	Mr Andrew Rowe
Alice Mahon	Mr Roger Sims
Sir David Price	Audrey Wise

Memorandum submitted by Professor Eva Alberman

Contents:

COMMENTS AND DIAGRAMS BASED ON TABLES PRODUCED FOR THE HEALTH COMMITTEE*

Social and Occupational Categories and Types of Birth Registration

Social class and occupational groupings are traditional indicators of economic and social circumstances, but their close relationship with other demographic factors, with educational level, and with culturally determined behaviour must be taken into account when attempts are made to understand their influence on health outcomes.

The Committee have asked specifically about relationships between social and occupational categories and birth registration for births inside and outside marriage, and Figures SC1 and SC2 (derived from Table 2A) give some idea of the complexity of the relationships between these variables.

Use of maternal and paternal occupation

Father's occupation is used for categorising occupation and social class in "inside marriage" and "joint registrations", but for sole registrations the mother's occupation is used. Since the nature of female occupations differs markedly from male occupations, and since in any case childbearing women are more likely than men never to have had any paid occupations, no meaningful comparison can be made between male and female occupational-based categorisations. It also means that births for whom no social class categorisation is possible are predominantly derived from "sole registrations".

An example of the influence of which parent's occupation is used is seen in Figure SC1, which shows that almost 70 per cent of mothers involved in sole registrations, but at most 5 per cent of fathers involved in other registrations, have not had any paid employment (although this does not imply unemployment).

Social class distribution and type of registration

For those sole registrations where the mother did give a codable occupation, it was most likely to be in Social Class III non-manual (Figure SC2), since this group includes most female dominated jobs such as shop assistants, or hairdressers. This also shows the overall tendency for social class categories derived from womens' occupations to be clustered around the middle of the distribution, compared with that derived from mens' occupations.

No account has been taken in these data of the close relationships of occupational status (and therefore social class) with parental age and with birth order (the latter currently available only for married mothers). "Sole" registrations will be to a group of mothers who are younger and probably more likely to be first births than the other registration groups, and these factors have a considerable influence on outcome. Moreover the absence of an acknowledged father on the birth certificate, or from the same address, almost certainly implies financial disadvantage, as well as lack of other kinds of support.

*Not reported

However to some extent patterns of social class distribution within the registration groups other than the "sole registrations" may also reflect different cultural patterns within social class grouping. The proportions of social classes I and II fall and of IV and V rise consistently, from the "inside marriage" registrations to joint registrations with the same address to joint registrations with different addresses.

Social class and birthweight distribution

The combination of the adverse influences in the groups born outside marriage must be taken into account in considering the findings on birthweight distribution illustrated in Figure SC3 (derived from Table 2A). This compares the distributions in the different registration groups, using livebirths in England and Wales as an example. The most favourable distribution, with fewer births in the low weight and more in the high weight groups, is in the "inside marriage" group, and the least favourable in the "sole" registrations.

Social class, type of registration and stillbirth and infant mortality rates

It is therefore not surprising (and very well known) that infant mortality rates, particularly after the first month (postneonatal) are lowest in births inside marriage (examples given in Figures SC 4 and 5 derived from Tables 3d and 3e). The effect, in joint registrations, of the father having resided at the same address is however somewhat variable. The most striking effects in these Figures relates to the groups usually grouped together as "other social classes", those who gave a paternal employment which was inadequately described and therefore not codable, and those who did not give details of any full-time occupation, either at the time of birth or before. As described in paragraph 1.1.2 the term unemployment is not used, and most of the latter group are "students", which would include those still at school right up to full-time higher education. These groups are clearly at much higher than average risk of infant death, particularly after the first month.

The Figures also show the fairly consistent, but smaller upwards gradient of risk of infant mortality with falling social class, a gradient that is most marked in the two largest groups: "inside marriage" and "joint registration" where parents gave the same address.

Births of < 1,500g and their mortality

The small proportion of births of very low birthweight contribute quite disproportionately to overall infant mortality. In the data provided to the Committee is Table 1b which gives for each Health District Health Authority the number of livebirths of this weight. The represent less than 1 per cent of all such births in England and Wales (Table 1b) but 47 per cent of neonatal deaths and 30 per cent of all infant deaths (Tables 1f and 1h). Figure BW1 for RHA's only, shows that the proportion of such births varies, being least in East Anglia, and highest in NE Thames, but that their mortality also varies, being lowest in East Anglia, Oxford and NE and NW Thames, and highest in the W Midlands.

It is known that a proportion of these very small babies also have severe congenital malformations, and in order to have some idea of the possible effectiveness of medical care in keeping normally formed low birthweight babies alive it is necessary to exclude those as far as is possible. Notifications of malformations are not linked with births, so this can only be done by excluding those that were certified as dying from this cause. This has been done in the next section.

District variations in (?)avoidable deaths

This question can be explored by the use of data in the series of Tables lc-lh, examples of which are illustrated in Figures AD. The nearest category to an "avoidable" death that can be achieved with these data are those of babies weighing more than 1,499g, and not certified as dying from a congenital malformation, although it must be remembered that without more information about the pregnancy and birth the interpretation of these as "avoidable" must be guarded.

The figures present the data in two different ways. Figures AD present infant mortality rates by region, the overall rate being calculated in the conventional way, all infant deaths being the numerator, and all live births in the same calendar year the denominator, and the result multiplied by 1,000 for ease of presentation. For the present analysis the rate is split into four groups, one component due to deaths under 1,500mg other than due to a malformation; the second in the same weight group but where a malformation was the cause of death; the third, deaths weighing 1,500g or more not due to a malformation; and the fourth the same weight group but where a malformation was the cause of death.

Figure AD1 gives the findings and the regions are ordered by the overall rate, the East Anglian RHA having the lowest overall rate (although it will be shown shown the sub-groups rates are not always the lowest), Yorkshire the highest. Figure AD2 is ordered by the proportion of deaths (of all weights) due to congenital malformations, and this time Mersey has the lowest rates due to this cause and Yorkshire still the highest. Figure AD3 is ordered by the proportion of the infant deaths weighing less than 1,500g without malformation as a cause, and this time West Midlands has the highest rates, although the East Anglia RHA remains as that with the lowest rates due to this cause. Figure AD4 is ordered by the proportion of deaths weighing 1,500g or

over, and not dying of a malformation, and now the lowest proportion of the NW Thames, and the highest again in Yorkshire.

Figures AD5-9 present the same rate data but in a different way. These give the actual mortality rate within the eight groups. These are unusual, and cannot be compared with most other published data, but they do give the mortality rate in the babies in these high risk groups. Both Regional and District data are illustrated in the Figures, which are however restricted to infant deaths only.

These figures confirm the higher risk in Yorkshire, for both the very low and the remaining weight groups, and indicate some Districts with apparently raised risks. For example Barnsley and Bassetlaw in Trent seem to have unusually high rates of non-malformation deaths in the babies weighing less than 1,500g; as does Shropshire in the West Midlands, and Pembrokeshire in Wales. The Isle of Wight also stands out as unusual. However these comments are based only on a rapid eyeballing of the tables, and no firm conclusions should be drawn without further statistical analyses. The figures are shown only as an example of the use of the data.

INTERNATIONAL COMPARISONS

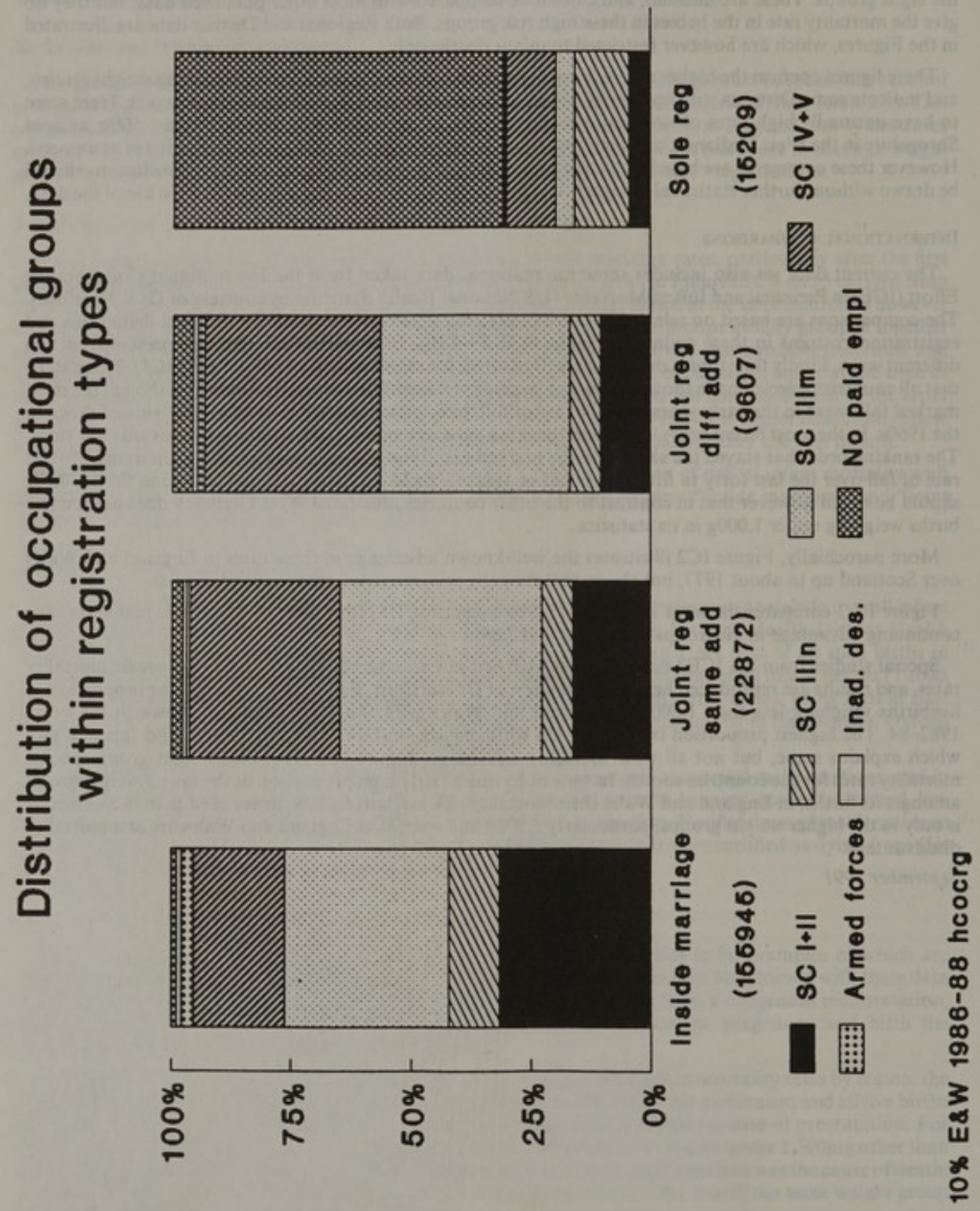
The current data set also includes some international data taken from the International Collaborative Effort (ICE) in Perinatal and Infant Mortality (US National Health Statistics by courtesy of Dr R Hartford). The comparisons are based on selected countries only, and make no allowance for different definitions and registration customs in these countries (Tables ICE T1-T10). Examples of the data are presented in two different ways. Firstly time trends over time are illustrated, for infant mortality only (Figure IC1). These show that all countries selected have shown rapid and largely consistent falls in infant mortality, although the most marked falls were in the early years, and the rate of fall, in England and Wales particularly, slowed down in the 1960s. In the most recent years illustrated there is a general tendency to a convergence towards low rates. The ranking order has stayed the same with the marked exception of Japan which has had an unusually fast rate of fall over the last forty to fifty years, and of West Germany, whose rapid fall started in the 1970s. It should be noted however that in contrast to the other countries illustrated West Germany does not include births weighing under 1,000g in its statistics.

More parochially, Figure IC2 illustrates the well-known advantage in these rates in England and Wales over Scotland up to about 1977, but shows that now the two countries' rates are very similar.

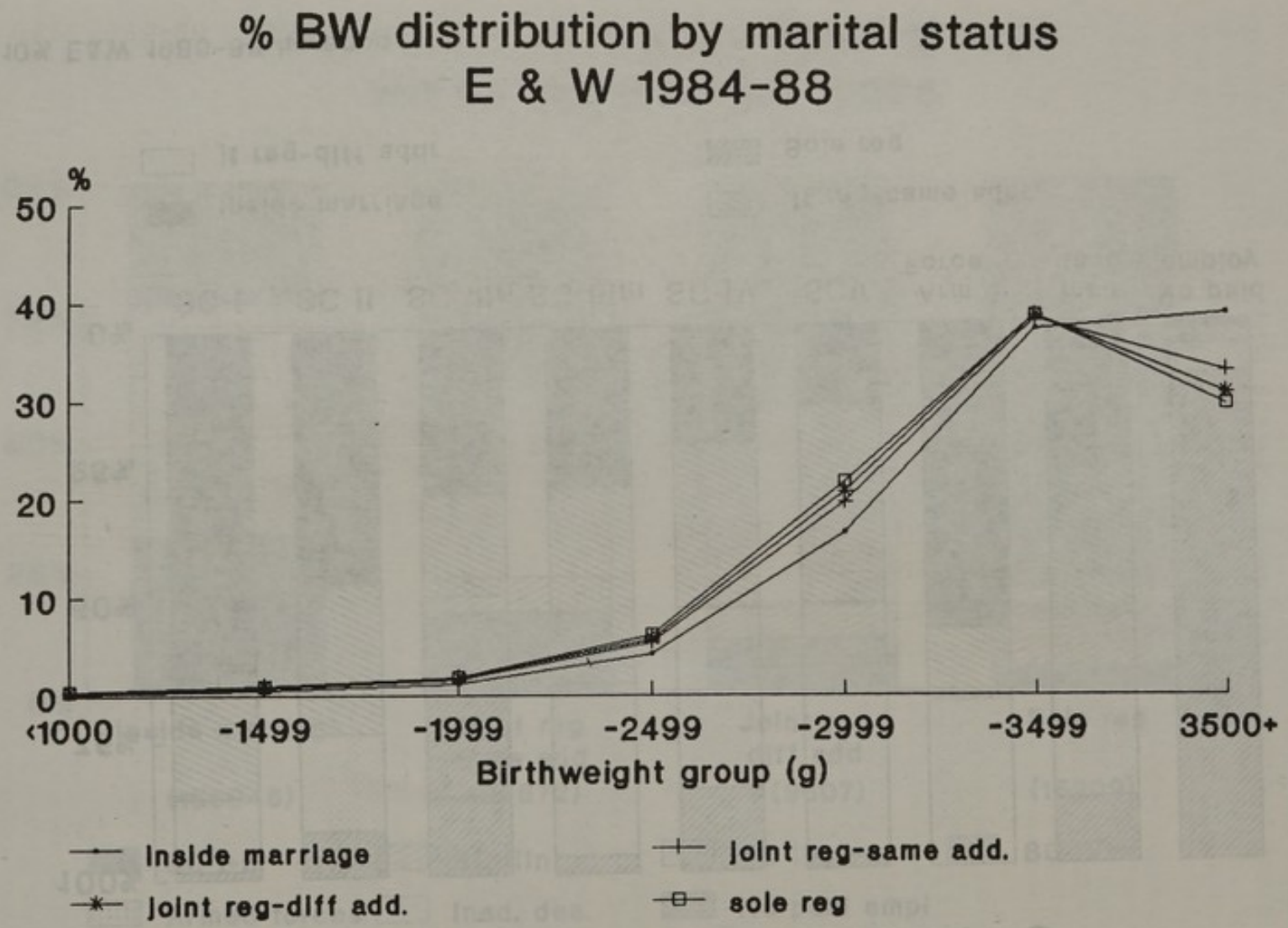
Figure IC 3 compares the most recent data (1989 except for US) for different age groups and shows the continuing advantage in all groups of Sweden and Japan.

Special studies from the ICE2 data have been carried out on international birthweight specific mortality rates, and results are reproduced here by permission of Dr Hartford. Figure IC4 compares the proportion of livebirths weighing less than 1,500g in England and Wales with the other countries shown in the years 1982–84. The highest proportion is amongst US white babies, and the lowest in Sweden and Japan, a fact which explains some, but not all their mortality advantage. Figure IC5 gives birthweight group specific mortality rates for the countries shown. In spite of having a fairly high proportion of the lowest weight group amongst its births, in England and Wales their mortality risk is relatively low, lower even than in Sweden. It is only in the higher weight groups, particularly 3,500g and over, that England and Wales are at a mortality disadvantage.

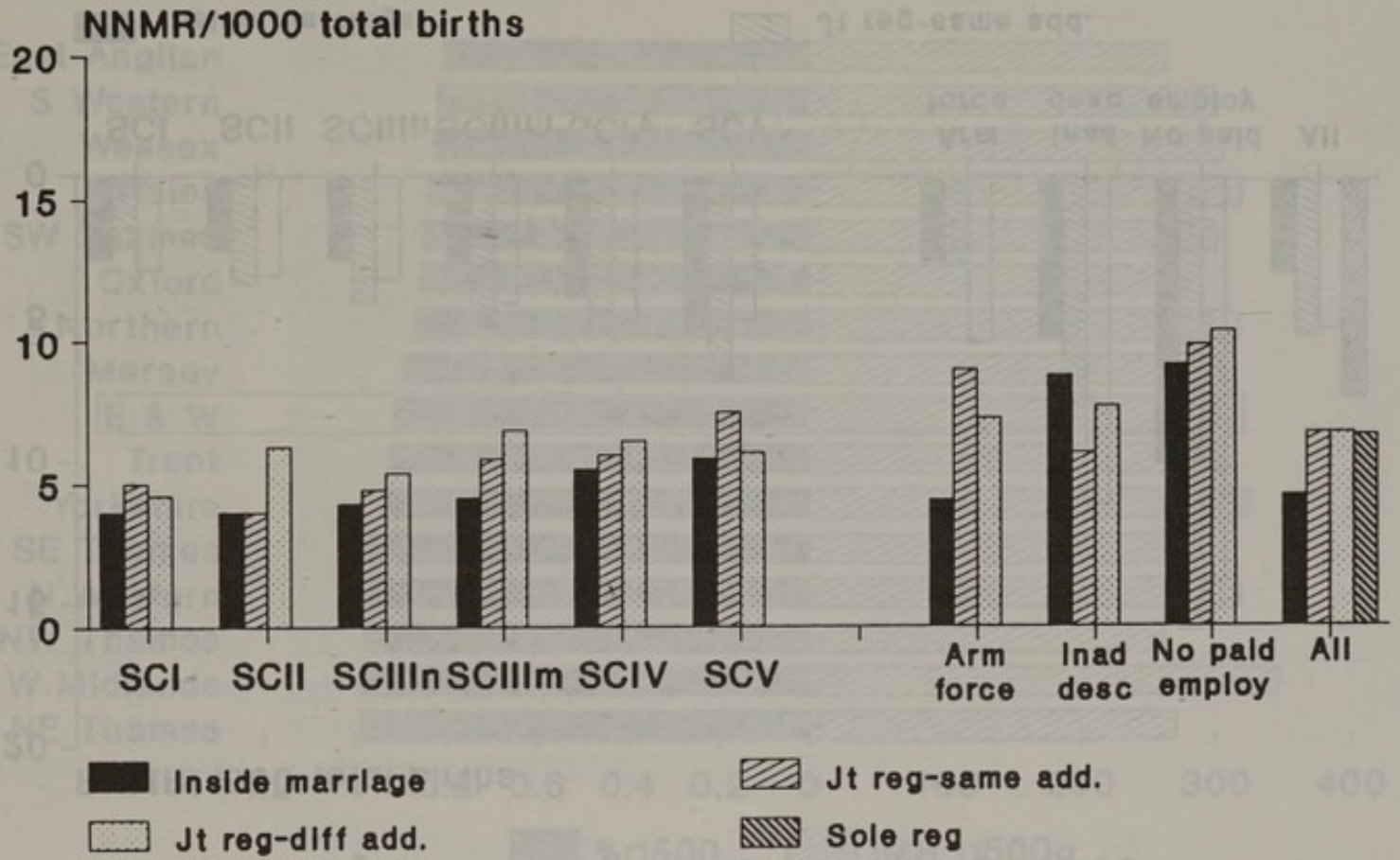
September 1991


Distribution of occupational groups within registration types
100%
75%
50%
25%
0%
Inside marriage (165945)
Joint reg same add (22872)
Joint reg diff add (9607)
Sole reg (16209)
SC I+II
SC IIIn
SC IIIm
SC IV+V
Armed forces
Inad. des.
No paid empl
10% E&W 1986-88 hcocrg

Type of registration
within occupational grouping
100%
75%
50%
25%
0%
SC I
SC II
SC IIIn
SC IIIm
SC IV
SCV
Arm Force
Inad desc
No paid employ
Inside marriage
Jt reg-diff addr
Jt reg-same addr.
Sole reg
10% E&W 1986-88 hcregoc

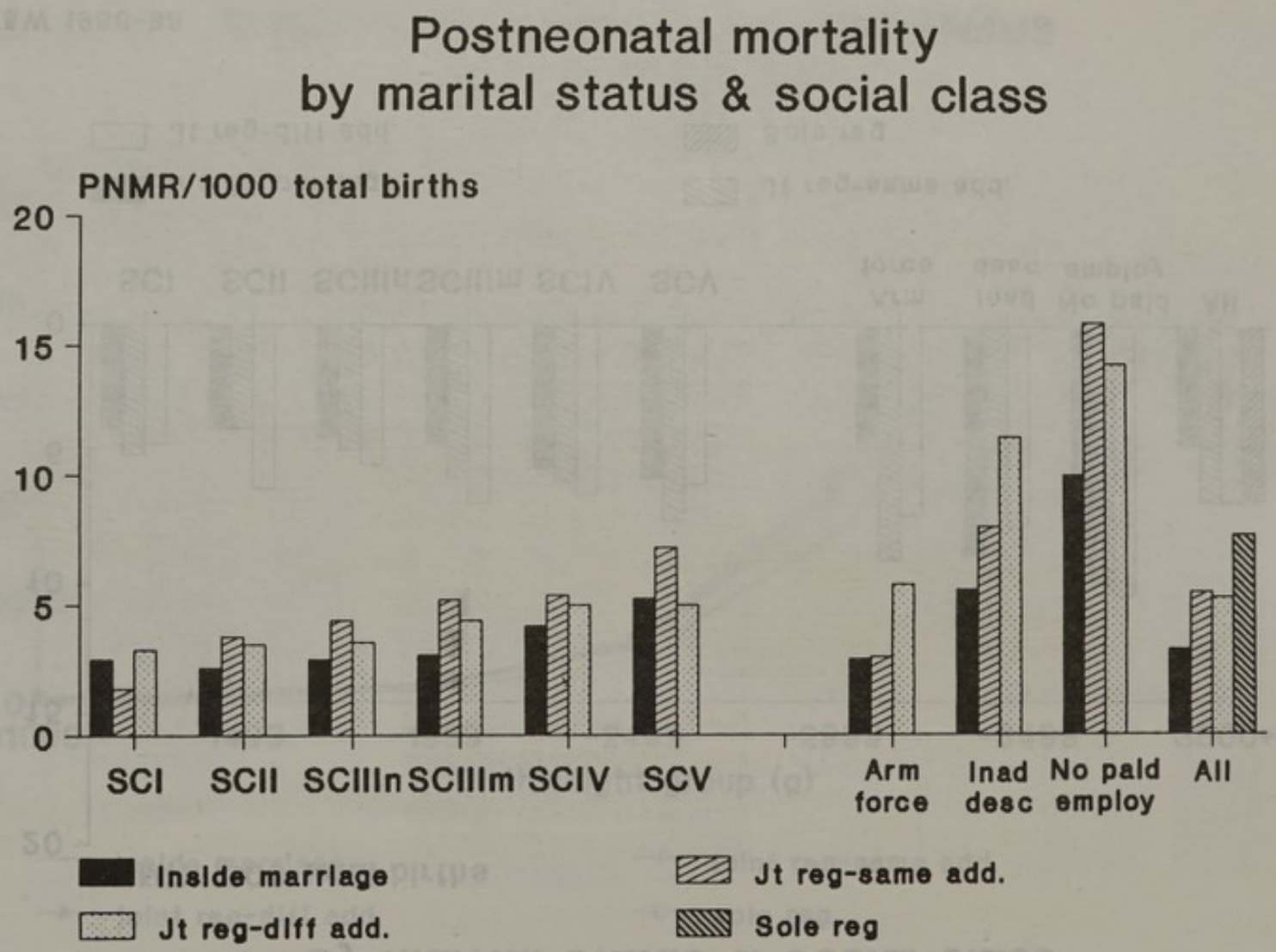

% BW distribution by marital status
E & W 1984-88
%
50
40
30
20
10
0
‹1000
-1499
-1999
-2499
-2999
-3499
3500+
Birthweight group (g)
Inside marriage
Joint reg-diff add.
Joint reg-same add.
Sole reg
OPCS livebirths hcbwma

Neonatal mortality by marital status & social class



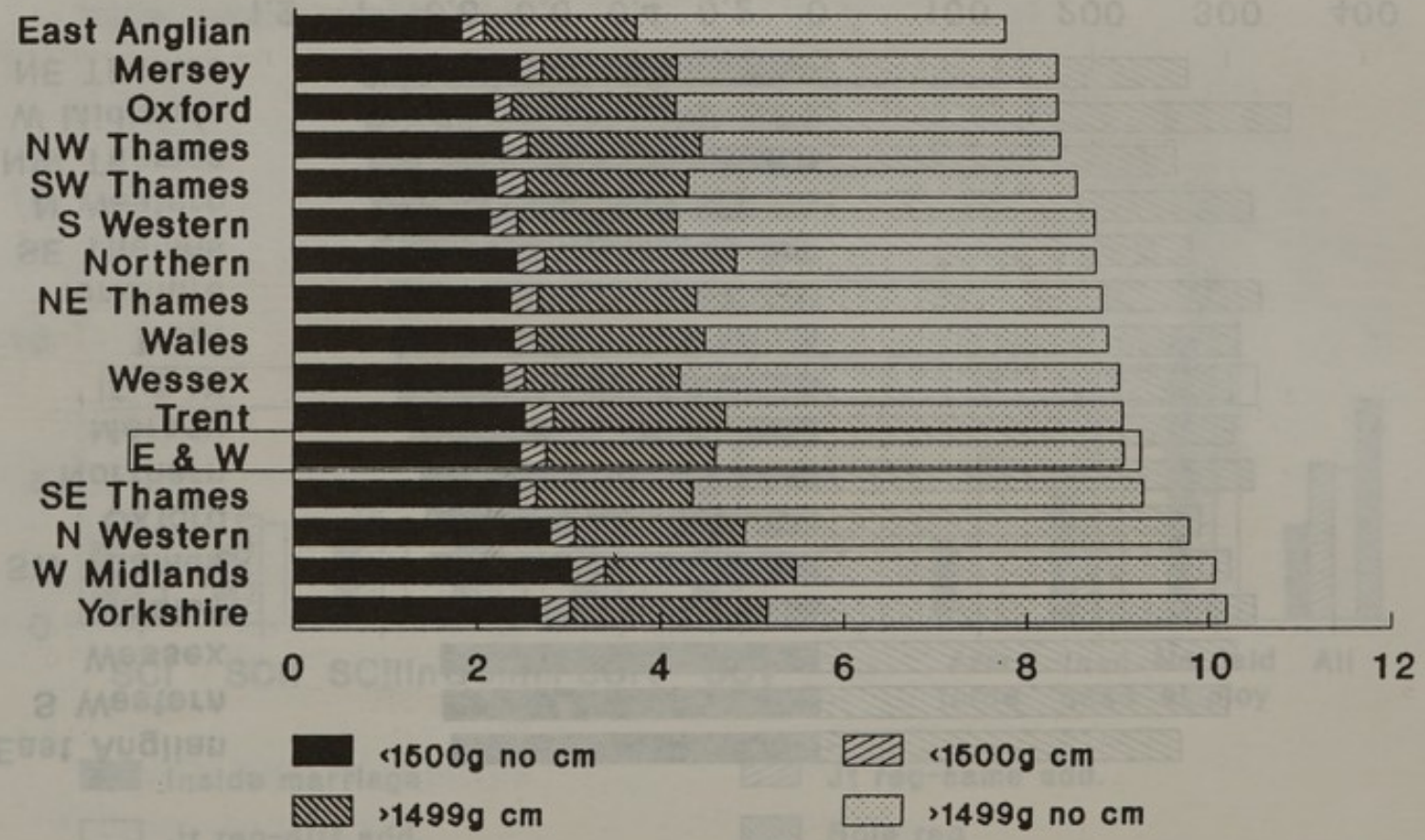
E&W 1986-88

/Continued


Postneonatal mortality
by marital status & social class
PNMR/1000 total births
20
15
10
5
0
SCI
SCII
SCIIIn
SCIIIm
SCIV
SCV
Arm force
Inad desc
No paid employ
All
Inside marriage
Jt reg-diff add.
Jt reg-same add.
Sole reg
E&W 1986-88

Incidence and IMR <1500g
All RHA's 1984-88
East Anglian
S Western
Wessex
Wales
SW Thames
Oxford
Northern
Mersey
E & W
Trent
Yorkshire
SE Thames
N Western
NW Thames
W Midlands
NE Thames
1.2 1 0.8 0.6 0.4 0.2 0 100 200 300 400
%<1500
IMR <1500g
OPCS

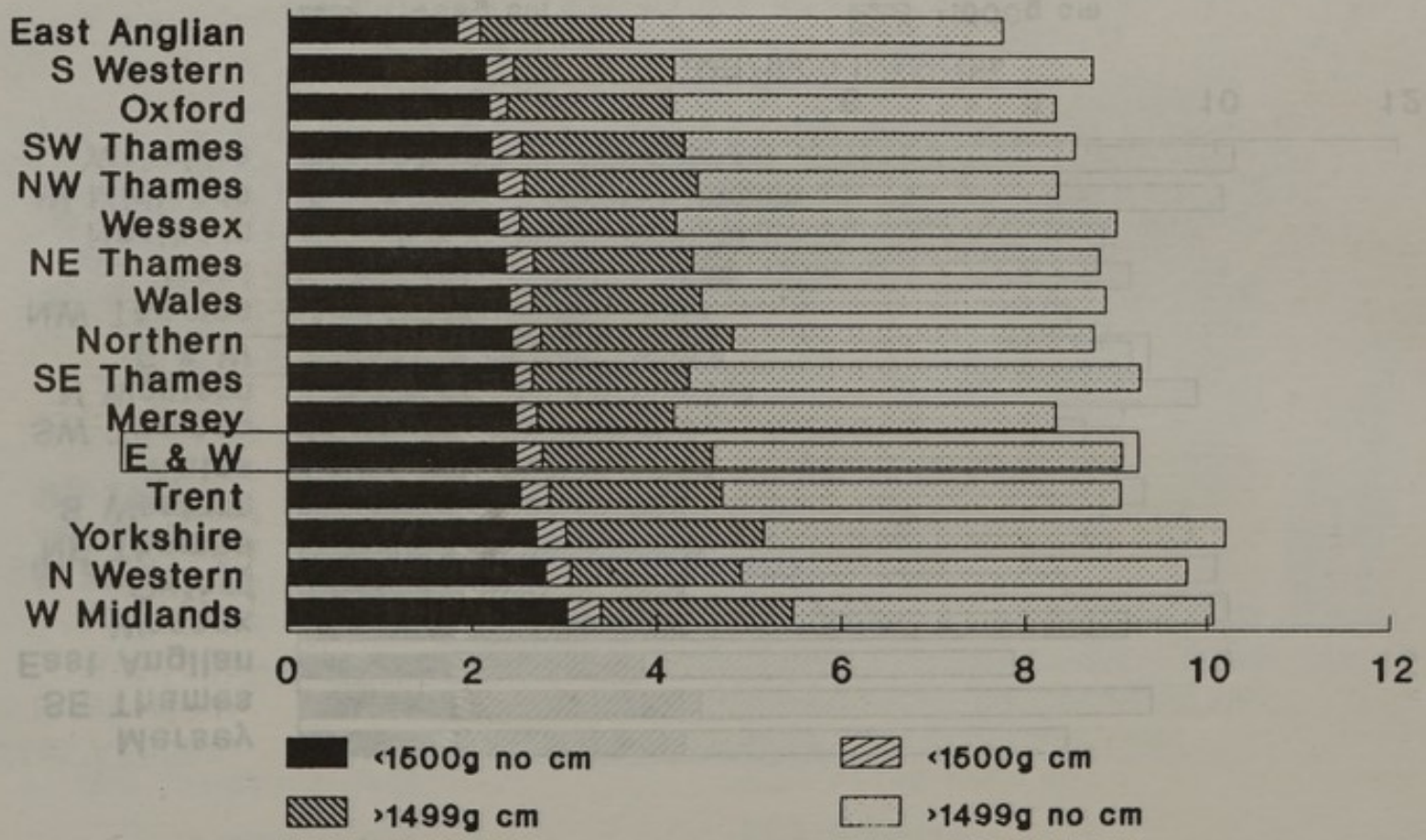
Infant mortality rate/1000 liveborn divided by weight and cong malfs



All RHAs-1984-88 hcrhaor1

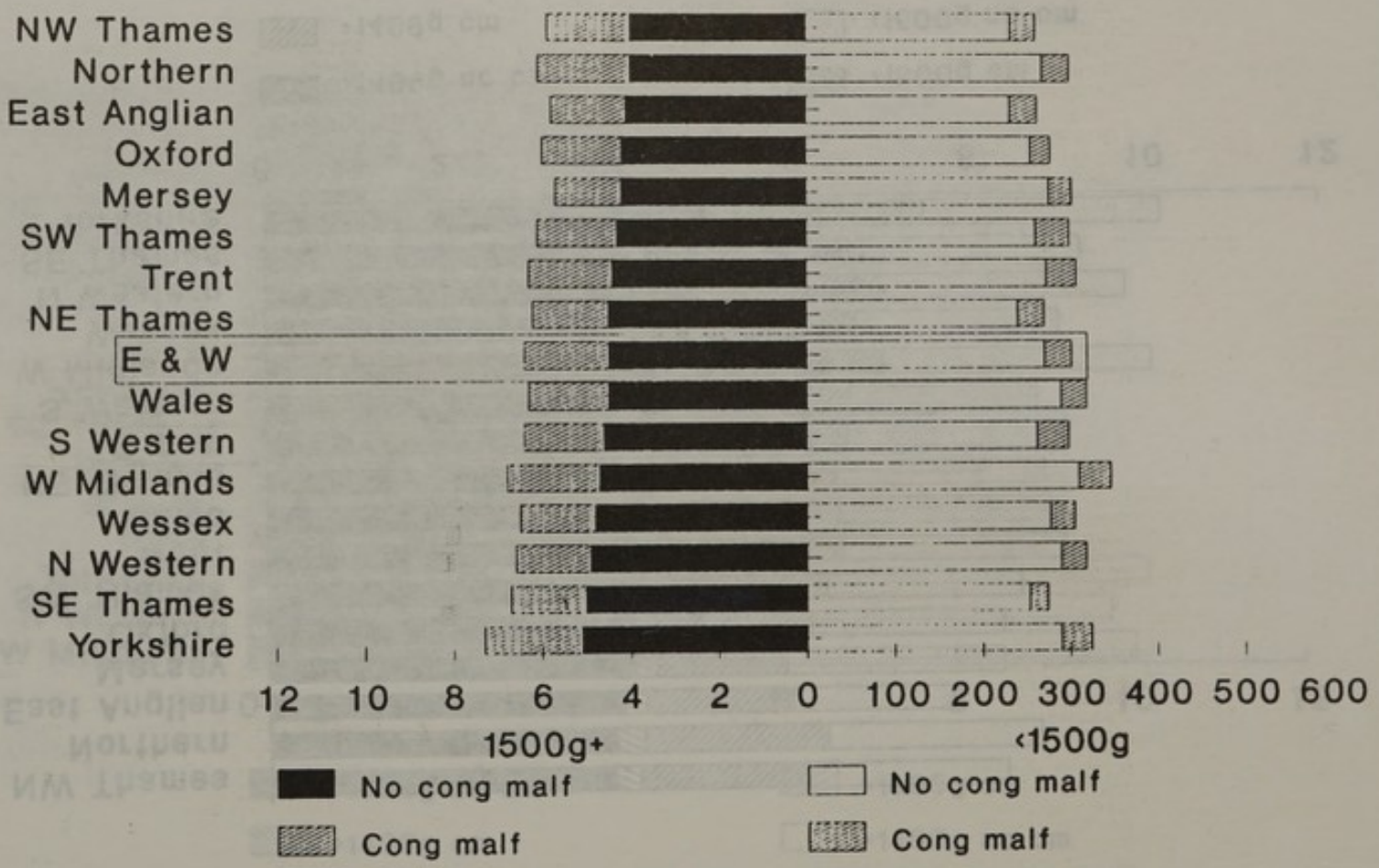
Infant mortality rate/1000 liveborn
divided by weight and cong malfs
Mersey
SE Thames
East Anglian
Wessex
Oxford
NE Thames
S Western
Wales
SW Thames
N Western
E & W
NW Thames
Trent
Northern
W Midlands
Yorkshire
0
2
4
6
8
10
12
IMR/1000 liveblrths
›1499g cm
‹1600g cm
‹1600g no cm
›1499g no cm
All RHAs-1984-88 hcrhaor3

Infant mortality rate/1000 liveborn divided by weight and cong malfs

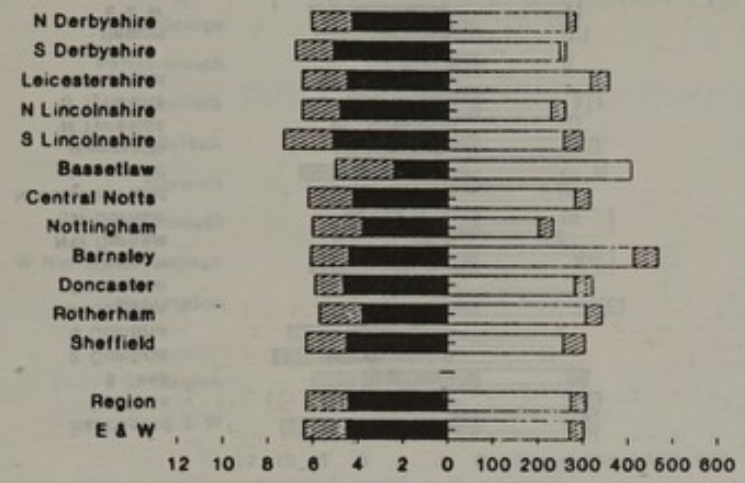


All RHAs-1984-88 hcrhaor2

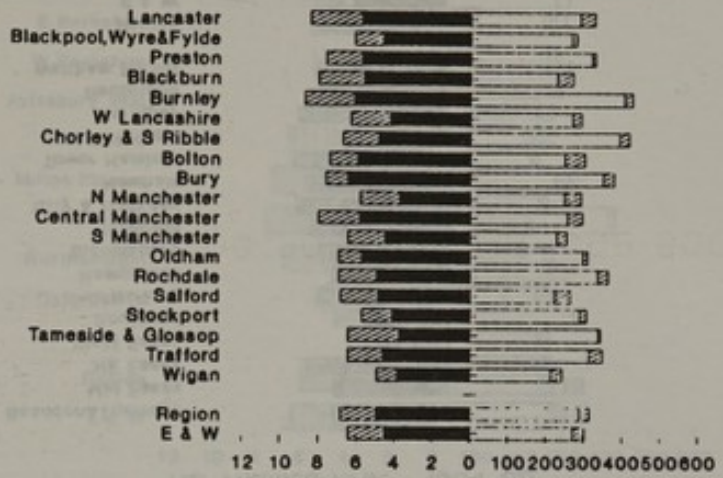
Infant mortality rate/1000 liveborn
divided by weight and cong malfs
NW Thames
Northern
East Anglian
Mersey
Oxford
SW Thames
Trent
Wales
NE Thames
E & W
S Western
W Midlands
Wessex
N Western
SE Thames
Yorkshire
0
2
4
6
8
10
12
›1499g no cm
‹1600g cm
›1499g cm
‹1600g no cm
All RHAs-1984-88 hcrhaor4


Infant Mortality Rate/1000 liveborn
NW Thames
Northern
East Anglian
Oxford
Mersey
SW Thames
Trent
NE Thames
E & W
Wales
S Western
W Midlands
Wessex
N Western
SE Thames
Yorkshire
12 10 8 6 4 2 0
100 200 300 400 500 600
1500g+
<1500g
No cong malf
Cong malf
No cong malf
Cong malf
All RHAs-1984-88

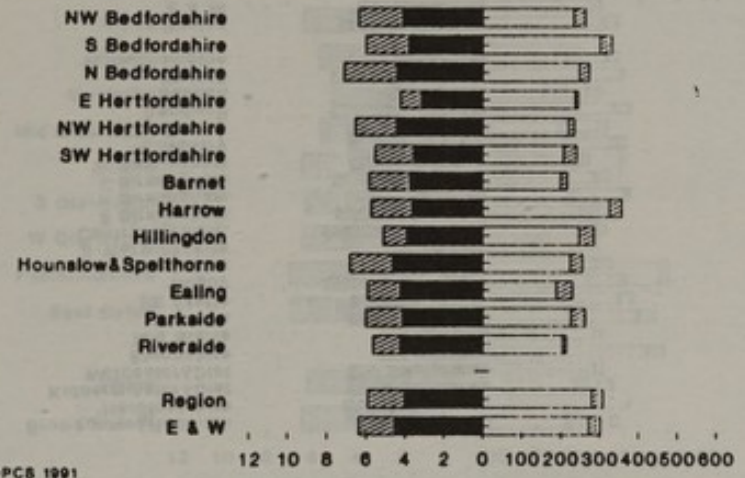
Trent RHA - 1984-88



N Western RHA - 1984-88

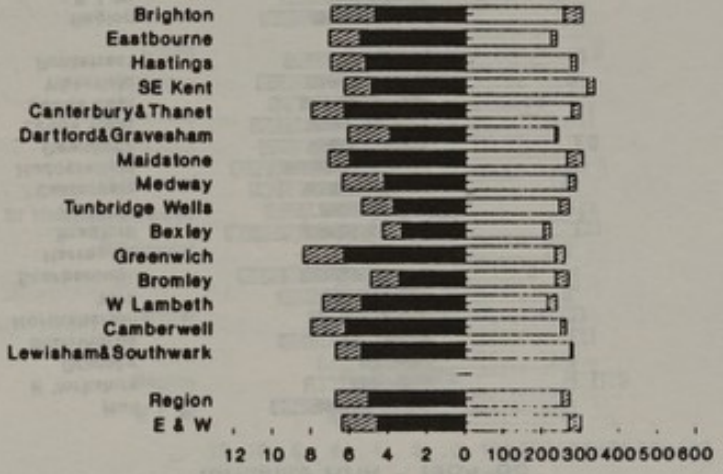


NW Thames RHA - 1984-88



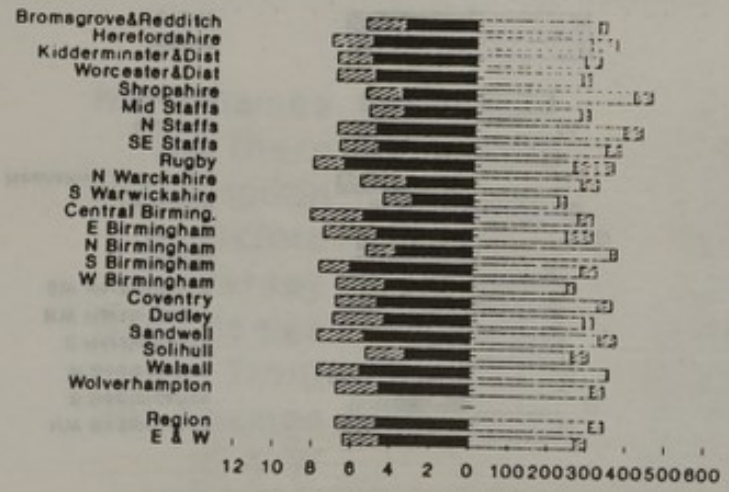
OPCS 1991

SE Thames RHA - 1984-88

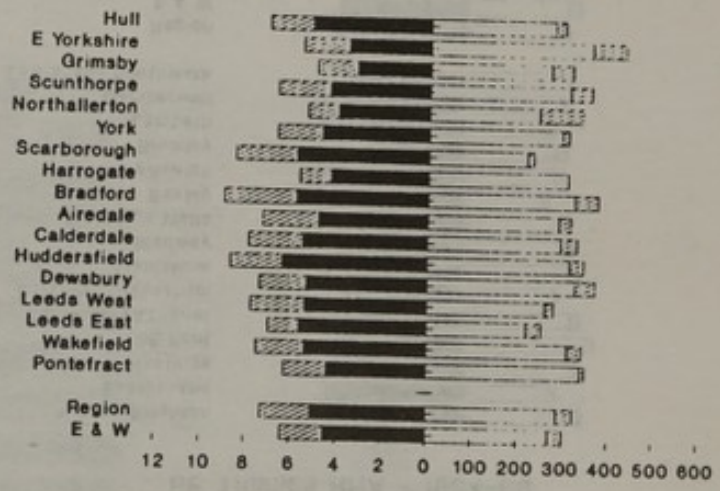


[Continued

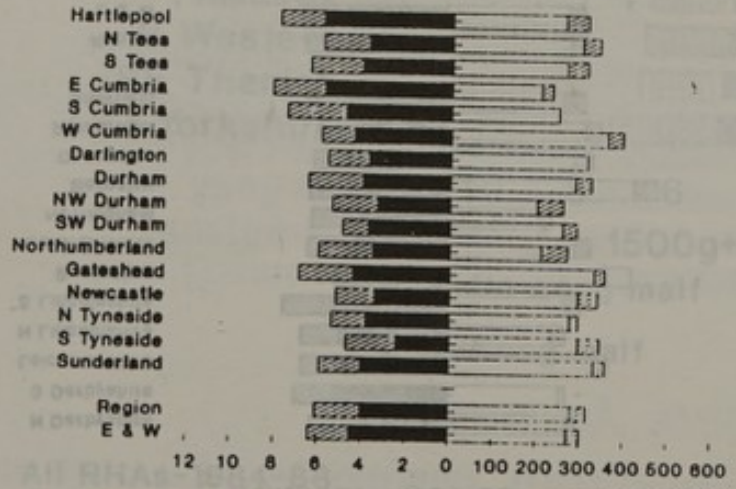
W Midlands RHA - 1984-88



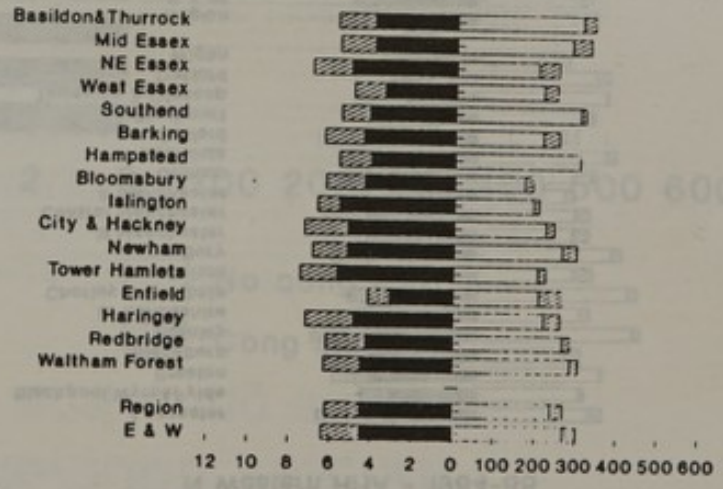
Yorkshire RHA - 1984-88



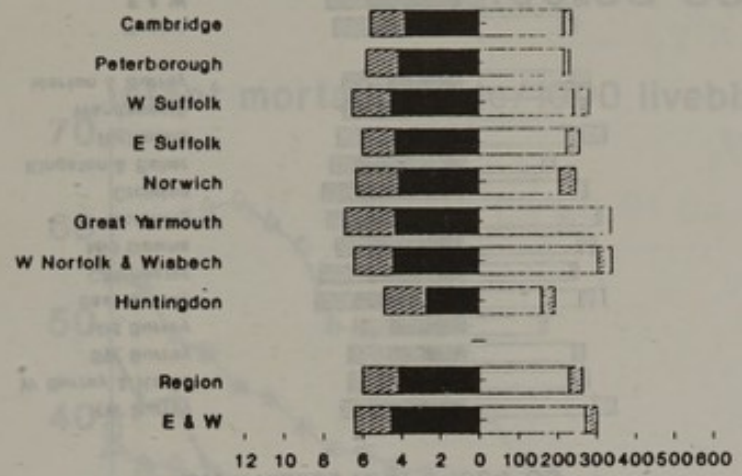
Northern RHA - 1984-88



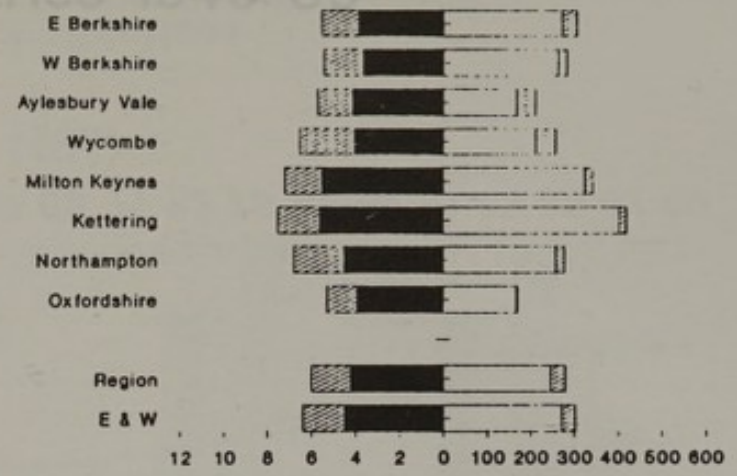
NE Thames RHA - 1984-88



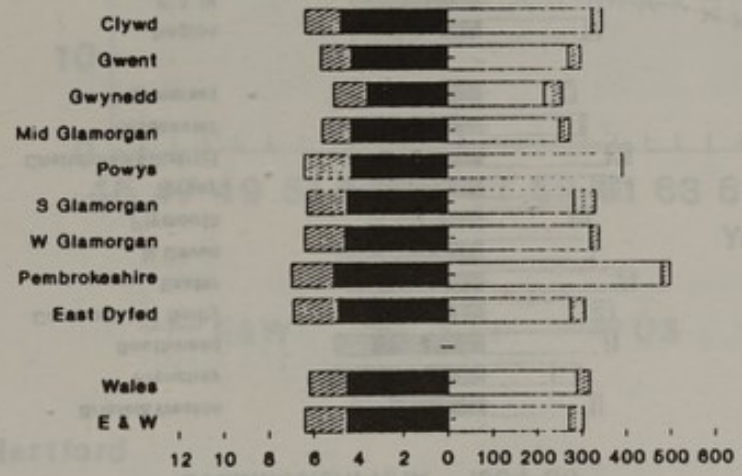
East Anglian RHA - 1984-88



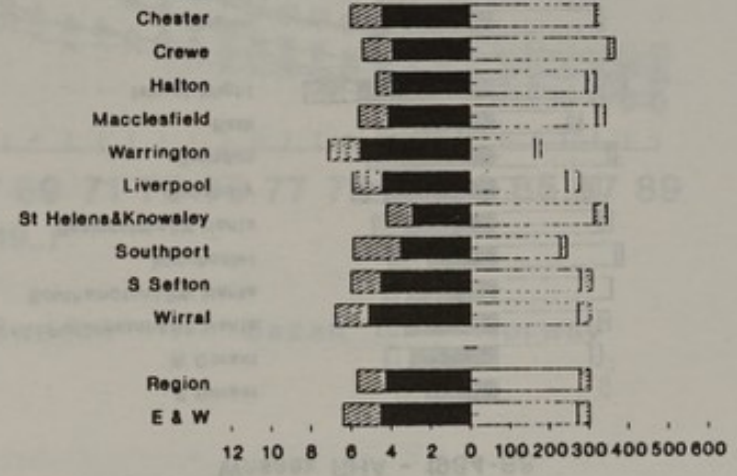
Oxford RHA - 1984-88



Wales - 1984-88

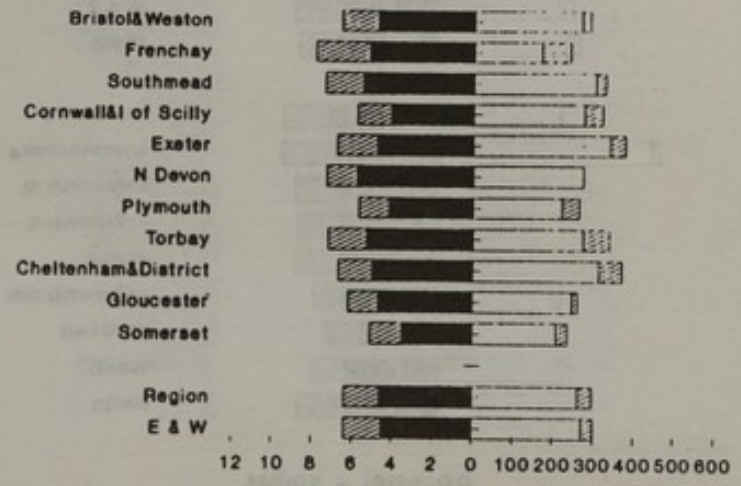


Mersey RHA - 1984-88

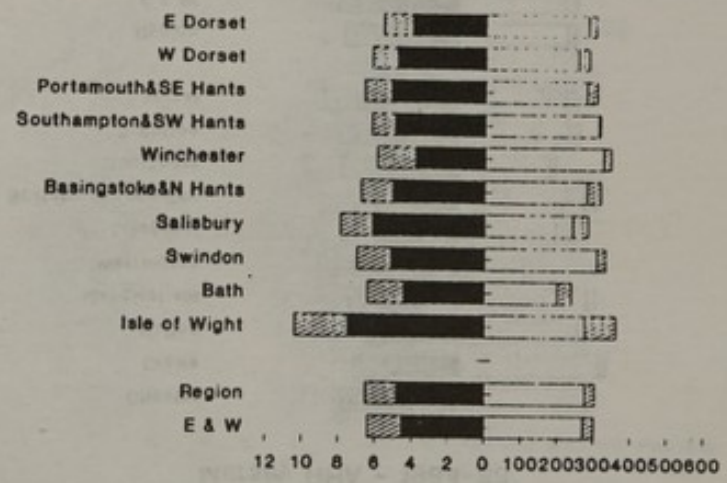


[Continued

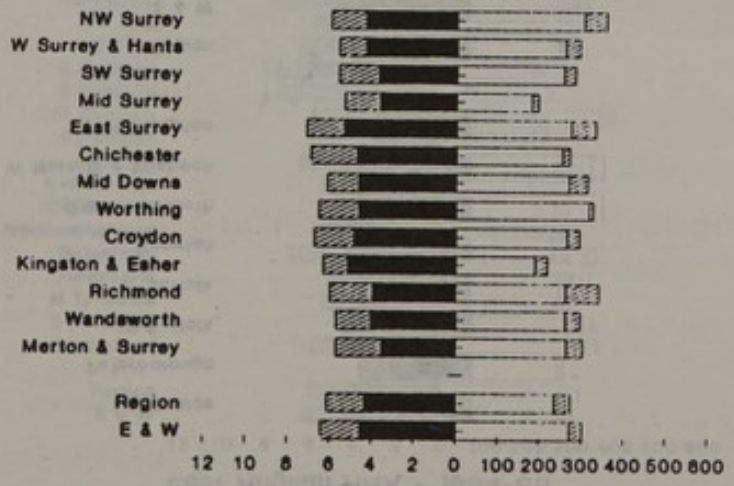
Southwestern RHA - 1984-88

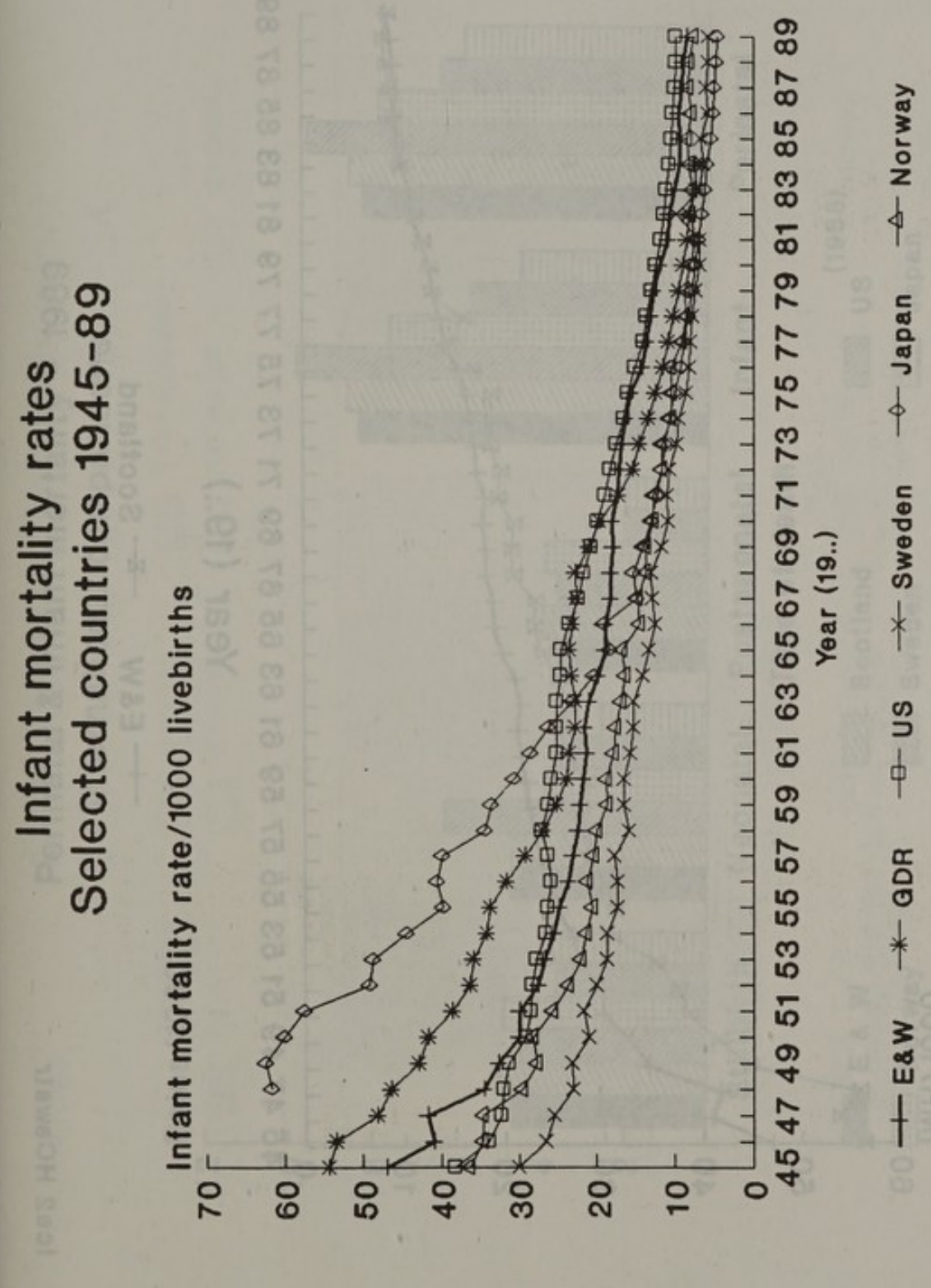


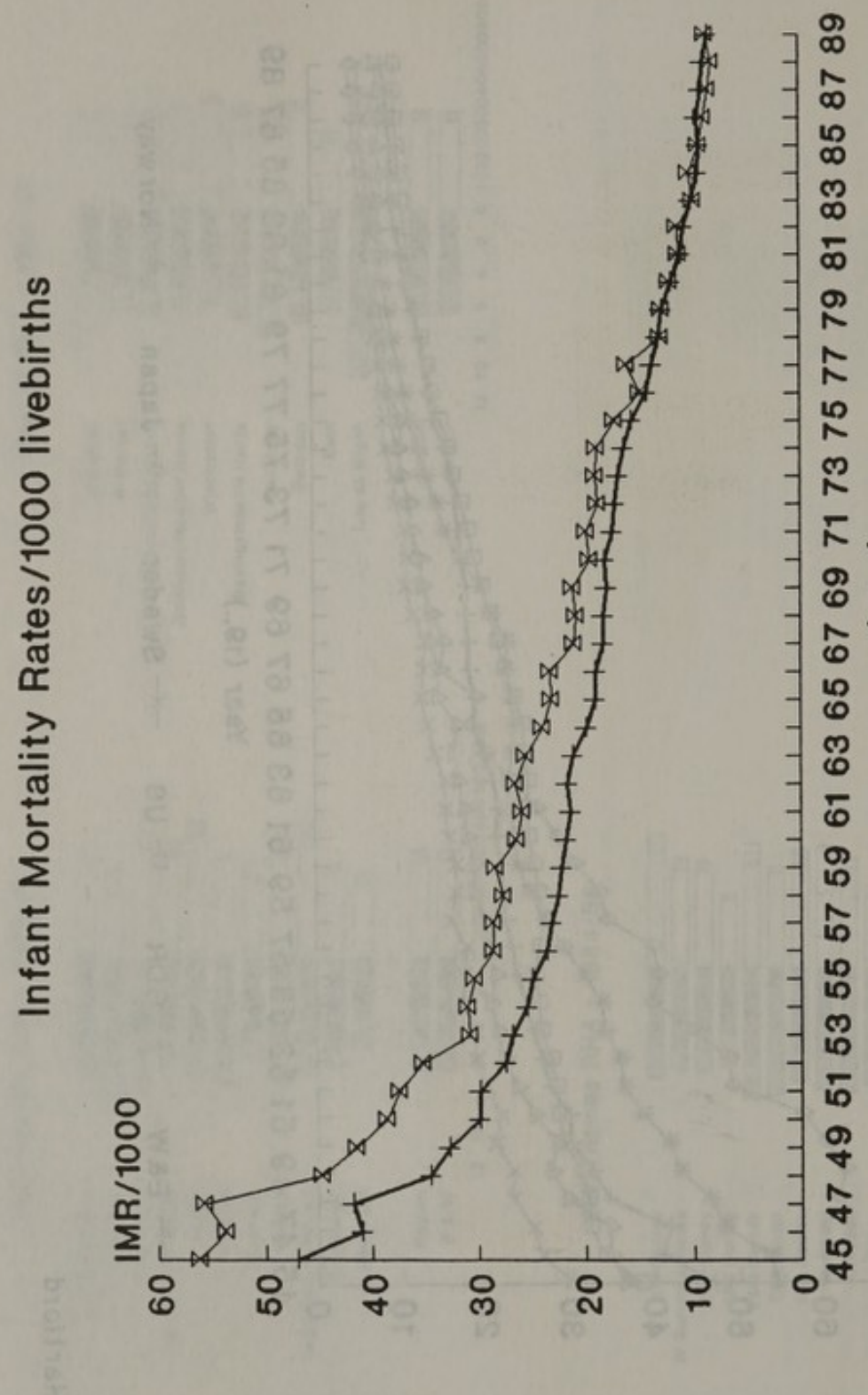
Wessex RHA - 1984-88



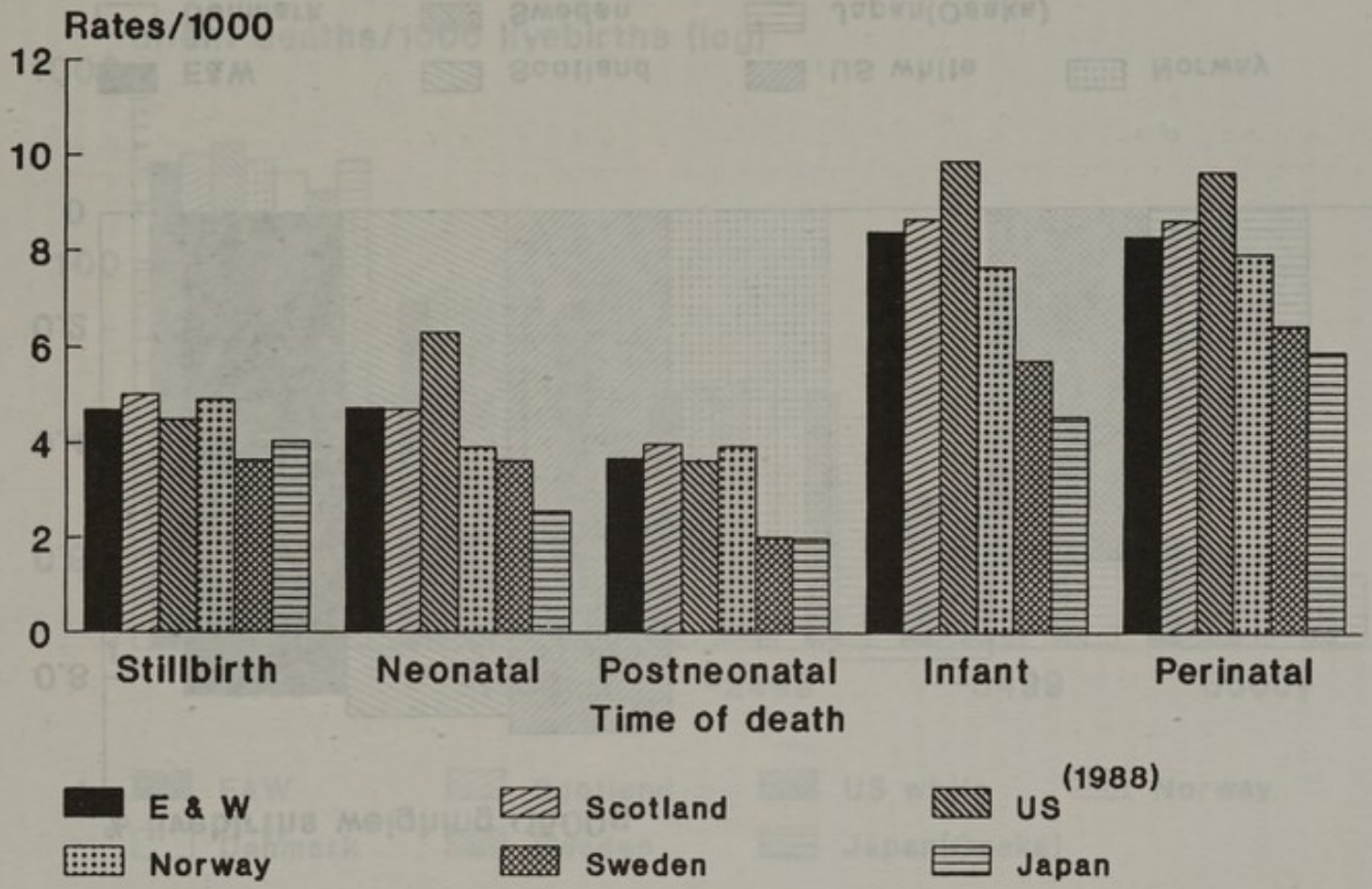
SW Thames RHA - 1984-88




Infant mortality rates
Selected countries 1945-89
Infant mortality rate/1000 livebirths
70
60
50
40
30
20
10
0
45 47 49 51 53 55 57 59 61 63 65 67 69 71 73 75 77 79 81 83 85 87 89
Year (19..)
E&W
GDR
US
Sweden
Japan
Norway
Hartford

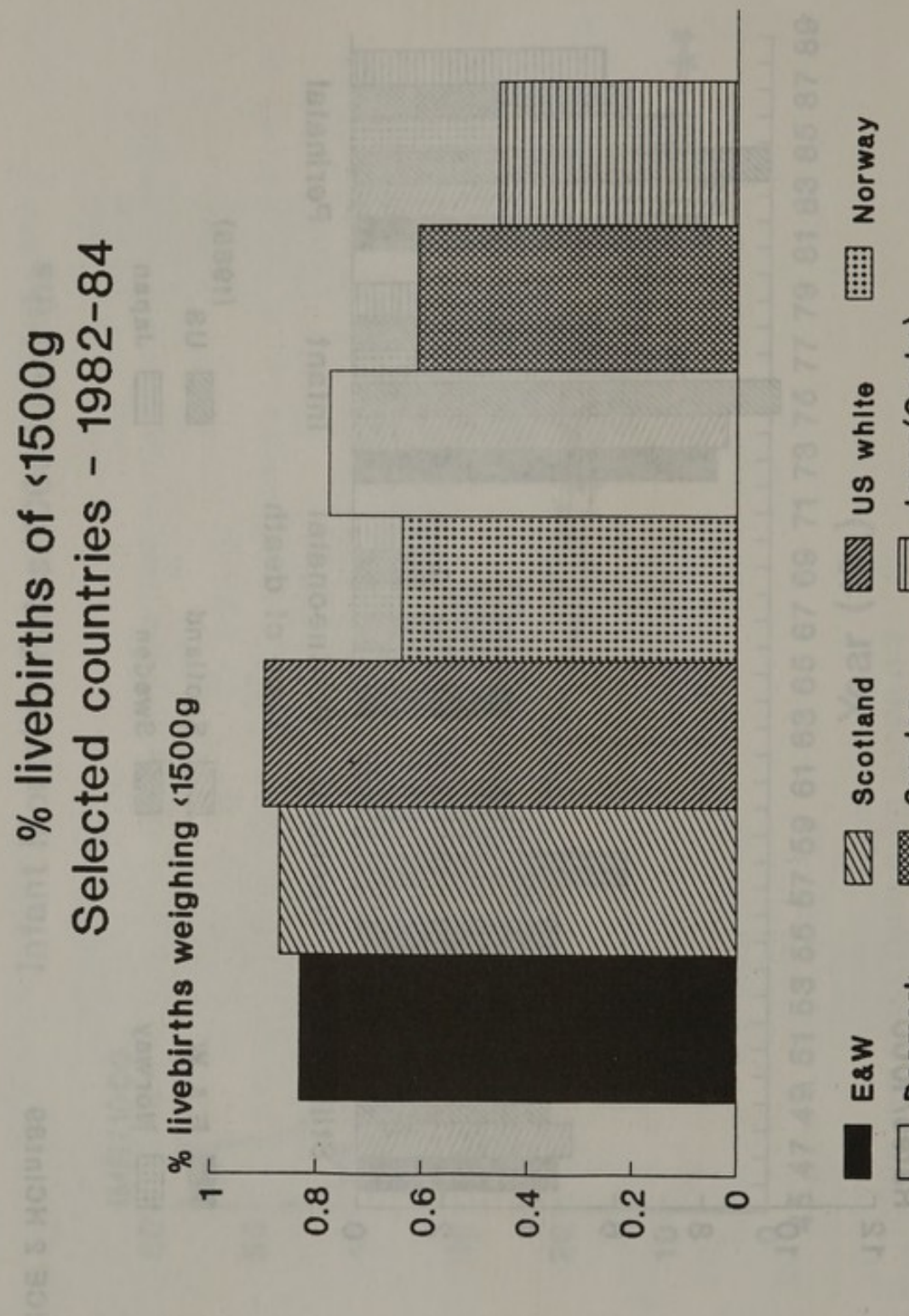

Infant Mortality Rates/1000 livebirths
IMR/1000
60
50
40
30
20
10
0
45 47 49 51 53 55 57 59 61 63 65 67 69 71 73 75 77 79 81 83 85 87 89
Year (19..)
E&W
Scotland
Ice2 HCewstr

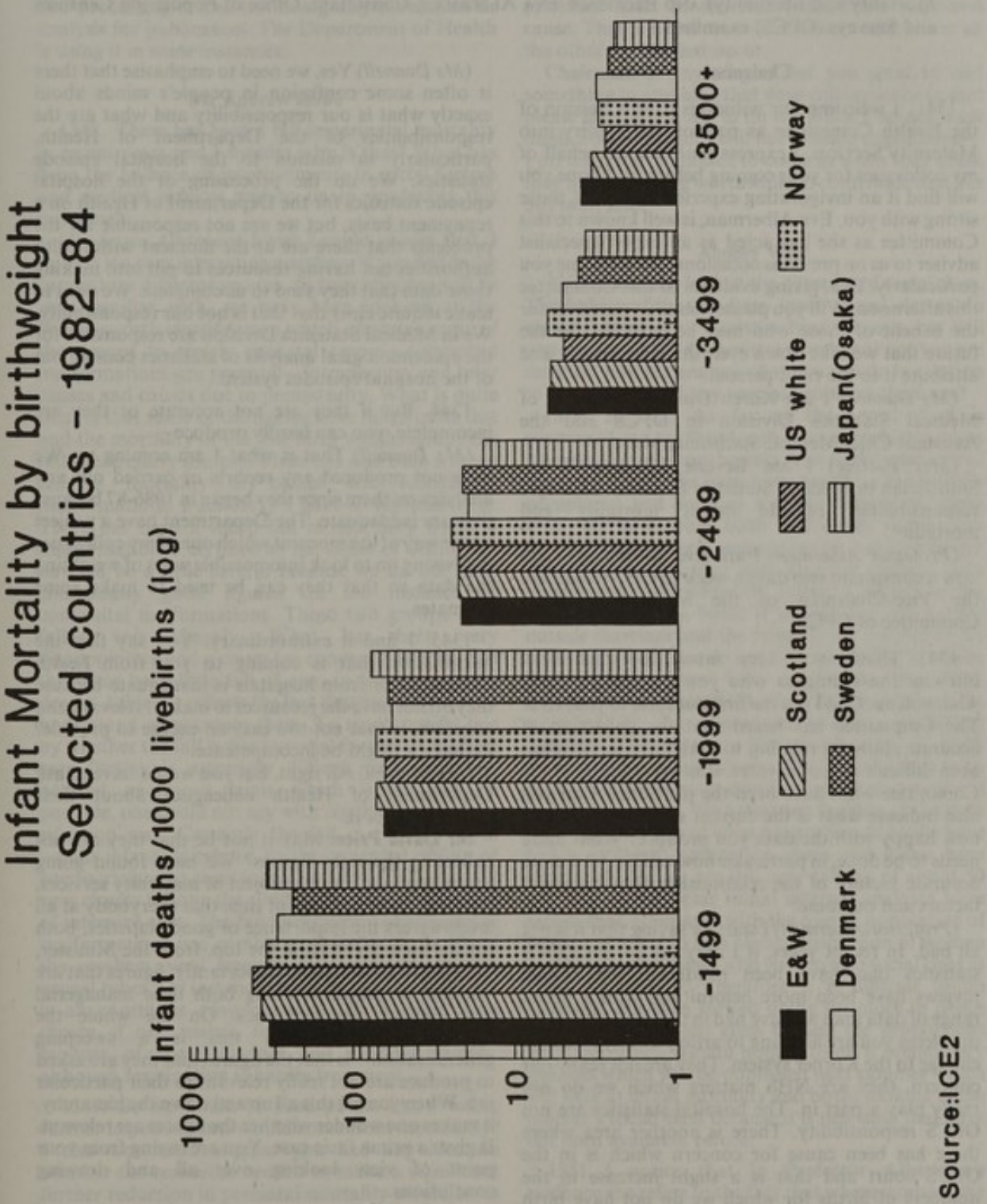
Perinatal & infant mortality - 1989 international comparisons



ICE 2 HCInt89

[Continued


% livebirths of <1500g
Selected countries - 1982-84
% livebirths weighing <1500g
1
0.8
0.6
0.4
0.2
0
E&W
Denmark
Scotland
Sweden
US white
Japan(Osaka)
Norway
Source:ICE2


Infant Mortality by birthweight
Selected countries - 1982-84
Infant deaths/1000 livebirths (log)
1000
100
10
1
-1499
-1999
-2499
-3499
3500+
E&W
Denmark
Scotland
Sweden
US white
Japan(Osaka)
Norway
Source:ICE2

Examination of Witnesses

MS KAREN DUNNELL, Head, Medical Statistics Division, MRS BEVERLEY BOTTING, Statistician (Infant Mortality and Morbidity) AND PROFESSOR EVA ALBERMAN, Consultant, Office of Population Censuses and Surveys (OPCS) examined.

Chairman

1341. I welcome our witnesses to this Session of the Health Committee as part of our inquiry into Maternity Services. I express gratitude on behalf of my colleagues for your coming before us. I hope you will find it an invigorating experience. One of those sitting with you, Eva Alberman, is well known to this Committee as she has acted as an expert specialist adviser to us on previous occasions. We welcome you particularly, Eva, giving evidence to this Committee this afternoon. Will you please identify yourselves for the benefit of those who may be ensuring for the future that we take down everything accurately and attribute it to the right person.

(*Ms Dunnell*) I am Karen Dunnell, the head of Medical Statistics Division in OPCS and the Assistant Chief Medical Statistician there.

(*Mrs Botting*) I am Beverley Botting. I am Statistician in Medical Statistics Division. My topic responsibilities include infant mortality and morbidity.

(*Professor Alberman*) I am Eva Alberman. I am now a consultant two days a week to OPCS and I am the Vice-Chairman of the Medical Advisory Committee of OPCS.

1342. Thank you very much for that brief introduction telling us who you are and precisely what you do. Can I put the first question to you, Eva? The Committee has heard that the collection of accurate statistics relating to maternity services has been difficult in recent years. Can you outline to the Committee what have been the problems? Can you also indicate what is the current situation? Are you now happy with the data you produce? What more needs to be done, in particular how can we get a more accurate picture of the relationship between social factors and outcome?

(*Professor Alberman*) I start by saying that it is not all bad. In recent years, if I may say so, the OPCS statistics that have been produced, the annual reviews have been more helpful and with a better range of data than we have had in the past. I think the problems you are alluding to arise possibly since the change to the Korner system. They are not really our concern, they are NHS matters which we do not really play a part in. The hospital statistics are not OPCS responsibility. There is another area where there has been cause for concern which is in the OPCS court and that is a slight increase in the numbers of births for which we do not have birth weight. That has gone up from almost none to a maximum for a year of 4 per cent and it is dropping off a little now. We thought at first this was a simple question of loss of information when there was a changeover. It clearly is not quite as simple as that. There are a variety of reasons for it and it is being looked into with great vigour. We hope that we will get this right very shortly. We are quite concerned about it and I am certainly very concerned about it.

1343. Karen Dunnell, do you wish to come in on that series of questions?

(*Ms Dunnell*) Yes, we need to emphasise that there is often some confusion in people's minds about exactly what is our responsibility and what are the responsibilities of the Department of Health, particularly in relation to the hospital episode statistics. We do the processing of the hospital episode statistics for the Department of Health on a repayment basis, but we are not responsible for the problems that there are at the moment with health authorities not having resources to put into making those data that they send to us complete. We need to make it quite clear that that is not our responsibility. We in Medical Statistics Division are responsible for the epidemiological analysis of statistics coming out of the hospital episodes system.

1344. But if they are not accurate or they are incomplete, you can hardly produce—

(*Ms Dunnell*) That is what I am coming to. We have not produced any reports or carried out any analyses on them since they began in 1986-87 because they are inadequate. The Department have a project under way at the moment which one of my colleagues is advising on to look into possible ways of weighting the data so that they can be used to make some estimates.

1345. I find it extraordinary. You say that the information that is coming to you from health authorities or from hospitals is inadequate because they do not have the resources to make it relevant and accurate. Is that not too easy an excuse to provide? Perhaps it might be incompetence.

(*Ms Dunnell*) All right, but you would have to ask Department of Health colleagues about their explanation of it.

Sir David Price: May it not be that they are not collecting the right figures? We have found going round, not just on this subject of maternity services, but over quite a period of time that everybody at all levels agrees the importance of good statistics, both for the view taken from the top, from the Minister, but also and much more importantly, figures that are relevant to people fulfilling both their managerial and clinical responsibilities. On the whole the impression I get—and this is a sweeping generalisation—is that the figures that they are asked to produce are not really relevant to their particular job. When you get this all up and down the hierarchy, it makes one wonder whether the figures are relevant. It gives a prima facie case. You are saying from your point of view looking over all and drawing conclusions.

1346. So in answering Sir David what needs to be done?

(*Ms Dunnell*) I do not think that from OPCS I can answer that because the answer lies in the health authorities who are not making complete returns to their regions for us to process.

Sir David Price

1347. You need the right raw material, do you not? You need the right, accurate raw material in order to do your job.

[**Sir David Price** *Cont*]

(*Ms Dunnell*) At the moment we are just collecting and processing it and not doing any tabulation or analysis for publication. The Department of Health is using it in some instances.

Mr Andrew Rowe

1348. There has been a fall in perinatal mortality in recent years and I wonder why is that? What has been the balance of improvements in social factors and medical services and so on in producing this outcome?

(*Professor Alberman*) I wish I could answer that. I think it is a very interesting question. If you divide the causes into different groups, as your advisers will be very familiar with, we have been looking at the Wigglesworth classification which allocates some of the groups to clearly prenatal causes—congenital malformations are prenatal—intrapartum and later causes and causes due to prematurity. What is quite clear is that some of the causes have fallen quite fast and the mortality of the low birth weight infant has fallen extremely sharply. There has also been a sharp fall in mortality of babies with congenital malformations. I am sorry I have to rephrase that. There has been a sharp fall in mortality where a malformation is certified as the cause of death. We have to be a little careful because we do not have enormously good figures on the instance of congenital malformations. Those two groups have fallen very sharply. What has been very disappointing and a cause for concern has been that there has been little fall, if any, in the antepartum deaths. I think it reflects the fact that we really do not understand what causes them. To try to weight this by whether the fall is due to social factors or medical care factors is extremely difficult and probably, without enormous trials which would not be possible, one could not say with confidence what the situation was. Certainly the fall in the low birth weight infants is related to the increased ability of paediatricians to cope with very low birth weight. It very closely follows the availability and the expertise of intensive care. The fall in mortality of congenital malformations is a combination of better health of the mothers, very recently the ability to prevent neural tubes, for instance, by giving folic acid which is an enormous advance, prenatal diagnosis and choice, if one wishes, for termination. That is a mixture of social factors and medical factors, although termination is hardly treatment.

1349. So we would be hard put to know where further improvements would come from necessarily? I also wondered whether you had any idea on whether the resources needed to make a significant further reduction in perinatal mortality would be as well spent doing that as on some other priority of the National Health Service?

(*Professor Alberman*) We have some clues from the social factors, which I must allude to. You have data on this. We are still seeing differences between different groups as far as paternal occupation and unsupported mothers are concerned. While one is seeing a differential between these groups, it is to me appealing to think that perhaps not medical care but support for those who are in difficulties might be helpful in reducing further perinatal mortality and, in humane terms, is an obvious way of proceeding. In terms of medical care, I think one of the research priorities must be the still births from unknown cause. That is a real cause for concern still, as are all the other deaths that occur.

Chairman: If any of you feel you want to add something to anything that your colleagues have said please do not hesitate to do so. While I do not want duplication—in fact I will not tolerate duplication—I do want our witnesses to come in when they think they have anything worthwhile to contribute that has not been said.

Audrey Wise

1350. I want to look at the question of social class. The babies of mother from lower social classes do worse. I think your statistics bear this out, but will you explain to the Committee whether or not you are satisfied with the analysis that you can do in relation to social class and any special problems there are?

(*Mrs Botting*) As far as the social class is concerned, we are faced with a huge problems when it comes to analysing the data. The traditional way of presenting statistics have been based on the father's occupation and deriving a social class based upon that. We have from birth and death registration details of the father's occupation for babies who are born within marriage and also for babies born outside marriage where the father is present at the registration of the birth. If the mother has a child outside marriage and the father is not present at the birth registration we do not have any father's details. Since 1986 women have been asked at birth registration whether they wish their occupation to be recorded. At the moment it is still a voluntary question. There is not a distinct place on the birth certificate to put this information. It is added in as an extra. It is a voluntary question which means that it is still incomplete. We have been looking at the data over time in terms of what proportion of births have had a mothers' occupation given and it has been increasing, but we are still only talking of about 50 per cent overall. Our initial internal analyses have shown that, compared with the overall population of women, it tends to be a higher proportion of women in higher social classes who wish to give social class at birth registration. Therefore it is difficult to do analyses. We have started doing far more in depth analyses as time has gone on and the proportions have increased. We are hoping to do a preliminary analysis which will be published next summer which will look at infant mortality and births looking at the mother's social class because it is new data that have not been available before.

1351. I notice that in Professor Alberman's evidence she refers to the fact that where women give a codable occupation it is more likely to be in social class III, non-manual, because that group includes most female dominated jobs such as shop assistants or hairdressers. That means that it does not relate to poverty because those occupations are very low paid occupations, even though they will be down as not the lowest social class. Can you see any way of relating the statistics more closely to issues of poverty?

(*Ms Dunnell*) No, I think is the blunt answer to that. What we collect at birth registration is defined by registration legislation and that is why the

[**Audrey Wise** *Cont*]
question that has been added about women's occupations does not have a place because we cannot just change the birth certificates. In fact we do not even have a question about income, or whatever your measure of poverty would be, on the census. The whole issue is quite a difficult question to ask. One has to find some kind of proxy measure. The traditional proxy measure that we use is this social class based on occupation.

1352. So that means that when you do your analysis on the influence of social background it is quite likely to understate the influence of such social factors?

(*Ms Dunnell*) It depends how you look at it. If you read some of the written evidence that we have sent you, you can see quite clearly that women who register births by themselves have completely different infant mortality rates from women in social class V who have a partner. It is pretty obvious that most women registering a baby on their own will probably be in poverty. We know from the things we have sent you already that very few of them had employment during their pregnancy or before the birth of the baby.

Chairman

1353. Are you implying by that, that the benefit system is not adequate enough to lift them above what you describe as poverty?

(*Ms Dunnell*) We have not defined poverty, but what I am suggesting is that a lone parent, given that she has only one source of income, is almost bound by any definition to be at the bottom of the pile. Where the line is drawn about where poverty begins or ends is for somebody else to decide.

Audrey Wise

1354. This means that when the Audit Commission and the Public Accounts Committee commented on the maternity services and used some of your statistics and used your social class analysis statistics and drew lessons about the influence of inequality, they were based on an incomplete analysis of social background? I am not blaming you or them or anybody, but I am just pointing it out.

(*Ms Dunnell*) They may have done. Sometimes all these people who cannot be classified on a husband's occupation fall into a category called "other". Those people should always be included and in these kinds of data you will find that that group always has the highest infant mortality rates by quite a large factor.

Sir David Price

1355. Following this line of argument, it strikes one that categorising the resources going into a family simply by the father's occupation is slightly primitive because if somebody has an occupation that is apparently lower on your pecking order that does not mean that the income is lower. Let me take a simple example. I know long distance lorry drivers who are probably in a lower category than a school teacher, but they have jolly sight larger incomes.

(*Ms Dunnell*) If you wanted a measure of poverty in birth statistics you would have to find a way of gathering it at the registration of the birth. That is extremely difficult because people do not agree about what is poverty. If it is to be done thoroughly, which the OPCS does, for the Department of Employment via something like the Family Expenditure Survey it involves a multipage questionnaire about every source of income coming into a household and then very complicated decisions about how you put all that information together. We have to stick with what we call proxy measures. Social class based on the occupation of the father, whatever we may think about it, is the traditional one and shows quite clearly very large differences between social groups. One of the things that people are now suggesting about that other group who do not have an occupation and the increasing numbers of people who do not have a job, or perhaps have never had a job, is that they are forming another class, an under class or some other class, which cannot be categorised by occupation.

(*Professor Alberman*) This is obviously something that is very central to our work and we are very concerned about it. Beverley Botting may want to add also the fact that we are looking actively at the possibility of using the current census data and linking it with subsequent births. There may be some way to do that. It will not give us the full answers in the way that Karen has described them, but we are not just lying back and giving up because the census gives us some opportunity. I believe the Office has announced that over the next 10 years it will be looking into new ways of classifying social class which may be more helpful. But all the problems that have been alluded to we are stuck with.

Chairman: That has been very helpful.

Alice Mahon

1356. Professor Alberman, you have already touched on and highlighted the great importance of infants of very low birth weight as major contributors to neonatal and infant natal mortality. Can you tell us what is happening to the numbers of very low birth weight babies being born, especially the smallest ones? Are there sufficient statistics collected concerning birth weight?

(*Professor Alberman*) We touched on the statistics earlier, that we were a little concerned. In this area it is of particular concern because the babies one is least likely to pick up are the deaths and the very sick babies because they are shifted from place to place and it is difficult to get their records to link. That is a real problem. Having said that, certainly we had very good data from 1983 to 1987 and even in that small number of years it was possible to show that right at the bottom end of the scale there seems to be an increase of the very smallest babies, partly because there has been an increase in multiple births—Mrs Botting can tell you more about that than anyone else—and partly, we believe, but it cannot be established, that the grey area between what is a still birth and what is a spontaneous abortion is a difficult area. Still births have a gestational age limit. Live births do not have a lower gestational age limit. Research has shown that a clinician's perception of what is a viable birth may affect whether that baby is registered or not. Even if it dies in a few minutes, some clinicians will register it or will consider it registerable and some will not. It seems that there has been an increase in the registration of these very small

[**Alice Mahon** *Cont*]
babies. I do not think that they have suddenly shifted birth weight. They must always have been there, but I think they are now being recognised. This is clearly increasing work load and also increasing the number of survivors at that very low end, because once they are treated the survival rate is improving sharply.

1357. Yet you state the mortality risk for very low birth weight babies in England and Wales is lower even than in Sweden, but for the highest weight groups we are at a mortality disadvantage. Can you tell us why you think that is?

(*Professor Alberman*) I can only give you my own personal opinion. I think this is where the social class differences begin to tell, although Sweden also has social class differences, but I think perhaps to a lesser extent. It is that group that is numerically the most important and one that we have to be very concerned about. The big babies outnumber the tiny babies by a very large extent.

Alice Mahon: Yes, it is worrying.

Mr Hinchliffe

1358. I am sure that all the witnesses will be aware that one of the issues that concerns this Committee in our inquiry and one that has been debated within the profession and among those people concerned about these issues is the issue of birth at home versus birth in hospital. We have received in the course of our inquiry strong arguments saying that birth at home is just as safe as birth in hospital. What are your views on this point?

(*Ms Dunnell*) Our problem is that only one per cent of births happen at home and that has been the case for quite a number of years. They are probably very biased socially and the numbers are not great enough to establish the answers.

Chairman: Biased towards which group?

(*Ms Dunnell*) The middle class, I would suggest, although I am not absolutely familiar with the statistics, but I think that was the case.

Chairman

1359. Would you like to add to that, Mrs Botting?

(*Mrs Botting*) It is also a problem also because from our statistics we are not able to identify whether the babies born at home were a planned delivery at home or were just because the woman could not get to the hospital or whatever. That is important. We cannot tell that and I believe it is a very disparate group. Numerically it is very small group.

Mr Hinchliffe

1360. So basically you are saying that from the figures there is not a great deal that we can contribute towards what has increasingly become a central issue as far as this inquiry is concerned?

(*Professor Alberman*) If and when the hospital episode statistics become complete and of good quality, my memory is that there is a question there on intention of place of birth. If one had that one would be in a better position, but even so with one per cent of the births and with a proportion of those being births that happened at home because they were a disaster—if they had a sudden bleed or a sudden disaster and the baby is born spontaneously at home—those babies ought to be removed in any case.

Chairman

1361. So what you are saying to the Committee is that there is no evidence from your unit at OPCS which would indicate that home births are more dangerous or are safer? You are saying that the sample is too small?

(*Ms Dunnell*) That is right.

(*Professor Alberman*) Yes.

Audrey Wise

1362. I want to ask one thing in relation to what you have been saying about the collection of the hospital episode statistics and the possibilities that might arise when this is done better. It has been put to us that maternity is not really about hospital episodes, but is about a process. Have you given any thought to that, Professor Alberman? How far do you think that the method of statistical collection in terms of hospital episodes will still be inadequate even when done better because it is not looking at the pregnancy, birth and post partum period as a process?

(*Professor Alberman*) I shall try to answer that with a non-OPCS hat on because I do not think OPCS has anything to contribute here. I can only answer from experience of my previous place of work at the London Hospital, where I was very closely involved in designing the collection of maternity statistics. It went very well as a process. We did not consider it as a series of episodes, although I realise that at the stage of coding it became that. The information collected at booking was entered on the hospital computer. It was already there when the mother came in in labour. In labour we simply had to add the details of labour and then as the mother and baby were discharged, if all was well, we simply added the details of the discharge. That formed a very neat systems which fed directly both to the Registrar of Births to inform him that a baby had been born and what the birth weight was and it was the source of birth notification so it went straight to the child health office. In my view it worked extremely well. The episode part of it is an artificial imposition which I agree does not go very well, but in practical terms it is perfectly simple to have a continuous process with computers as they are at the present and this works very well indeed.

1363. Is the Korner system like that?

(*Professor Alberman*) It was an extension of the Korner system, built round it and we built in information on booking. It was the Korner data set, the birth notification, a registrar's notification and the maternity information system all in one. Other people have similar systems. It works well.

1364. Do any of you collect any data that would shed light on the argument over what might constitute the desirable minimum levels of intervention in child birth, either in terms of obstetric management generally or by individual technical procedures?

(*Several*) No.

1365. Do you know whether any such statistics are collected by anybody?

[**Audrey Wise** *Cont*]

(*Ms Dunnell*) The maternity HES. The maternity hospital episode statistics.

1366. So you rely on them for that? But they are the statistics that are not in a good state? So in other words at present and for the last few years there have not been any.

(*Ms Dunnell*) We have a problem.

1367. Is it correct that there was a whole 18 months or two years missed out of collection of statistics relating to maternity?

(*Mrs Botting*) That is right. The previous data collection was a 10 per cent sample of hospital in patients. That ceased at the end of 1985, I believe. The Korner basic data set came in the following year, but in order to ease the implementation the maternity data set was planned to be implemented the following April. I believe it came in in the September of that year, so you have a gap when there were no data collected.

1368. Who selected maternity as the area which was dispensable, do you know?

(*Professor Alberman*) Not us.

Audrey Wise: Just as well.

Chairman

1369. Do you know who was?

(*Professor Alberman*) I honestly do not know and I am quite glad I do not know.

Audrey Wise

1370. What proportion of all children at school age suffer from serious disabilities? Do you have any of that?

(*Ms Dunnell*) Off the top of my head I cannot remember, but OPCS did a survey of the prevalence of disability in school children in 1985. That will have the most reliable figure for four and five year olds in it.

1371. So you can send us that?

(*Ms Dunnell*) Yes.

1372. Will that shed any light on the contributions of very low birth weight, congenital abnormality and birth asphyxia to the production of these results.

(*Ms Dunnell*) Only indirectly. It gives information about the basic causes as perceived by the parents of the child's disability. So if it was a congenital abnormality it will be recorded as such. Those numbers were very small in relation to unknowns and more medical things, but it is there.

1373. I appreciate and understand what you have said about the current situation in relation to home births and the small number, too small to be statistically useful. But decisions were taken about what should happen in relation to the place of birth at an earlier stage when there were usable statistics. Mrs Marjorie Tew has done work analysing those. Do you have any view about her statistical work in this matter?

(*Professor Alberman*) I think Mrs Tew knows that I have great respect for what she has done. She has really made us think very hard, certainly she has made me think very hard, about assumptions that I had made pretty readily. Having said that, I have in the past looked at these statistics very carefully. It is extremely difficult statistically to prove that for a normal delivery home birth is any safer than hospital birth. In hindsight with a normal delivery, a normal delivery is a normal delivery. The problem is the hindsight. The problem is that there is always a bias in hospital deliveries however you look at it towards those with problems. Some of these problems can be defined and one can allow for them. One can define someone who is known to have a breech delivery. One can define someone who is known to have had previous problems or who has a bleed, but there is always an indefinable bias, a clinician's hunch, if you like, that there is something not quite right, which tends to push people into the hospital area and that makes any analysis of retrospective data very difficult to interpret. I still sit on the fence, although I have certainly thought very hard about Mrs Tew's information. It has been enormously valuable for us.

1374. The question has not normally been posed concerning whether hospitals are less safe. In fact the claim was that hospitals were more safe and even the only safe place. From the cautious way which you have expressed your answer I think that you are saying that that would have been a misunderstanding of the statistics at the time the decision was made.

(*Professor Alberman*) I think even the statistics we gathered at that time did not give a completely clear answer. I am not speaking for OPCS here again, I am sorry. For babies with problems, certainly for the low birth weight, there is evidence that the mortality is lower in babies who have been nursed particularly in level 3, the highest type unit, and you have to get there quickly, so for problems the situation is different. For normal births I remain on the fence.

Mr Sims

1375. Am I right in thinking that there is no follow up of babies who have been treated in neonatal intensive care units? If I am do you think there should be? Would that be practicable?

(*Ms Dunnell*) Certainly OPCS do not do any routine follow up of them. I am sure there are probably studies around the country where the babies are followed up. It would have to be a special study, but it is not done routinely. It would be done routinely through the pre-school surveillance system which again is looked after by district health authorities because every child gets into the surveillance system and is looked after until it goes to school by a health visitor. In that sense there is follow up, but it does not get into our routine national statistics.

1376. It does not reach you?

(*Ms Dunnell*) No.

1377. It could do though, if there was a mechanism for it?

(*Ms Dunnell*) It could, yes.

1378. That does not sound as if you are enthusiastic about it.

(*Ms Dunnell*) If we could get the resources to do it we would be enthusiastic about it.

1379. I shall not pursue that. Professor Alberman, in your paper you refer to avoidable deaths with the use of question marks and inverted commas. Would

[**Mr Sims** *Cont*]
you care to tell us how you reach a definition of an avoidable death?

(*Professor Alberman*) I wish I had not even used the word. I should have learnt by now that that is a word one really should not use. It slipped in and I did put quotes around it and a question mark. Again I have learnt through hard experience that we really cannot say what is avoidable and what is not avoidable without intensive studies of every single case. I used that as a shorthand for babies that weighed more than 1,500gms and where the cause of death was not certified as due to a congenital malformation. It is a very crude grouping indeed, but at least it does get rid of the causes that we understand and contribute to high levels of mortality.

1380. In which case you are not presumably able to say why there appear to be regional variations in them?

(*Professor Alberman*) This is really coming back to the bigger babies. I think this is one of the most important questions that we need to look at. I think the proposed confidential inquiries will, if all goes well, help us to explain some of these. Again we have learned a lot about confidential inquiries. The maternal mortality confidential inquiries have taught us that it is very difficult to say what is avoidable and sometimes you really do need a control.

Mr Rowe

1381. I want to ask a very loaded question, but I do not think the load falls on you. It is my anxiety that an enormous amount of effort, money and resource is put into keeping alive children who would, until very recently, have died and who, having been kept alive, are severely handicapped in one form or another and remain a tremendous charge on the National Health Service. It is very difficult to put that in any non-loaded way, but I have done my best. Do we have any evidence or statistics about that argument?

(*Ms Dunnell*) I do not think we do, and this is part of the problem. One can make estimates of it from some of the information in the disability survey, but again that did not inquire in great depth about what the causes of the disability were. I think it is something which people are now doing research projects on and I am sure that it is something that you can build up economic models of, for example. We are not doing anything in OPCS on it, no.

Chairman

1382. Perhaps Eva I may put one further question to you specifically. I am somewhat surprised that you have not said anything to date about birth asphyxia as the cause of death. Would you comment on that and let us have your views? Perhaps you would add also, if you wish, any comment or observation on Andrew Rowe's question.

(*Professor Alberman*) First on birth asphyxia, I have learnt a lot since our early days—I think we all have. It is quite clear that birth asphyxia is shorthand for a very complicated series of events, many of which have started long before labour occurred. Even if the child is born with "asphyxia" or "anoxia" or whatever, often the cause has gone back some time. That has been shown since our earlier inquiries. Nevertheless there is no doubt that acute events still occur, but numerically they are less important, that is events that are not a sequelae of earlier trouble. There is no doubt that they are less frequent than I used to think. It is still an important cause. It is probably still an important cause for many stillbirths, but here we just do not know. I think we would like to know. If I could speak to the question, again not on the behalf of OPCS, coming back to the follow up of low birth weight children, there are a number of excellent follow ups that have been carried out in this country and in other countries. UCH is an obvious one, Scotland, Northern Region, many centres, Liverpool, Mersey have done very good surveys on this and other countries. The situation as I see it is that the survival is increasing rapidly. Yes, there is a small increase of survival of children who are subsequently severely handicapped, but it is actually outbalanced by a survival of children of that birth weight who are normal and a great joy to their families. That is the case. The economic argument is a difficult one, but it seems that advances in scanning, or imaging, are coming along so fast now—I know we said this 10 years ago, but it is a different situation since then—one will increasingly be in a situation where one could identify children who are likely to be hopelessly damaged and act accordingly, although this is a difficult problem. That is my opinion.

Mr Rowe: Thank you, that is a very encouraging comment.

1383. Thank you very much indeed, is there a final observation that any of our witnesses would like to make to the Committee on a matter that is of importance, they believe, but has not been touched on by us?

(*Ms Dunnell*) I think you have covered the ground very well.

Audrey Wise

1384. If you were making a recommendation or could influence the making of a recommendation about the collection of statistics, what would your top priority be?

(*Ms Dunnell*) My personal priority would be to collect more information about morbidity and disability in children and less about mortality. That is my personal preference.

(*Professor Alberman*) I go along with that.

Chairman: I thank our witnesses very much indeed for the excellent evidence which they have given. If Karen Dunnell and Beverley Botting can now retire, Eva I should like you to stay on the top table, and if Mrs Tew could join us I should be most grateful.

Memorandum submitted by Mrs Marjorie Tew

I was very pleased that the Health Committee invited me to submit a memorandum relevant to its inquiry into the maternity services. My submission on Antenatal Care is attached herewith. Arguing with reference to the evaluated evidence of actual experience, my paper presents an uncompromising challenge to the orthodox views on the value of antenatal care as practised and makes radical recommendations for reform. My paper is consistent with the findings, presented in greater detail in the chapter (3) "The practices of attendants before birth" in my book "Safer Childbirth? A critical history of maternity care", published in 1990, to which it makes several references. If you, or members of the Committee, are not aware of this book and would like me to send you a copy, please let me know. It contains also evaluated material highly relevant to the other subdivisions of your inquiry.

The Members may well want to dispute the unfamiliar, revolutionary statements I make and I would be very willing to submit myself to their cross-questioning. In turn, my paper will doubtless suggest to you many questions to which your members would like responses, backed up by factual evidence and not simply unconsidered beliefs, from defenders of orthodox antenatal practices.

In the time available I have not been able to write my paper directly around the core areas you detailed. It concentrates on "the findings of recent research and its implications", with references to costs (unquantified) (paras 8.1-3.5) and unofficial policy (para 4.2). If "current policy" is meant to refer to official policies, these were traced in chapter 5 of 'Safer Childbirth?' pages 147-165, finishing up with the contributions of the Social Services Committee in 1980 and 1984 – quite a long story – but like unofficial policy dominated by the Royal College of Obstetricians and Gynaecologists and their all-pervasive influence on the medical and midwifery professions, on the Health Authorities, and on medical and midwifery education. My paper refers to the facts that "things go wrong" often, not from natural causes, but because of obstetric treatments, intended to be preventive but in fact provocative. I think that this core area should make a clear distinction between natural and iatrogenic causes of complications; it is now unquestionable that obstetric interventions at any stage, using high technology, much more often do harm than good. The price of using them routinely in the hope of reducing risk for the few is greatly to increase risk for the many. One of the specific core areas, which the Committee definitely ought to investigate is the role of high technology in maternity care.

I am not making any formal submission on preconception care. I know of no evaluation of the service such as it exists. Facilities for genetic counselling for the few who fear they may be carriers of serious hereditary disease seem worth while. Infertility clinics are very costly and have low success rates; they may not be a good use of scare resources. For the vast majority the only necessary and sensible advice is to follow the well established rules for healthy living, applicable to everyone, and it certainly does not need medically organised and State funded preconception clinics to disseminate this knowledge. I plan to prepare a submission on delivery/birth before the due date.

I should probably have made it clear in my personal introduction that I do not represent any organised body of professional providers or consumers of the maternity service. In this field, I work as an independent medical researcher on a voluntary basis in my own time. For this reason, I have given you my home address and telephone number where you can reach me with less delay than via the Medical School, should you wish to do so.

I am delighted that the Health Committee has decided to investigate the maternity service in view of the information now available on which to make balanced judgements and justifiable recommendations. I wish you all much success in your deliberations.

ANTENATAL CARE

Contents

SUMMARY

The accepted belief, that medically orientated antenatal care makes an essential contribution to the safety of childbirth, is challenged in the light of the evaluated ineffectiveness of the treatments used. It is recommended that the number of clinics providing high technology, high cost, obstetrician dominated care be reduced, and the unproven diagnostic tests no longer used routinely. They should be replaced by small, low technology, low cost clinics offering socially supportive care by midwives. The effectiveness of antenatal care would thereby be improved and its cost, direct and indirect, greatly reduced.

ANTENATAL CARE

Personal introduction

1.1 As a research statistician working in 1975-76 in the then Department of Community Health at Nottingham University Medical School, I noticed that the relevant official published statistics did not support the widely held belief on which the maternity services were organised, namely, that hospitalisation and obstetric management were the essential factors on which the safety of childbirth depended. Deeper research into further reliable statistical sources confirmed my early findings. These were published in several articles in professional journals and included one criticising the Report of the House of Commons Social Services Committee in 1980, the "Short Report" (Tew, 1980).

1.2 Further researches into the biological, sociological, psychological and historical aspects of maternity care produced evidence which explained the reasons why the statistical findings are as they are and traced how official policy had been formed. All this evidence was brought together in my book, "Safer Childbirth? A critical history of maternity care", published in 1990, which has since been favourably reviewed. It includes one chapter on antenatal care and in another reviews the Social Services Committee's Reports of 1980 and 1984.

The purpose of antenatal care

2.1 The justification for antenatal care depends on the belief that childbirth is an inherently dangerous process, but that many of its dangers can be foreseen and forestalled by appropriate medical interventions. Its objectives may be defined as to alleviate the anxieties and discomforts of pregnancy, but more importantly, to detect and treat complications at an early stage, so that later serious complications may be prevented and the mortality and morbidity associated with childbirth thereby reduced.

2.2 The actual results over nearly seventy years, when analysed, show not only that the specific objectives have rarely been achieved, but also that the underlying belief is gravely mistaken (Tew 1990, p. 289).

The process and results of medically oriented antenatal care.

3.1 Despite increasing medical involvement in antenatal care, the maternal mortality rate was higher in the early 1930s than it had been in the 19th century and it was higher for women in the richer classes who were more likely to buy the services of doctors. The dramatic and sustained decline after 1935 was associated with the introduction of antibiotics and more effective blood transfusion, which removed from intranatal care much of the dangers of puerperal sepsis and haemorrhage for which obstetric interventions had been largely responsible. It is impossible to show any positive correlation between obstetric interventions, either at the antenatal or intranatal stages, and the continued decline in all the specific causes of maternal mortality (Tew, 1990, pp. 211–3).

3.2 Since the 1950s, because maternal mortality has been a diminishing problem and one which was apparently resolving itself, independently of medical care, the Maternity Services have been concerned primarily with the welfare of the infant.

4.1 Maternity care can be considered from two distinct but interrelated aspects, one the medical and physical aspect, the other the social and emotional aspect. That the medical aspect is much the more important has hardly been questioned by those in authority (despite its manifest inability to improve maternal mortality), so that the antenatal service has been organised predominantly to suit medical requirements.

4.2 Clinics may take place in obstetric hospitals or at the practices of general practitioners, with participation by midwives, but in all cases their conduct follows the standards laid down by specialist obstetricians. The standards define the characteristics and conditions in the pregnant woman which are claimed to predict high risk, beyond the competence of general practitioners and midwives to manage and certainly requiring care by obstetricians in hospital clinics.

4.3 The criteria by which risk is routinely judged are in fact very fallible predictors of adverse outcomes (Reynolds et al., 1988). While epidemiological findings indicate that the chance of perinatal death is greater in the presence of certain characteristics, the vast majority of babies will be delivered safely even when the predicted risk is high, while a few babies will die even when the predicated risk is low, whichever birth attendant gives antenatal of intranatal care.

4.4 Nor have the diagnostic tests which obstetricians have developed, however sophisticated the technology employed, proved to be more reliable indicators of later complications. This is even true for the widely acclaimed and widely practised test of electronic fetal monitoring (Banta & Thacker, 1979; Prentice & Lind, 1987).

4.5 Nor have obstetricians been able to produce any evidence that their antenatal care reduces the predicted high risk from most of the identified conditions. It was admitted in an authoritative obstetric source that, except for haemolytic disease of the new born, obstetric therapies were either ineffective or unproven (Kerr, 1980).

4.6 Carrying out the tests has led to frequent over diagnosis (falsely predicting complications) and to unnecesary, hazardous interventions which often carry greater risk than the conditions they purport to ease and thereby increase rather than reduce later complications and mortality. In those cases where the diagnostic tests are correctly interpreted as identifying impaired fetal growth, the favoured treatment is to cut short the pregnancy, but it has never been demonstrated that the prematurely delivered infant survives more healthily in the stressful environment of the neonatal intensive care unit than in the apparently unsatisfactory womb. Where the tests are incorrectly interpreted, as they often are, the risk to the infant is without doubt seriously increased by premature delivery (Tew, 1990, pp. 99–100).

4.7 The wider practice of screening tests has greatly increased antenatal inpatient admissions for supervised bed rest, but the benefits of this have not been proven and there are some disbenefits (Grant et al., 1982; Tew, 1990, p. 99).

4.8 Ultrasound, and other screening tests like amniocentesis, are more reliable at identifying lethal congeniatal malformations (Neilson & Grant, 1989). If therapeutic abortion follows, the perinatal mortality rate will be reduced. Ultrasound has proved beneficial in specific conditions, but there is no evidence that its routine use has made most viable births safer (Thacker, 1985). There has not been time to assess its long-term dangers, if any, but its routine use will make it impossible to trace any future morbidity back to fetal experience since there will be very few contemporaries who were not scanned *in utero* to act as comparison controls.

4.9 Since on impartial evaluation more positive disbenefits than positive benefits have been demonstrated from its component practices, medically oriented antenatal care as a whole cannot have contributed to the impressive decline in perinatal mortality over the last 50 years.

Socially oriented antenatal care

5.1 Antenatal care as organised has paid little more than lip service to the importance of social and emotional factors in the process of birth and its safety.

5.2 Obstetricians have realised that mortality rates are always higher in the lower social classes, but their treatments have never been able to narrow the disparity (Tew, 1980).

5.3 Where pregnant women are clearly anaemic or otherwise undernourished, dietary supplements are beneficial. Even more beneficial would be advice about the constituents of a healthy continuing diet and help to make it available. Whether dietary supplements are of any benefit to healthy women and their babies is uncertain, so there is no value in dispensing them routinely (Rush et al. 1989).

5.4 Obstetricians have failed to realise that the emotional factors are of overriding importance, for it is these which initiate and co-ordinate the physical factors. Essential for the efficient working of the emotional factors are self-confidence and lack of fear in the women. Arrangements in antenatal clinics, particularly those held in large obstetric hospitals with large and changing staffs, are very successful at undermining a woman's self-confidence and the obstetric propaganda disseminated by most care givers to justify their interventions is very successful at implanting fear (Short Report, 1980; Tew, 1990 pp. 89-91).

5.5 Screening tests to uncover the possible signs of asymptomatic but potentially dangerous conditions are as likely to create as to relieve anxiety in the expectant mother (Alexander & Keirse, 1989; Tew, 1990 p.81).

5.6 A woman's self-confidence can be built up if the circumstances of antenatal care allow her to form a trusting and continuing relationship with one or a small number of her attendants (Flint & Poulengris, 1987).

Conclusions to be drawn

6.1 Thorough and disinterested analysis of the accumulated evidence from all sources finds that it consistently and convincingly discredits obstetricians' claims, that it is their management, antenatal and intranatal, which has increased the safety of birth over the last 50 years. Indeed, it has probably prevented mortality rates from falling as fast as they would otherwise have done (Tew, 1990, p.263). For by far the most important determinant of safe childbirth is the health of the mother, beside which the positive contribution of the medical component of obstetric care is marginal. The provisions of the Maternity Service are, therefore, seriously ill-balanced.

6.2 Mortality rates had become so low by the 1980s because by then the health status and physical development of most childbearing women had become so good, thanks to the adequate diet which most have been able to enjoy throughout their lives from their conception onwards.

6.3 The best hope for further reductions in mortality lies in reducing the number of preterm and underweight births (the sub-group at by far the highest risk of death), which the interventions of antenatal care over the last 30 years have completely failed to do (Tew, 1990, pp. 100, 277).

6.4 Preterm birth and low birth weight are strongly related to the inadequate nutrition and stressful life styles associated with poverty. Antenatal care, directed towards easing these social problems, ensuring a nourishing diet and inspiring self-confidence, self-respect and self-care in the women concerned, would have a

much better chance of preventing preterm and low-weight births and hence lowering mortality and childhood morbidity.

Recommendations

7.1 Since evidence is so conspicuously lacking that obstetrician dominated antenatal care as delivered up to the present time has made a net positive contribution to the increased safety of birth, there is no justification for allowing it to continue in its present form.

7.2 Antenatal clinics should be reorganised; in only a minority of them should medically oriented care be dominant, with greatly reduced need for obstetrically qualified staff.

7.3 In most clinics care should be socially oriented and most effectively provided in small, intimate, low-technology, low-cost clinics dominated by midwives whose training bridges the social and medical aspects of childbirth and whose ancient philosophy recognises the need to provide emotional support. Midwives are already prepared to organise such clinics (Association of Radical Midwives, 1986).

Financial implications

8.1 These reorganised arrangements would greatly reduce the financial costs of antenatal care.

8.2 In most clinics the provision of technological equipment would be limited to what is known to be beneficial in routine use and would comprise relatively unsophisticated and inexpensive instruments.

8.3 The high capital and maintenance costs of more sophisticated equipment, including electronic fetal monitors and ultrasound, would have to be met only in the minority of clinics serving as referral centres for specific complications or carrying out well planned research.

8.4 Further financial savings could be generated:

8.4.1 if the frequency of antenatal attendances was reduced, which could probably be done safely for most women;

8.4.2 if fewer unreliable diagnostic tests, giving false predictions of impending complications, were used. This would be an economy in itself and would lead to a train of further economies:

8.4.3 fewer women would be admitted for hospital inpatient care:

8.4.4 (this expense would be further reduced if the ineffectiveness of bed rest as a remedy for many conditions was recognised);

8.4.3 fewer intranatal interventions would be called for, so that in turn fewer babies would be born needing extremely costly neonatal intensive care (Cooke, 1988), and fewer graduates from neonatal intensive care units would go on to need the extra hospital care in childhood which they do (Skeoch et al, 1987).

8.5 If the primary objective of the Maternity Service is truly to serve the interests and improve the welfare of the receivers of care, the mothers and babies, rather than the professional and financial interests of the providers of the service, then the money saved from the reformed, low-cost, low-technology antenatal care could be devoted to programmes directed at relieving the nutritional deficiencies and the social stresses of the small subgroup of mothers in greatest need and to ensuring that the children in poor families receive the nourishment and care necessary for their healthy physical and emotional development, for these will be the parents of the next generation who will in turn inherit their capacity to produce healthy or unhealthy offspring.

March 1991

REFERENCES

Alexander, S. and Keirse, M. J. N. C. (1989) *Effective care in pregnancy and childbirth*, (eds Chalmers, I., Enkin, M. and Keirse, M. J. N. C.), chapter 22, Oxford University Press, Oxford.

Association of Radical Midwives (1986) *The Vision. Proposals for the Future of the Maternity Service*. ARM. Ormskirk.

Banta, D. and Thacker, S. (1979) Electronic fetal monitoring: is it of benefit? *Birth and the Family Journal*, 6, 4.

Cooke, R. (1988) Outcome and costs of care for the very immature infant. *Br. Med. Bull.*, 44(4), 1133–51.

Flint, C. and Poulengeris, P. (1987) *The 'Know Your Midwife' Report*, 34 Elm Quay Court, Nine Elms Lane, London SW.

Grant, A., Chalmers, I. and Enking, M., Physical interventions intended to prolong pregnancy and increase fetal growth in *Effectiveness and Satisfaction in Antenatal Care* (eds Enkin, M. and Chalmers, I.), William Heinemann, London, Chapter 13.

House of Commons Social Services Committee (1980) *Perinatal and Neonatal Mortality; Second Report from the Social Services Committee 1979–80*, Chairwoman, R. Short, HMSO, London.

Kerr, M. (1980) The influence of information on clinical practice in *Perinatal Audit and Surveillance* (ed Chalmers, I.), RCOG, London, 319–26.

Neilson, J. and Grant, A. (1989) *Effective care in pregnancy and childbirth*, (eds Chalmers, I., Enkin, M. and Keirse, M. J. N. C.), chapter 27, Oxford University Press, Oxford.

Prentice, A. and Lind, T. (1987) Fetal heart rate monitoring during labour—too frequent intervention, too little benefit? *Lancet*, ii, 1375–7.

Reynolds, J., Yudkin, P. and Bull, M. General practitioner obstetrics: does risk prediction work? *J. R. Coll. Gen. Pract.*, 38, 307–10.

Rush, D., Green, J., Mahomed, K. and Hytten, F. *Effective care in pregnancy and childbirth*, (eds Chalmers, I., Enkin, M. and Keirse, M. J. N. C.), chapters 17, 18, 19, Oxford University Press, Oxford.

Skeoch, C., Rosenberg, K. et al., (1987) Very low birth weight survivors; illness and readmission to hospital in the first 15 months of life. *Br. Med. J.* 2, 579–8.

Tew, M. (1980) Facts not assertions of belief. *Health Soc. Serv. J.*, 12 September, 1194–7.

Tew, M. (1990) *Safer Childbirth? A Critical History of Maternity Care* Chapman and Hall, London.

Thacker, S. B. (1985) Quality of controlled clinical trials. The case of imaging ultrasound in obstetrics: a review. *Br. J. Obstet. Gynaecol.*, 92, 637–44.

Supplementary Memorandum submitted by Mrs Marjorie Tew

DELIVERY/BIRTH

Contents

I. Summary

1.1 Evaluation of the results of actual experience totally discredits the beliefs on which the organisation of the maternity services has been founded. The obstetric management of intranatal care has not made most births safer and hence has not been the cause of the great decline in maternity related mortality and morbidity in the last 50 years. On the contrary, the evidence strongly favours the disillusioning interpretation that obstetric management makes birth less safe, not only for those at low pre-delivery risk, but also for those at high risk.

The close association between mortality and socio-economic deprivation, in childbirth as in other human conditions, points to the probability that falling mortality rates are causally related to the rising standards of nutrition which successive generations have been able to enjoy in the course of the twentieth century. Safe childbirth is more a social, that a medical problem; it is more likely to be promoted by social, rather than obstetric interventions.

1.2 *III. How current policy for the organisation of intranatal care was shaped*

The part played by official committees of inquiry from 1946 to 1988 in shaping the policy for the organisation of intranatal care is traced, but their success as impartial arbiters between conflicting interests and the importance of their recommendations relative to the influence of the dominant professionial body, the Royal College of Obstetricians and Gynaecologists (RCOG), are questioned (paras. 3.1–11.5). The strong influence of the RCOG on several aspects of policy at clinical level is considered (paras. 12.1–12.8).

1.3 *IV. Services provided*

A brief reference is given to the places of birth and the frequency of births in each place in the 1980s (para. 13.1).

Mention is made of the recent Home from Home innovation at Leicester Royal Infirmary (para 13.2).

1.4 V. The cost and cost effectiveness of services

The lack of detailed data is deplored, but it is a reasonable hypothesis that costs, capital and current, are highest in the largest institutions with the most technological facilities. Such provisions can only be cost effective if the outcomes of treatment, in terms of mortality, morbidity and satisfaction for the users, are better there than in alternative places of delivery (paras 14.1-15.2), which research now shows they most frequently are not (paras 17.1-22.4).

1.5 VI. What happens when things go wrong?

This section considers the uncertainties and inaccuracies in defining complications, in interpreting signs of impending disaster, and in initiating treatments which reduce anticipated dangers without creating others which may in the end prove more serious. There is good reason to doubt that many of the apparent deviations from what obstetricians define as the normal progress of labour are better corrected by a prompt obstetric intervention than by patient waiting for the woman's reproductive system to recover by itself from its apparent aberration, which it often does. Many of the complications in later labour are the consequences of earlier interventions. The need to make provisions for "when things go wrong" is best met by providing the kind of intranatal care where "things rarely go wrong", which is supportive midwifery, especially in the relaxed setting of the home (para 17.24). Finally, there is a disturbing lack of evidence that obstetric management improves the outcome for most of the high risk complications once they have happened (paras. 16.1–16.9).

1.6 VII. The findings of recent research

1.6.1—the evaluation of earlier results

Analyses of the actual results of maternity care in Britain and Holland, using a variety of statistical techniques, all point to the same conclusion, that obstetric management has not improved the safety of most births, whether at low or high pre-delivery risk, and, therefore, that it has not been the cause of the great decline in related mortality experienced over the last 50 years. This conclusion discredits the entire basis on which the maternity service is organised. The conclusion is attacked vociferously by the supporters of the present system, but they cannot show it to be invalid (paras 17.1-17.24).

1.6.2—the evaluation of obstetric techniques

Results are reported of specific studies which have been conducted, usually with obstetrician participation, to assess whether perinatal outcomes are in the event improved by various obstetric interventions, commonly undertaken for this purpose. In comparisons between groups matched for pre-delivery risk, outcome is rarely better and usually worse for the group exposed to the intervention (paras 18.1-18.5).

1.6.3—obstetric management of the chief causes of perinatal death

It is shown that obstetric interventions are inappropriate instruments for reducing the three leading causes of perinatal death, low birthweight, congenital malformation and hypoxia and that, despite insistent claims to the contrary, they do not do so (paras 19.1-21.2).

1.6.4—maternal satisfaction

Women's emotional reactions to obstetricians' and midwives' care are briefly reported (paras 22.1-22.4).

II. Personal introduction

2.1 The following two paragraphs largely repeat the personal introduction to my submission on Antenatal Care.

2.2 As a research statistician working in 1975–76 in the then Department of Community Health at Nottingham University Medical School, I noticed that the relevant official published statistics did not support the widely held belief on which the maternity services were organised, namely, that hospitalisation and obstetric management were the essential factors on which the safety of birth depended. Deeper research into further reliable statistical sources confirmed my early findings. These were published in several articles in professional journals and included one criticising the Report of the House of Commons Social Services Committee in 1980, the Short Report (1).

2.3 Further researches into the biological, sociological, psychological and historical aspects of maternity care produced evidence which explained the reasons why the statistical findings are as they are and traced how official policy had been formed. All this evidence was brought together in my book, "Safer Childbirth? A

critical history of maternity care', published in 1990, which has since been favourably reviewed (2). It includes one chapter describing intranatal obstetric practices and two chapters evaluating the results of care, one for the mother, one for the child. In another chapter it reviews the Social Services Committee's Reports of 1980 and 1984. Most of the material in this submission is drawn from my book.

2.4 In the field of maternity care, I work as an independent voluntary researcher, I do not represent any body of professional providers or lay users of the maternity services.

III. How current policy for the organisation of intranatal care was shaped

3.1 The official policy for the maternity services is to provide for all births to take place in an obstetric hospital. This objective was substantially achieved by the late 1970s and the 1980s saw the gradual whittling away of the remaining shortfall, so that for most childbearing women there has since been no effective choice in place of delivery.

3.2 Birth in a medical institution had become more popular in the course of the 20th century, particularly in the United States of America and the former British Dominions, where a vigorous medical profession realised that this arrangement would benefit its practitioners and claimed that it would benefit its clients.

3.3 By 1940 the British medical profession was coming to share this view. In particular obstetricians, organised since 1929 in the College (later Royal) of Obstetricians and Gynaecologists (RCOG), were completely convinced of its rightness. They also recognised that the best way to ensure delivery under their control was to increase their influence over antenatal care.

4 – 10 The part played by official committees of inquiry

4 *Maternity in Great Britain, 1946*

4.1 The RCOG collaborated in writing the report of a survey *Maternity in Great Britain* in 1946 which has to admit "the complete lack of reliable statistics on the provision of antenatal care and the results it achieves" (3, p. 6), but nevertheless recommended that "Greater efforts should be made to publicise the antenatal services and stress the importance of early and regular supervision" (3, p. 210).

4.2 With regard to care at delivery, the Report dismissed the survey finding of much lower stillbirth and neonatal mortality rates for births at home, although these included a disproportionately large number to poor mothers in poor housing and with large families, the demographic subgroup at highest risk of a fatal outcome; instead it picked on the fact that 5 per cent of the births booked for home delivery developed complications, for which they were transferred to hospital and suffered very high mortality. Although there was no evidence that births booked for hospital delivery would not have developed the same complications or, if they had, would have suffered lower mortality, it was considered that "Until the incidence of such emergencies can be reduced, there is a good case for the encouragement of institutional delivery", for after all "if a sufficiency of maternity beds is provided in suitable institutions . . ., there is little doubt that in England, as in America, the institutional habit would be established for the large majority of confinements' (3, pp. 203, 204).

4.3 These findings and recommendations were to be re-echoed in every subsequent inquiry.

5. *The Guillebaud Committee, 1956*

5.1 When the National Health Service came into force in 1948 hospital medicine, in obstetrics as in all other specialities, was accorded a central role. Hospital care is expensive to provide. Most witnesses to the Guillebaud Committee, which reported its investigations into the NHS's financial problems in 1956 (4), considered that it would be sufficient to provide for 50 per cent of deliveries to be in hospital, but the RCOG attested, without substantiating evidence, that institutional confinement provides the maximum safety for mother and child and therefore obstetric beds should be provided for all women who need or will accept it.

6. *The Cranbrook Committee, 1959*

6.1 Since the Guillebaud Committee did not feel qualified to judge the medical issues and disagreements involved, the Cranbrook Committee was set up to review the maternity services and they reported in 1959 (5). The RCOG reiterated its unsubstantiated assertion that hospital confinement offered maximum safety. The committee were easily persuaded that obstetric management, using interventions, was unquestionably safer for births predicted to be at higher risk, because the mother or fetus had certain characteristics or conditions, and for all births booked for delivery outside hospital but which developed later complications. They did not wait for the results of a nationwide survey of perinatal mortality, conducted in 1958 under the auspices of the RCOG and including among its objectives the gathering of information about the possible effects of place of confinement (6), far less propose that, when available, these should be impartially evaluated to verify obstetricians' claims and confirm that the policy recommended was soundly based (see below paras 7.1 and 17.4—17.7).

6.2 The RCOG's uncontested claims on physical safety overrode claims made by other witnesses for the emotional advantages of home confinement and the committee went on to recommend that provision should be made for 70 per cent of deliveries to take place in hospital.

6.3 At this time the theory underlying the re-organisation of all hospital care was that this could be provided most effectively and economically in the larger, District General Hospitals which were being developed to take over the functions of smaller specialist hospitals and where the expensive equipment and its operators, necessary for the application of technological advances, could be more conveniently concentrated. Any inconveniences felt by the patients were rated as of much lesser importance. The medical profession was not required to produce evaluated evidence to substantiate this theory.

6.4 The general policy was applied equally to maternity care. It accorded with the wishes of the RCOG and offered a surer road to their objective.

6.5 The necessary consequence of increased hospitalisation was decreased domiciliary maternity care and the downgrading of midwives, both as a professional group and as practitioners of a different philosophy, that of supporting and facilitating the natural process of reproduction. Their increased workload in community post-natal care was poor compensation.

7. *The Peel Committee, 1970*

7.1 The future of domiciliary midwifery and maternity bed needs were the subject of a further report in 1970, the Peel Report (7), prepared by an advisory committee of the Ministry of Health, chaired by the then President of the RCOG. By then the results of the 1958 Perinatal Survey (6) were available and an honest appraisal of them should have informed the Committee's deliberations. That the results totally contradicted obstetricians' claims about the greater safety of hospital delivery, in general and specifically in high risk cases, was not acknowledged (see below, paras 17.4—17.7 and Table 2).

7.2 The only finding referred to was the high mortality rate for births transferred to hospital because of late complications. The Report again relied on the untested assumption that obstetric management throughout would have resulted in lower mortality rates for these births.

7.3 The Report also pointed to the contemporaneous trends of increasing hospitalisation and decreasing perinatal mortality, implying agreement with the popular but convenient fallacy that the former trend was the cause of the latter. Later statistical analysis has actually shown a strongly negative correlation between the trends, the greater annual increases in hospitalisation being associated with the smaller annual decreases in perinatal mortality, which suggests that the increases in hospitalisation have actually kept the mortality rate from falling as fast as it would otherwise have done (2, pp. 262-5, and below, Table 1 and Figure 1).

7.4 Relying on these completely unsound pieces of evidence, the Peel report recommended that "sufficient facilities should be provided to allow for 100 per cent hospital delivery" (7, para 277) and that "Small isolated obstetric units should be replaced by larger combined consultant and general practitioner units in general hospitals" (7, para 283).

8. *The House of Commons Social Services Committee, 1980*

8.1 Although these recommendations had been largely implemented, the perinatal mortality rate had not fallen as much in Britain as in some other countries and the disparities between the social classes and between the regions had actually widened. These results prompted the House of Commons Social Services Committee to set up their own inquiry into why babies were "unnecessarily dying". They published their findings in the Short Report in 1980 (8). The expert advisers they appointed were unquestioning supporters of the obstetric management of pregnancy and delivery and its claims of providing maximum safety.

8.2 Although the advisers could not give the Committee satisfactory explanations as to how maximum safety was achieved, led them to misinterpret statistical results specially prepared for them, and did not make them aware of recent evaluations of existing results which showed that obstetricians' standard defences of the higher actual mortality of hospital births were invalid (1; 2, p. 71, refs 28-31), they succeeded in allaying Members' reasonable doubts and persuading them to make recommendations about the organisation of delivery care which simply reinforced those of the Peel Report. These ensured obstetricians' monopoly as providers of maternity care and the further effective lowering of the status of midwives.

9. *The House of Commons Social Services Committee, 1984*

9.1 This committee conducted another inquiry in 1984 to follow up how far the recommendation in their 1980 Report had been implemented (9). The same expert advisers led them, optimistically and with the usual disregard of the need for substantiating evidence, to take some of the credit for the continuing decline in perinatal mortality, though more obstetric management had once again failed to narrow the disparities between the social classes and between the regions, despite protestations by obstetrician witnesses in 1980 that it could do so.

9.2 The need was stressed for delivery to take place in hospitals with immediate access to facilities for anaesthesia and neonatal resuscitation and other intensive care. The committee was not made aware that the need for these facilities resulted to a large extent as side-effects of the obstetric management of labour, the consequences at first and second hand of the liberal use of drugs to relieve the greater pain caused by obstetric interventions (see below, para 16.8). These expensive facilities are therefore necessary adjuncts only to the obstetric intranatal care as recommended by this and previous committees: they are seldom needed in the non-interventive, supportive midwifery care as discouraged by this and previous committees.

10. *The House of Commons Social Services Committee, 1988*

10.1 What little their Report on Perinatal, Neonatal and Infant Mortality (10) had to say about the Maternity Service again revealed the biased guidance given by the same professional advisers as before, who were apparently oblivious of the mounting evidence which discredits claims that obstetric management makes birth safer.

10.2 Hence, while the Committee did understand the higher mortality associated with poverty and was encouraged to make the usual vague recommendations for improvements in social welfare, they were encouraged to go on believing that, contrary to all previous experience, it lies within the powers of Governments and Health Authorities to achieve immediate reductions in the higher mortality rates by increased allocations of resources to the medically directed maternity and paediatric services.

10.3 They were not encouraged to recommend halting, far less reversing, the current policy of closing small local maternity units, despite the unquestionable record of these of greater safety for low risk deliveries and greater acceptability to the women concerned, and the policy of deterring confinements.

10.4 They were not encouraged to recommend less aggressive obstetric management, so as to avoid the higher mortality and morbidity demonstrated to be associated with interventions and the consequent need for facilities for anaesthesia and neonatal intensive care. Rather than recommeding measures to reduce this need, they were concerned to recommend that "unambiguous guidance on the structure and quality of intensive care services for ill babies be issued to regional health authorities" and a programme of compliance with it (10, para 36).

10.5 They recommended that the Department of Health initiate "... social and medical research aimed at establishing the reasons for, and reducing the incidence of, low birthweight" (10, para 14). But they held out no prospect that, if the proposed research confirmed the existing evidence that obstetric management had hitherto failed to improve either the incidence of or outcome for low-weight births, policy for the maternity service would be changed appropriately (see below, Table 2 and paras 17.9—17.10.; 19.1—19.3).

10.6 Shielded from the evaluated findings of past results, the Committee were less concerned to recommend policy and practices soundly based on justifiable grounds than to ensure efficient machinery for the universal adoption of unsound, unjustifiable practices.

11. *Policy recommended; policy followed*

11.1 The purpose of official committees is to weigh the arguments presented by all interested parties. It is obvious that all the official committees considering maternity care have been most strongly influenced by the submissions of obstetricians, without scrutinising their validity. There is reason, however, to doubt whether the acquiescent recommendations in their reports have in fact determined the direction of policy or simply given the seal of official approval to what would have happened in any case. Recommendations intended to protect and palliate other interests, for example those of midwives, seem to have been largely ineffective.

11.2. The Peel Report (7, para 248) commented "Even without specific policy direction the institutional confinement rate has risen from 64.6 per cent in 1957 to 80.7 per cent in 1968, and shows every sign of continuing to rise..." (which it did, to 96.5 per cent in 1988). In all countries where Western medicine is dominant, hospitalisation is the favoured policy for childbirth. In no country has there ever been evidence that this policy has made birth safer for most mothers and babies. The policy has become accepted thanks primarily to the persuasive propaganda, diligently dispensed by eloquent obstetricians, falsely claiming greater safety for their management of delivery in hospital and falsely attributing greater dangers to the care provided at home or in isolated maternity units by their rivals, the midwives and general practitioners. Their propaganda depended on the misrepresentation and concealment of actual results and the improper use of techniques of statistical analysis. (see above para 8.2 and below, paras 17.4.—17.7., 17.9.—17.10., 17.12.—17.13., 17.15., 21.2.)

11.3 Some obstetrician witnesses to committees of inquiry have gone as far as proposing that home-delivery should be made illegal. All committees have stopped short at recommending this. Nevertheless, many providers of maternity care advise and act as though it were illegal and put every possible obstacle in the path of any woman intrepid enough to ask to give birth at home. Her hopes will almost certainly be frustrated unless she can prove that she is at "low risk" according to obstetricians' ever stricter criteria. (In a study in 1989 in West Berkshire, an area of abundant good health, only 30 per cent of all births were judged at low enough risk of completing a natural process without complications not to need obstetric management.) (11).

But there is no evidence that the predicting criteria used correctly identify those pregnancies which will go on to develop complications (12), and no evidence that obstetric management will make complications less likely or improve the outcome of most of those which do occur.

11.4 A woman has to satisfy similar, and equally unjustifiable, criteria to be allowed to deliver in a GP maternity unit unattached to an obstetric unit. The restrictive admision conditions effectively reduce bookings, so that the unattached GPUs are often underused and the average cost per delivery is raised (see below, 14.3, 14.4).

11.5 Despite the overwhelming evidence, of which it has been made aware, that obstetric management in hospital makes a net decrease, and not a net increase, to the safety of birth as a whole, the Ministry of Health repeatedly uses the supposed greater safety as grounds for defending its adherence to the policy to total hospitalisation, not only in its attestations to House of Commons Committees, but also in its many answers to letters from critical and better informed members of the public.

12. *Policy at the clinical level*

12.1 The RCOG has exercised immense influence over the conduct of maternity care by several routes.

12.2 It has obtained widespread adherence to its ever stricter criteria for the initial booking of place of delivery and the subsequent transfer to hospital of outside bookings. Most general practitioners and midwives conform with these unofficial regulations, either because they believe them to be right or because they fear to lay themselves open to accusations of negligence should a complication occur. Once booked for or transferred to hospital, a mother is committed to the obstetric management of her delivery, to the range of interventions currently thought to be in the best interest of herself and her baby, without reference to what she might judge her best interest to be.

12.3 The RCOG prescribes the qualifications which must be held by practitioners at consultant, registrar, and general practitioner levels: its requirements, therefore, dominate the contents of training courses given in medical schools and teaching hospitals. These requirements concentrate on the physical aspects of reproduction; social and emotional aspects receive at best incidental attention.

12.4 The research pursued by leading obstetricians in medical schools is likewise biased towards biochemical and biophysical, rather than epidemiological or psychological interests. Evaluation of therapies has not hitherto received systematic attention.

12.5 The RCOG has set down recommended policies and practices in several published documents of its own (13; 14; 15). Its Fellows and Members make many contributions to published literature and teaching material on the subject.

12.6 The RCOG has also exercised immense influence on the training of midwives, which has increasingly been directed at producing competent obstetric nurses, confident in carrying out maternity care according to obstetricians' principles and using instruments of high technology, but unconfident in trusting the proven methods of supportive midwifery and using only low technology. Midwives' influence on policy has become peripheral, though their influence on actual practice can be considerable.

12.7 Despite this direction of training, some variety persists in the actual practices of medical and midwife practitioners, which allows some scope for informative comparisons of outcomes following different practices.

12.8 Variety has persisted also despite the Ministry of Health, through its Maternity Services Advisory Committee, issuing guidelines to try to ensure that the same standards are observed in all Health Districts. Regional variations in the incidence of certain interventions are recorded in Hospital Inpatient Enquiry Reports.

IV. Services Provided

13.1 According to a recent survey (16), 67 per cent of births in the United Kingdom took place in the 125 hospitals with more than 2,000 annual deliveries, 28 per cent in the 149 hospitals with 501–2,000 annual deliveries, around 4 per cent in the 217 smaller hospitals, and under 1 per cent at home. The survey gives detailed information about the facilities then available at the different sites. The smaller sites, with fewer technological facilities, are considered by obstetricians to be unsafe despite having far lower mortality rates than the larger, well-equipped hospitals.

13.2 Some hospitals have opened a Birthing Room, a less clinical setting than the conventional labour ward, with technological equipment available but concealed. Leicester Royal Infirmary, where over 6,000 babies are born each year, has gone further and claims to have pioneered the country's first low technology. Home from Home unit, a relaxed setting conducive to natural labour and providing continuity of care under the control of its own team of midwives. The innovation has been so successful that the size of the unit has

been doubled from three rooms to six. So long as it maintains its clinical independence, this unit is a model worth copying.

V. THE COST OF SERVICES

14.1 All committees of inquiry have accepted that the first objective is to provide a safe service for all births. They have not considered the financial costs, far less the cost effectiveness, of alternative provisions. This they would have found practically impossible to do with any accuracy, since the necessary distinctions are not made in the accounting systems in the Ministry of Health.

14.2 It is, however, common sense and general knowledge that costs (capital and current) are much higher for hospital inpatient care and treatment involving the use of complex technological equipment than for care at home and treatment using only simple equipment.

14.3 The average cost per patient of hospital care obviously depends on the number of patients over whom the total costs can be spread. It may be, also, that the costs for maternity patients cannot be exactly distinguished from the costs for other departments using the same facility. Independent estimates based on the limited data available have, however, agreed that unit costs are lower in the small hospitals and lower still for community care and home confinements (17; 18; 19). Any extra expenses incurred in reorganising from a more costly to a less costly system should soon be recouped.

14.4 Nevertheless, many District Health Authorities have justified closing small maternity hospitals, despite their excellent safety records and strong local support, because they are said to be too costly. On the other hand, the Bath DHA retained the unattached GP units in its area precisely because of the much higher cost of concentrating deliveries in the obstetric unit in Bath. It is fair to question what the true grounds have been for closing small units.

14.5 Establishing accurate costing in the Maternity Service should be a priority for the reformed National Health Service and the Audit Commission. They should find scope for substantial savings.

Cost effectiveness.

15.1 When it comes to cost effectiveness, the issue is unambiguous. Since their results show that mortality rates are consistently higher in the large obstetric hospitals and this excess can never be explained by the excess of births there at high predicted, pre-delivery risk, the higher financial costs of obstetric hospital care cannot find justification in its proven greater safety.

15.2 It is unlikely that high technology obstetric management as a whole could be cost-effective unless the procedures it commonly comprises are individually cost-effective. If they do not justify their extra costs on safety grounds, and many specific research studies have shown that they do not (see below, paras. 18.1—18.5), they cannot be justified on financial grounds.

VI. WHAT HAPPENS WHEN THINGS GO WRONG?

— Why do things go wrong? Can you be sure that things have gone wrong?

16.1 Obstetric propaganda, emphasising the dangers of birth, has succeeded in making everyone excessively apprehensive. Cautious birth attendants are made constantly liable to overdiagnose impending complications.

16.2 It is assumed that "things going wrong" are preceded by signs and that these signs can be reliably diagnosed by birth attendants. This is not so, even when the most advanced equipment is used. For example, "things are going wrong" if the fetus becomes distressed, but there is no test which distinguishes all the fetuses which really are distressed, and only these. There is wide variation both in the interpretation by attendants of the traces of electronic fetal heart rate monitors and in the action taken in response; some healthy fetuses suffer delivery by caesarean section, while distress in some fetuses is not detected (20; 21; 22).

16.3 It is assumed that detected signs of "things going wrong" are reliable predictors that "things actually will go wrong". In the event, many apparently developing complications can resolve themselves safely without intervention. For example, many malpresentations and misplaced placentae, diagnosed in pregnancy, are likely to right themselves by the onset of labour; some more will do so with no more than mild, non-invasive intervention (23).

16.4 It is assumed that obstetric interventions reduce the dangers of complications in viable fetuses and infants. It is admitted that interventions create dangers of their own, but it is assumed that the dangers of prompt intervention are less than the dangers of waiting to see whether the complication will resolve itself. Gestations and labours of above average length are counted as "things going wrong" and taken as signals for intervention to cut short the pregnancy or labour. There is no evidence that, in general, outcome is improved by such measures (24; 25; 26; 2, pp. 123–4).

16.5 In short, it is assumed that the more serious complications will most certainly benefit from delivery in hospital and obstetric interventions. With rare exceptions, actual results of perinatal mortality consistently discredit the validity of this assumption (see below, para 17.4–17.10; 17.18–17.22; and Tables 2, 3, 4).

16.6 When "things go wrong" with the mother, as when she suffers severe hypertension in pregnancy, obstetricians are certain that she should be under their care, but they are not so certain what elements in their care can be relied on to make it beneficial (27). For several decades there have been too few maternal deaths from this cause to make comparisons of mortality between places of delivery or methods of treatment. Intensive treatment to control her blood pressure may be to the advantage of the mother but to the disadvantage of the child (28). Perinatal mortality associated with severe maternal hypertension was higher for births in hospital than in GPUs/home in 1958 (see Table 2 attached) and in 1970 (33.4 v 15.6/1000). There is not later material for comparisons. The greater safety of current obstetric care, if any, is as yet unproven.

16.7 When the mother suffers a severe postpartum haemorrhage, speedy access to facilities for blood transfusion is essential and in this respect obstetric hospitals are well placed to meet the need. The need, however, more often arises in obstetric hospitals, for it is more likely to follow induced labours and instrumental deliveries than spontaneous labours and physiologic deliveries. Severe haemorrhages are rare in healthy women. Prophylactic injections to prevent haemorrhage—a benefit widely held to outweigh associated disbenefits—can be given at any place of delivery.

16.8 When "things go seriously wrong" with the newborn infant, speedy access to facilities for resuscitation and other neonatal intensive care is essential. But it must be remembered that many of the things that go wrong are the side-effects of the intranatal management; the drugs given to the mother to relieve the exceptionally severe pain of drug induced and accelerated labours pass through to the baby and impair its instincts to start breathing independently and to suck, or there may be damage from instrumental deliveries. Some of the babies have had their gestation deliberately shortened, so that their vital systems are not sufficiently developed for independent functioning. (See below, para 19.1–19.3).

16.9 Very often, "things which actually do go wrong" do so from treatment induced causes. Their incidence could be greatly reduced simply by reducing the frequency of obstetric interventions, both antenatally and intranatally.

16.10 Where 'things have gone wrong' from natural causes and a premature child has been spontaneously delivered, it is assumed that healthy survival is most likely to follow delivery in hospital with immediate access to high technology intensive care. This was not the outcome of hospital deliveries in 1958 or 1970 (see Tables 2, 3, 4), nor in Holland in 1986 (see below, para 17.21). Survival was claimed by paediatricians in Bolivia to be as good if the very tiny infant was kept warm between the mother's breasts, with unrestricted access to their own milk supply, a vastly cheaper form of care with better psychological results. No controlled comparison has yet been made in Britain but the option is worth investigating.

VII. The Findings of Recent Research

— the evaluation of earlier results.

17.1 The overriding superiority claimed for the obstetric management of childbirth rests on assumptions, propagated by obstetricians and widely accepted by the medical and lay public, that their interventions can usually reduce and never increase the natural hazards. The interventions are assumed to be particularly advantageous for births predicted to be, or in the event found to be, at high risk. When at last tested in the light of actual results, the assumptions are found to be totally invalid.

17.2 Hospitalisation of delivery is assumed to make it safer and therefore increased hospitalisation, with increased obstetric management, is assumed to have been the cause of the great reduction in maternal and perinatal mortality since 1940.

17.3 When data, as in Table 1 and Figure 1 attached, became available to test this assumption, the cause and effect relationship was found to be the reverse of that claimed (see above para 7.3; 2, pp. 262–5).

17.4 The nationwide 1958 survey of perinatal mortality (6) found the Perinatal Mortality Rate/1000 births (PNMR) to be much higher in hospital (50.0) than in GP units (20.3) and home (19.8).

17.5 More significantly, the results, as summarised in Table 2 attached, show that mortality was much higher in hospital at all levels of risk in respect of the three predicting factors for which data were published and also for the outcomes, gestational length and infant birthweight. Given the excess mortality in all subgroups, it is arithmetically impossible that the greater proportions at high risk in hospital could have accounted for more than a small part of the overall higher mortality there (2, pp. 241–4).

17.6 Far from supporting the assumption that obstetric management is especially advantageous for births at high risk, predicted or realised, the results manifestly discredit this basic principle on which the justification of obstetric management relies.

17.7 These conclusions could have been drawn by any impartial analyst of the Report, published in 1963 and available to the Peel Committee in 1970. Yet obstetricians managed to convince everyone, everywhere,

that their survey had demonstrated that home was the most dangerous place for birth and as such must be phased out as fast as hospital beds could be provided to meet the demand (see above, para 11.2).

17.8 One (unspoken) reason for this extraordinary distortion of evidence must have been the obstetricians' need to crush the professional rival who dominated domiciliary midwifery with such embarrassingly successful results. The committee, chaired by the President of the RCOG, was easily persuaded to make co-operative recommendations (see above, para 7.4.)

17.9 Also available to the Peel Committee, but ignored by them, were the mortality data on low-weight births, a subgroup at highest risk. This information was collected routinely by the Ministry of Health and from 1954 to 1964 published in the Annual Report of the Chief Medical Officer for England and Wales (29); thereafter it was collected but made available to the public only on request.

17.10 The data, published and unpublished, are summarised in Table 3 attached. They show that, in total and at weights over 1500 grams, birth was very much safer at home than in hospital. At weights under 1500 grams there was no significant difference in the chance of survival beyond 28 days. These routine annual results were entirely consistent with those of the 1958 survey and absolutely contradicted the claim that birth at home must be phased out for the safety of the infant (2, pp. 248–50).

17.11 Another survey of British Births was conducted in 1970, again under the auspices of the RCOG. Between the 1958 and 1970 surveys, the proportion of births in hospital had risen from 49 per cent to 66 per cent, but the excess PNMR there had risen even more. For although the PNMR had fallen everywhere, it had done so by a smaller proportion for the hospital births (44.4 per cent) than for the births in GPUs (73.3 per cent) and at home (77.7 per cent). This indicates that, if the proportion of births in hospital had not increased the national PNMR would have fallen by more than it did. The conclusion is the same as that pointed to by the trend analysis referred to above (paras 7.3; 17.3.) and concurs in discrediting the claim that the decline in mortality was *caused* by the increase in hospitalisation.

17.12 This information was publicly available in 1975 (30) and should have been made known to the House of Commons Social Service Committee's inquiry in 1980 (see above, para 11.2).

17.13 The 1970 survey's detailed findings on perinatal mortality were not published until 1978 (31), but the most illuminating material was released only in 1983 after a lengthy private campaign. The obstetrician analysis of the survey had constructed a Labour Prediction Score, a weighted summary of what were accepted as the most important risk factors operating up to and including the first stage of labour. A score was calculated for every birth in the survey. The births, and associated deaths, could then be classified by mortality rate and place of delivery.

17.14 The results are summarised in Table 4 attached. They confirm the earlier findings of higher mortality rates at all levels of predicted risk and emphasise the wider disparities at higher levels of predicted risk. Births in GPUs/home with scores of 2 and over must have had the same complications as the booked births in hospital with the same score, and the same complications for which some of their peers were transferred to hospital. The low interventive care they received outside hospital obviously led to much safer outcomes than did the higher interventive care received by most of those in hospital (2, pp 254-6).

17.15 Although not published, these facts must have been known in the mid 1970s to those privy to the survey data. They were not, however, revealed. No hint was given that the policy of total hospitalisation could not be justified by results (see above, para 11.2).

17.16 On the contrary, hospitalisation was encouraged to proceed apace. Once the possibilities of alternative maternity care had been virtually eliminated, the possibility of embarrassing statistical comparisons had also been eliminated.

17.17 The results of the 1958 and 1970 surveys and the official data on low-weight births (Table 3) were entirely consistent with the official, routinely published rates of stillbirths and perinatal mortality by place of delivery, as long as a reasonable proportion of births were allowed to take place outside of obstetric hospitals (32).

17.18 Only in Holland did alternative options in care continue to be available; by 1986 around 36 per cent of all births still took place at home with a PNMR (2.2), only one sixth of the PNMR in hospital (13.9). The disparity was too large to be explained by any plausible exccess of cases at high pre-delivery risk in hospital whether there as the result of initial booking policy or later transfer.

17.19 Unlike in England, only some deliveries in Dutch obstetric hospitals are under the care of obstetricians using interventive obstetric practices (70 per cent in 1986), while some (29 per cent in 1986) are under the care of independent midwives using only the same supportive, low-interventive practices as are legally permitted for their home deliveries.

17.20 The disparity was even wider between the PNMRs for the obstetricians' deliveries (18.9), and for midwives' deliveries in hospital (2.1) and at home (1.0). These disparities, which are virtually certain to be real—not due to statistical chance, cannot be explained by the excess under obstetricians' care of births predicted to be at high risk on account of maternal age or parity or short fetal gestation (the only risk factors for which data are available).

17.21 Considering only the births after short gestation, the PNMR for the obstetricians' deliveries was 86, nearly three times as high as the PNMR for midwives deliveries (30). Obstetricians' deliveries may have included a greater proportion at highest risk, those after the very shortest gestations, but it is unlikely that this excess was sufficient to account for all the excess mortality.

17.22 The recent Dutch evidence, therefore, supports the conclusion from all earlier results, that most births are much safer under the supportive, low-interventive care of midwives than under the interventive management of obstetricians (2, pp 266-70).

17.23 Obstetricians and their supporters understandably dispute the validity of this conclusion, but they have not been able to produce evidence to refute it in the 14 years since they were first publicly challenged to do so.

17.24 The difference between the PNMRs for the Dutch midwives' deliveries of women at the same degree of pre-delivery risk in hospital (2.1) and home (1.0), though small in absolute terms, is statistically highly significant. It indicates that the benefits of a familar environment outweigh the benefits of proximity to facilities for obstetric interventions should "things go wrong". It does not support the compromise contention that the best of all worlds is provided by facilities for low technology, low interventive intranatal care at the same site as facilities for high technology, interventive care, though that compromise is undoubtedly an advance (see above, para 13.2).

— The evaluation of obstetric techniques

18.1 The claim that obstetric management as a whole makes the natural birth process safer requires that the specific interventions used, certainly those most frequently used, should improve the safety of the specific conditions diagnosed as carrying danger. Most of the practices, antenatal and intranatal, which may seem to have been beneficial in certain cases of pathology, had never been tested to ensure that they would be beneficial in the wider use to which they have come to be routinely applied.

18.2 In the name of promoting safety, the frequent use of intranatal interventions like induction of labour, forceps delivery and episiotomy, was advocated and increasingly implemented over three decades. The later reduced popularity of these interventions has not been accompanied by reduced safety. Nor has the continuing decline in overall perinatal mortality been dependent on the increased use of caesarean section, for mortality has fallen as much or more in areas where the section rate has not increased (33; 34).

18.3 Hospitalising births and submitting more of them to the interventions of obstetric management could only have reduced total death rates if the specific death rates for subgroups at the same degree of pre-delivery risk were lower following this treatment than any alternative. Whenever retrospective comparisons have been made between the results of actual experience or prospective trials carried out to evaluate common practices, it has been found that outcome has seldom been better and often been worse in the groups which had intervention than in matched groups which did not (31; 35; 36).

18.4 This is true for antenatal interventions which aim to forestall later complications (37; Tew's submission on Antenatal Care, paras 3.1–4.8).

18.5 It is also true for intranatal practices such as the induction of labour (24; 25; 31; 38), episiotomy (39), pain relief including epidural anaesthesia (40), electronic fetal monitoring (21; 22; 41) and caesarean section (42; 43; 44). There is no evidence that, in general, the dangers of a labour longer than average are greater than the dangers of artificially accelerating it, any more than that the dangers of a pregnancy longer than average are greater than the dangers of artificially ending it (24; 25).

— The obstetric management of the chief causes of perinatal death

19.1 Fetuses and infants of subnormal weight, especially when born preterm, make up only a small minority of all births, but a majority of all perinatal deaths. Obstetricians have made these high risk births their special concern. One most effective way of reducing overall perinatal mortality would obviously have been to reduce the proportion of low-weight births. Yet obstetric antenatal treatments have been largely ineffective in postponing preterm spontaneous deliveries (45) or preventing retarded intra-uterine growth, while the inevitable effect of obstetric intranatal interventions, induction and caesarean section, has been to shorten gestation and increase preterm deliveries. As a result, the low-weight subgroup made up a greater proportion of all births in 1987 (7.1 per cent) than in 1958 (6.7 per cent) and of all perinatal deaths in 1987 than in 1958 (65 per cent v 53 per cent), which means that the contribution of low weight births (the product of proportion and specific PNMR) to overall mortality has increased from 54 per cent in 1958 to 65 per cent in 1987.

19.2 Obstetricians and neonatologists encourage the popular belief that it is their high technology treatments which now keep alive tiny babies who formerly would have been expected to die, and indeed the PNMRs for low weight babies have fallen greatly. But the PNMRs for heavier babies have fallen even more, and it is now known that most of this decline cannot be attributed to obstetric or paediatric management. There are therefore strong grounds for doubting the validity of the professionals' claim relating to the underweight babies.

19.3 The grounds are strengthened by the fact that the British and Dutch results quoted (paras 17.10; 17.21) have recorded highest PNMRs for the low weight or preterm births under obstetricians' care, which suggests that the PNMRs for such births as a whole would have fallen more if fewer of them had experienced this kind of care. This would have reduced the contribution these births make to overall mortality, which would then have fallen by more than actually happened.

19.4 The spontaneous occurrence of preterm, low weight birth is more likely when the mother is undernourished or suffers undue stress. These are social problems which are not appropriately addressed by the treatments of scientific obstetrics. Supportive midwifery, on the other hand, is often found to be associated with heavier birthweight and more mature babies, even when the mothers are deprived.

19.5 Intervening to curtail pregnancy has increasingly become best accepted obstetric practice when potentially life-threatening conditions are diagnosed in the mother, like severe hypertension, or in the fetus, like growth retardation. Plausible as this theory may seem as an example of good preventive medicine, controlled trials have not been carried out to confirm that babies with shortened gestation survive more surely and more healthily in the alien environment of the neonatal intensive care unit, which itself presents many risks, than they would have done if left in an unsatisfactory womb.

20.1 The second most frequent cause of perinatal death is congenital malformation. The only way in which obstetric care can reduce mortality is through the therapeutic abortion of malformed fetuses identified by antenatal diagnostic procedures. Some congenital malformations are known to be associated with the parents' poor nutritional and health status. Social and environmental measures to improve this would probably reduce the incidence of malformations.

21.1 The third most frequent cause of perinatal death is hypoxia-lack of oxygen, the fetus depends for its adequate supply of oxygen on an efficient maternal-placental-fetal circulation. In labour, this efficiency may be impaired, but all too often the impairment is caused by the side-effects of concomitant obstetric interventions, undertaken in the hope of averting some other danger, including fetal hypoxia itself, sometimes rightly, sometimes wrongly diagnosed. The instrument most often used to diagnose fetal hypoxia, electronic heart rate monitoring, has proved to be notoriously unreliable (20) and misinterpretation of the traces has led to many unwarranted and harmful interventions in the birth of healthy fetuses.

21.2 Evidence casting doubt (since confirmed) on the value of electronic monitors was already available in 1980, yet the House of Commons Social Services Committee was advised to make a sweeping recommendation to ensure the continued and extended use of this intriguing diagnostic gadget. This recommendation pleased obstetricians and has since been most thoroughly implemented. Electronic monitoring has become routine procedure in all obstetric hospitals.

— maternal satisfaction.

22.1 Women have become thoroughly indoctrined by medical and, at second hand, lay advice that the only safe place to give birth is in an obstetric hospital under obstetric management and that they are irresponsibly risking the lives of their babies by seeking to give birth anywhere else. In consequence, as long as they are thus falsely informed, most of them would opt for hospital delivery.

22.2 Nevertheless, there is a vast library of anecdotal evidence to show that few of them get any enjoyment from the procedures by which their babies are extracted from them. They have to surrender control of their bodies. They get through the ordeal with the help of liberal intakes of pain relieving drugs, without proper instruction about the adverse effects of these on their babies' healthy survival. They are denied the satisfaction of completing a demanding function under their own responsibility. They are never taught that birth without interventions but with emotional support is a process which most of them are well able to carry through successfully, without adverse after-effects for themselves and their child.

22.3 Studies of the few women who have experience of birth under both methods of care show their overwhelming preference for low intervention, supportive midwifery (46; 47).

22.4 Nearly all women have been deprived of informed and effective choice of the place in and the method by which they will give birth. They have been deprived of control of their own natural reproductive function. The effect of this destruction of maternal self-confidence and the degrading of the role of motherhood may well have social repercussions far beyond the initiation of these processes in the obstetric hospital.

VIII. Recommendations

23.1 The Ministry of Health, the Health Authorities and the medical profession should publicly acknowledge that hospitalisation and obstetric management cannot be shown to make most births safer.

23.2 They should therefore cease propagating their false claims that hospitalisation and obstetric management do make most births safer.

23.3 They should reorganise the maternity service to conform with the experience of the actual results of care.

23.4 They should immediately stop advising against domiciliary deliveries and remove the effective restrictions on them. They should gradually increase the numbers of community midwives until there are enough to allow as many women as would prefer to give birth at home to do so.

23.5 They should immediately stop the closure of unattached general practitioner maternity units, particularly those in rural areas, and in due course reinstate units units closed against the wishes of the local population.

23.6 They should immediately abandon the indefensible criteria, by which women are categorised as "high" or "low" risk and which are now manipulated to ensure that few births are allowed to take place at places other than an obstetric hospital.

23.7 Until mothers recover their self-confidence after a long period of brainwashing and while they still think birth safer in an obstetric hospital, more of the beds provided there should be in Home from Home units and Birthing Rooms, under the control of midwives. Midwives should not be discouraged from delivering in hospital women to whom they have given antenatal care in the community—the so-called "domino" deliveries.

23.8 Routine obstetric management in obstetric wards should be limited to procedures which are known to be beneficial to the mother or baby. The results of well designed trials should be consulted to determine which procedures and diagnostic techniques used routinely, like electronic fetal monitoring, are not beneficial. These should be discontinued, no matter how satisfying they are to obstetricians or convenient they are to hospital time tables and conveyor belts.

23.9 For the conditions where obstetric interventions are assumed to be more life-saving than life-threatening, notably the interventions which shorten gestation, well designed trials should be organised to establish the validity or otherwise of the assumption. Among assumptions which are held to justify common practices but which results suggest may not be valid are that birth and neonatal survival are made safer

- by the transfer to hospital and obstetric management of births which are booked for delivery elsewhere but in which complications are later diagnosed, often on doubtfully valid criteria;
- by interventions to shorten labour so as to keep within the artificial time limits set by obstetricians on doubtful criteria;
- by the premature delivery from the stressed environment of a less than satisfactory womb and transfer to the also stressed environment of a neonatal intensive care unit.

23.10 Also in need of evaluation are common practices for the care of the newborn, culminating in the practices of neonatal intensive care, the need for which would be much reduced if the above recommendations were implemented.

23.11 The argument should not be accepted that it is unethical to withhold interventions favoured by obstetricians from those participants in evaluation trials who are assessed as at high risk; on the contrary, it is unethical to impose treatments which there is reason to suspect do more harm than good, notably among births of low weight (see above, para 16.10).

23.12 The above recommendations have implications for staffing.

23.12.1 More midwives, trained and practising as midwives and not obstetric nurses, would be needed. This need would probably be readily met, for the shortage of midwives is attributed to their being deprived of responsibility and opportunity to practise the skills of true midwifery.

23.12.2 Fewer obstetricians at all grades would be needed. This reduced demand would solve the currently reported difficulty of recruiting new entrants to the specialty.

23.12.3 The general practitioners who prefer to provide no or only partial maternity care should refer women in the first place to midwives instead of hospital obstetricians.

23.13 The reformed National Health Service and the Audit Commission should make establishing accurate costing throughout the Maternity Service a matter of priority. They should find scope for substantial savings.

April 1991

Table 1 Trends in hospitalisation and perinatal mortality
England and Wales

Year	*Births in obstetric hospitals*			*Perinatal mortality/1000 births*		
	% of all births	*% change from year before*	*Rank of change*	*Rank of change*	*% change from year before*	*Actual*
1969	69.6					23.4
1970	73.0	+4.9	1½	12	+0.4	23.5
1971	75.6	+3.6	5	7	−5.1	22.3
1972	78.8	+4.2	4	11	−2.7	21.7
1973	82.3	+4.4	3	9	−3.2	21.0
1974	86.6	+4.9	1½	10	−2.9	20.4
1975	87.9	+1.8	6½	5	−5.4	19.3
1976	88.3	+0.5	12	4	−8.3	17.7
1977	89.9	+1.8	6½	8	−4.0	17.0
1978	91.2	+1.4	8	3	−8.8	15.5
1979	92.3	+1.2	9½	6	−5.2	14.7
1980	93.4	+1.2	9½	2	−9.5	13.3
1981	94.2	+0.9	11	1	−11.3	11.8

Sources: reference 32

Figure 1 Drawn from the data in Table 1

Scattergram of ranks of proportional changes in rates of hospitalisation and perinatal mortality. Rank 1 denotes the greatest increase in hospitalisation and the greatest decrease in perinatal mortality. Rank 12 denotes the smallest increase in hospitalisation and the only increase in perinatal mortality.

Table 2 Births and perinatal mortality rates (PNMR)
at places of birth and different levels of risk in Britain, 1958

Risk factor	*Level of risk*	*Percentage of births*		*PNMR/1000 births*	
		Hospital	*GPU/home*	*Hospital*	*GPU/home*
Maternal parity					
1 and 2	low	38.1	54.3	47.6	15.8(a)
0 and 3	moderate	54.5	35.0	46.6	23.5(a)
4 and over	high	7.4	10.7	88.0	29.2(a)
Social class					
I and II	low	16.3	15.5	38.8	15.2(a)
III and IV	moderate	67.9	70.7	49.3	19.4(a)
V, unmarried, no information	high	15.8	13.8	65.0	30.2(a)
Maternal toxaemia					
None or mild	low	75.8	85.7	38.4	16.3(a)
Moderate	moderate	6.6	3.9	51.9	26.3(b)
Severe and unknown	high	17.6	10.4	97.6	37.2(a)
Fetal gestation					
38–41 weeks	low	74.8	80.0	22.1	11.3(a)
>41 weeks	moderate	12.7	12.2	34.0	17.6(a)
<38 weeks	high	12.5	7.8	205.3	75.3(a)
Infant birthweight					
>2500 grams	low	91.1	95.5	22.6	12.1(a)
2500 grams and under	high	8.9	4.5	327.6	161.2(a)

Significance of difference between PNMRs: (a) $p < 0.005$; (b) not significant.
Source: reference 6.

Table 3 Mortality of low-weight births by place of delivery, England and Wales (stillbirths plus neonatal deaths per 1000 births)

Period	*Birthweight (grams)*	*Hospital*	*Home*	*Significance of difference*
1954–58	<2500	296	181	p <0.00001
1959–64	<2500	269	162	p <0.00001
1967–73	<1001	898	868	not significant
	1001–1500	621	635	not significant
	1501–2000	270	242	p <0.01
	2001–2250	116	99	p <0.02
	2251–2500	56	40	p <0.001

Source: reference 29 and unpublished data 1967–73.

Note: "hospital" includes GPUs; "home" includes private nursing homes and also the neonatal transfer to hospital of sick babies.

Table 4 Percentage of births and perinatal mortality rate (PNMR) at different labour prediction scores (LPS) in different places of birth.

LPS	*Level of risk*	*Percentage of births*		*PNMR/1,000 births*	
*Hospital**	*GPU/home*	*Hospital**	*GPU/home*	*Hospital**	*GPU/1,000*
0-1	Very low	39.4	59.4	8.0	3.6 *(a)*
2	Low	23.0	22.3	17.9	4.8 *(b)*
3	Moderate	15.6	10.6	32.2	2.0 *(c)*
4-6	High	18.2	7.5	53.2	14.2 *(b)*
7-12	Very High	3.8	0.2	162.6	166.6 *(d)*
0-12	All levels	(n = 11,141)	(n = 4,660)	27.8	4.9

* Obstetric beds only.

Differences in PNMRs in these large samples of births have the following chances of being real:

(a) 97.5%; *(b)* 99.5%; *(c)* 99.9%; *(d)* 2.5%.

Source: Unpublished data from the British Births 1970 survey.

References

1. Tew, M. (1980) Facts not assertions of belief. *Health Soc. Serv. J.* 12 September, 1194-7.

2. Tew, M. (1990) *Safer Childbirth? A critical history of maternity care*. Chapman and Hall, London.

3. *Maternity in Great Britain* (1946), (survey undertaken by a Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee), Oxford University Press, Oxford.

4. Ministry of Health (1956) *Report of the Committee of Enquiry into the Cost of the National Health Service*, Chairman C. Guillebaud, HMSO, London.

5. Ministry of Health (1959) *Report of the Maternity Services Committee*, Chairman, The Earl of Cranbrook, HMSO, London.

6. Butler, N. and Bonham, D. (1963) *Perinatal Mortality*, Churchill Livingstone, Edinburgh.

7. Ministry of Health (1970) *Domiciliary Midwifery and Maternity Bed Needs: the Report of the Standing Maternity and Midwifery Advisory Committee*, Sub-committee Chairman, J. Peel, HMSO, London.

8. House of Commons Social Services Committee (1980) *Perinatal and Neonatal Mortality; Second Report from the Social Services Committee, 1979-80*, Chairwoman, R. Short, HMSO, London.

9. House of Commons Social Services Committee (1984) *Perinatal and Neonatal Mortality Report: Follow-up; Third Report from the Social Services Committee, 1983-84*, Chairwoman, R. Short, HMSO, London.

10. House of Commons Social Services Committee (1983) *Perinatal, Neonatal and Infant Mortality, First Report from the Social Services Committee, 1988-89*, Chairman, F. Field, HMSO, London.

11. Street, P., Gannon, M., Holt, E. (1991) Community obstetric care in West Berkshire *Br. Med. J.* 302, 698-700.

12. Reynolds, J., Yudkin, P. and Bull, M. (1988) General practitioner obstetrics: does risk prediction work? *J. R. Coll. Gen. Pract.*, 38, 307-10.

13. Joint Working Party of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners (1981) *Report on Training for Obstetrics and Gynaecology for General Practitioners*, RCOG, London.

14. Royal College of Obstetricians and Gynaecologists (1982) *Report of the RCOG Working Party on Antenatal and Intrapartum Care*, RCOG, London.

15. Royal College of Obstetricians and Gynaecologists (1983) *Nutrition in Pregnancy*, RCOG, London.

16. Chamberlain, G. and Gunn, P. (1987) *Birthplace*, John Wiley, Chichester.

17. Stilwell, J. (1979) Relative costs of home and hospital confinements. *Br. Med. J.* 2, 257–9.

18. Gray, A. and Steele, R. (1981) The economics of specialist and general practitioner maternity units. *J. R. Coll. Gen. Pract.*, 31, 586–92.

19. Mugford, M. (1990) Economies of Scale and Low Risk Maternity Care: What is the Evidence? *Maternity Action*, 6–8.

20. Grant, J. (1991) The fetal heart rate trace is normal, isn't it? *Lancet*, 337, 215–8.

21. Banta, D. and Thacker, S. (1979) Assessing the costs and benefits of electronic fetal monitoring. *Obstet. Gynaecol. Surv.*, 34, 627–42.

22. Prentice, A. and Lind, T. (1987) Fetal heart rate monitoring during labour—too frequent intervention, too little benefit? *Lancet*, ii. 1375–7.

23. Enkin, M., Keirse, M. and Chalmers, I. (1989) *A Guide to Effective Care in Pregnancy and Childbirth*. Oxford University Press, Oxford, Chapters 14 and 20.

24. Steer, P. (1986) Postmaturity—much ado about about nothing? *Br. J. Obset. Gynaecol.* 93, 105–8.

25. Gibb, D., Cardozo, L. et al. (1982) Prolonged pregnancy: is induction of labour indicated? *B. J. Obstet. Gynaecol.*, 89, 292–5.

26. Cardozo, L., Fysh, J. and Pearce, J. (1986) Prolonged pregnancy: the management debate. *Br. Med. J.*, 293, 1059–63.

27. Redman, C. (1982) Management of pre-eclampsia. *in Effectiveness and Satisfaction in Antenatal Care* (eds M. Enkin and I. Chalmers). William Heinemann, London, Chapter 12.

28. Blake, S. and Macdonald, D. (1991) The prevention of the maternal manifestations of pre-eclampsia by intensive hypertensive treatment. *Br. J. Obstet. Gynaecol.*,98, 244–8.

29. Chief Medical Officer of the Ministry of Health, *On the State of the public health. Annual Reports for the years 1954 to 1964, Maternal and Child Health*, HMSO, London.

30. Chamberlain, R., Chamberlain, G. et al. (1975) *British Births 1970 vol. 1, The First Week of Life*, Heinemann, London.

31. Chamberlain, G., Philipp, E. et al. (1978) *British Births 1970 vol 2, Obstetric Care*, Heinemann, London.

32. Registrar General, *Statistical Reviews of England and Wales for the years 1969 to 1973* and Office of Population Censuses and Surveys, *Birth Statistics for the years 1974 to 1985*, HMSO, London.

33. Harley, J. (1980) Caesarean section. *Clin. Obstet. Gynaecol*, 7, 529–57.

34. O'Driscoll, K. and Foley, M. (1983) Correlation of decrease in perinatal mortality and increase in caesarean section rates. *Obstet. Gynaecol.*, 61, 1–5.

35. Chalmers, I., Enkin, M. and Keirse, M. (eds) (1989) *Effective Care in Pregnancy and Childbirth*, Oxford University Press, Oxford.

36. Enkin, M., Keirse, M. and Chalmers, I. (eds) (1989) *A Guide to Effective Care in Pregnancy and Childbirth*. Oxford University Press, Oxford.

37. M. Enkin and I. Chalmers (eds) (1982) *Effectiveness and Satisfaction in Antenatal Care*. William Heinemann, London.

38. Chalmers, I. and Keirse, M. (1989) Evaluating elective delivery in *Effective Care in Pregnancy and Childbirth*. Oxford University Press, Oxford, Chapter 60.

39. Simpson, D. (1988) Examining the episiotomy argument. *Midwife, Health Visitor and Community Nurse*, 24(1), 6–17.

40. *Inch, S. Birthrights*, Hutchinson, London.

41. Lumley, J., Lester A. et al. (1983) A randomised trial of weekly cardiotography in high-risk obstetric patients. *Br. J. Obstet, Gynaecol.*, 90, 1018–26.

42. Kennedy, R. and Patel, N. (1986) The significance of increasing caesarean section rates. *Br. J. Hosp. Med.*, November, 336–41.

43. Yudkin, P. and Redman, C. (1986) Caesarean section dissected. *Br. J. Obstet. Gynaecol.*, 93, 135–44.

44. Pinion, S. and Mowat, J. (1988) Pre-term caesarean section. *Br. J. Obstet. Gynaecol.*, 95, 277–80.

45. King, J., Grant, A. et al. (1988) Betamimetics in preterm labour. *Br. J. Obstet. Gynaecol.*, 95, 211-22.

46. Kitzinger, S. (1978) Women's experiences of birth at home. in *The Place of Birth* (eds S. Kitzinger and J. Davis), Oxford University Press, Oxford., pp 135–56.

47. O'Brien, M. (1978) Home and hospital confinement: a comparison of the experiences of mother having home and hospital confinements. *J. R. Coll. Gen. Pract.*, 28, 460–6.

Supplementary memorandum submitted by Mrs Marjorie Tew

I do hope that Members will not allow themselves to be mesmerised by medically generated concepts of high and low risk pregnancies, as though these were distinct and reliable guides for appropriate but different types of maternity care. They serve to promote much less the welfare of mothers and babies than the professional interests of obstetricians.

Since the job of doctors is to treat illness—deviations from normality, so it is seldom challenged that obstetric treatment is appropriate in the case of possible or actual deviations, rightly or wrongly diagnosed, from normal pregnancy. Therefore, the treatment of any condition that can on any pretext be labelled "high risk" falls without dispute in the domain of obstetricians. The more liberal the definition of high risk, the wider and more powerful is the empire of obstetricians. To maintain this in the face of a healthier childbearing population, the definition of high risk has had to be steadily extended both in Britain and Holland.

The salient facts are however:—

1. That the parameters used, in Holland as well as Britain and other countries, so to categorise risk are found on analysis to be very unreliable predictors of outcome; in only a small minority of cases is the high predicted risk actually realised;
2. that only for a few complications, which affect only a small proportion (probably less than 5 per cent) of viable pregnancies, is there sound evidence that obstetric management either prevents them from occurring or improves their outcome;
3. that obstetric management does not reduce the extra risk for viable fetuses arising from natural conditions such as increasing maternal age;
4. that many of the complications which eventually do occur are the consequence of earlier obstetric interventions.

July 1991

Examination of Witness

MRS MARJORIE TEW, Research Statistician, Nottingham University Medical School, examined.

Chairman: I welcome Mrs Marjorie Tew to the front bench. We look forward to putting a few questions to you, Mrs Tew. All those that are giving evidence to us this afternoon will realise that because of what has been going on in the House we are under some pressure and time is of the essence, but clearly you have published extremely interesting evidence. Professor Eva Alberman has already referred to it in a kindly way. The first question, though, Mrs Tew, is from my colleague, Andrew Rowe.

Mr Rowe: I would much rather have Mrs Tew tell us what she wants us to know. My question is one that should really come second to that. I would rather have Mrs Tew's statement first, if I may.

Chairman: Audrey, would you like to come in, or perhaps I should ask Mrs Tew to give us her comments?

Audrey Wise

1385. Mrs Tew could perhaps give us the essence in a nutshell.

(*Mrs Tew*) I had rather assumed that you would not know who I was and that I would have to say who I was like everybody else. If we can skip that bit, that is all right.

Chairman

1386. Mrs Tew, we are happy to skip that bit.

(*Mrs Tew*) Unlike everybody else since 1977 my work in maternity care has been unpaid. I do not represent any professional body or any group of consumers. I am just a loner. I am not clever enough to guess what Mr Rowe had in mind.

Audrey Wise

1387. You challenged the accepted wisdom on the safety of various places of birth. Can you say very briefly what led you to make that challenge?

(*Mrs Tew*) Quite simply I was teaching medical students how much they could learn about different diseases and conditions from the official statistics, from the OPCS or the Registrar General. We chose, among other things, maternal mortality and perinatal mortality and I was very surprised to find that the statistics then available did not support the universal belief that hospital birth was the safest. I decided to investigate further and all my further findings supported my first inference and that is how I became involved with maternity care.

Chairman

1388. What else would you like to tell us about your findings because they are a little controversial perhaps in the eyes of some?

(*Mrs Tew*) They are really revolutionary and my first reaction to them was: "I can't be right. Everybody else knows that medical intervention, medical management of birth, makes it safer. I am the odd one who says it is not". But the statistics do not support this. First of all there is the obvious evidence that since 1950 mortality rates have gone down a lot. At the same time hospitalisation rates have gone up and everybody fell into the trap of making a causal connection between these two serial time trends. When you carry out the first statistical test to see whether there is likely to be a causal connection, you find that the causal connection, if any, is in the opposite direction. We found that the years when hospitalisation increased most were the years when perinatal mortality declined least. There is a strong negative correlation between these figures. I said that far from causing the decline in mortality the hospitalisation has prevented mortality from falling as fast as it would otherwise have done. My most respected critics, the Director of the National Perinatal Epidemiology Unit and his staff, say that I am not right in saying virtually that there is a causal connection the other way, although when I say that the mortality rate would have fallen more if there had been less increase in hospitalisation—indeed if there had been none at all—you can get this answer also by another orthodox statistical technique, so that while there might be a logical flaw in my reasoning it is at that point supported by attacking the problem in other ways.

Mr Rowe

1389. I am somewhat astonished that having heard quite a lot of evidence and received a lot of evidence from a large number of people who have doubted whether hospitalisation is the most effective way of ensuring safe childbirth, that you remain a loner. I feel lots of people should be piling in behind you and I wonder whether you have any comment on that? Also is there not a serious difficulty that if, as we have just heard, for instance, very low birth weight babies need to get a very high degree of specialist care very quickly, then there has to be a presupposition that at least those children should be born in or very close to the place where they can get care. That creates, I would have thought, the old problem that nobody knows which is the baby that will need the care. Normal births appear to be quite happily carried out at home, but nobody quite knows which one is going to be normal.

(*Mrs Tew*) Yes, this is the standard argument. If it were so that no birth was disadvantaged by having obstetric care and a very small proportion—because these tiny babies do represent a very small proportion—were going to be advantaged, then I would agree. But the evidence is that to secure the advantage of the tiny proportion you are submitting the majority to a disadvantage.

Chairman

1390. Can we put the question on behalf of the Committee, why are so many groups and organisations not—as I think Andrew Rowe said—piling in behind you to support the statistics, even Professor Eva Alberman, who is sitting beside you, while respecting the research that you have done—I think her phrase was that she sits on the fence. Do you think it is just vested interests, that the RCOG and others have a vested interest to get as many people into hospital as possible, or is it for other reasons that they have not piled in to support you? This Committee is not unsympathetic to your view. I think we would like to see more home confinements;

[**Chairman** *Cont*]
the enjoyment and the relaxation of birth rather than the tension of birth in a very clinical institution.

(*Mrs Tew*) When I said I was a loner, I was just surprisingly ignorant in 1975 when I came across these statistics, that there was anybody objecting to hospital treatment. It was not until I succeeded in getting the first article published that I began to realise there was a whole movement of women and some midwives who were supporting me. I have had a great deal of support and sympathy from such groups. I have not had any money from anybody.

1391. I am not sure that we can provide that.

(*Mrs Tew*) Nobody has offered me a post. Everybody else who gives evidence is in post. I am not employed.

Chairman: We understand that and we still greatly respect the work that you have done and the evidence that you have brought forward, but has there been any independent appraisal of your source data and of your methodology. I know that the RCOG has made some comment about your particular research and statistics, but has there been any appraisal of your evidence and the research which you have done which would, as it were, perhaps vindicate the views that you are seeking to put forward?

Mr Rowe

1392. Has there been any replication by others?

(*Mrs Tew*) Yes, as to my sources I have only used the most reputable sources, the statistics that have come from the OPCS or its predecessor, the Registrar General or the Department of Health or, in the case of Holland, the Central Bureau of Statistics, from the surveys carried out under the auspices of the Royal College of Obstetricians and Gynaecologists, and from articles or books written by well-respected researchers and published in well-respected publications. There are no better statistics than those I have used. As to the methodology, from time to time there have been responses from qualified statisticians. I once had the rare good fortune to have an article published in *The Lancet* in which I blotted my copy book by making an awful statistical howler. A statistician wrote to *The Lancet* and to me to point this out. Happily for me when the error was corrected my case was far stronger than the one that I was making!

Chairman

1393. But how would you respond to the NPEU, which has said they are not convinced that Mrs Tew has taken adequate account of the selection factors involved when drawing her conclusions?

(*Mrs Tew*) I should say that the NPEU agree with most of my findings and they followed up with a research report of their own which they called "Where to be born?" and much of that agreed with me, but they disagree with me in the point I have already made about my claim that mortality would have gone down faster if it had not been for increased hospitalisation. They also cling to their view that I do not make sufficient allowance for what they call subtle selection biases which lead women at different degrees of predicted risk to deliver in different places. My understanding is that most selection is done on the undiscriminating criteria of broad risk groups. Such subtle selection as there is occurs too rarely to affect many births or to make it worth while for obstetricians to define, measure and record the elusive criteria. Purely on arithmetic grounds this clinical judgment about which I am sceptical would affect the figures only marginally and the differences which have to be explained are wide. All the known and measured risk factors are interdependent. Allowing for the risk from one accounts for most of the risk from the others. I have proposed that emotional factors may well be independent of the known risk factors, but they have not been measured. But if hospital births include an excess at high risk on account of unfavourable emotions such as anxiety and tension, this would account for some of the unexplained differences in mortality rates, for the unexplained excess mortality in hospital rates, but it would be a hospital induced risk, a strong argument against hospitalisation. No other risk factors, subtle or otherwise, have yet been identified and measured, so there is absolutely no way of ascertaining that hospital births can include an excess of these. I therefore refute NPEU's criticisms as invalidating the conclusions of my analysis.

1394. I think that is a very good place at which to thank you for the evidence you have given, a very positive end. It would perhaps be unfair to Marjorie Tew for you, Eva, to have a 30-second response.

(*Professor Alberman*) May I make not a response but a comment and that is that we are very hung up on mortality as an outcome, and I think Karen Dunnell made that point too. If we really were not to use mortality, but to use satisfaction as an outcome, the answers might be very different. But then you are still faced with a possible mortality problem. To that extent I have learned a lot, and I think we all have, from Mrs Tew's work.

Chairman: Thank you very much Professor Alberman. Thank you very much indeed, Mrs Tew. Perhaps you can now retire to the back bench, a place that I have occupied for over 20 years in this place!

Mr Rowe: I hope, Chairman, that they will be a lot quieter!

Chairman: I see!

Memorandum submitted by the Association for Community-Based Maternity Care*

Introduction

1. The Association for General Practice Maternity Care is an organisation formed to foster primary care obstetrics and to support choice in maternity care, in particular place of birth. The Association was formed in 1989. The membership comprises approximately two thirds general practitioners and one third midwives with a small group of much valued consultant obstetricians. We have developed important links with consumer groups such as the National Childbirth Trust, the Association for Improvement in Maternity Services and Maternity Alliance. The Association for General Practice Maternity Care was formed by general practitioners concerned at the loss of choice of place of birth. We felt that care at birth had been taken over by large hospitals and specialist obstetricians, and that this was wrong for two reasons:

(a) The scientific evidence does not exist to justify centralising maternity care.

(b) Such centralisation has been shown by consumer survey not to be welcomed by women.

We are therefore a unique organisation involving professionals from different disciplines working to support consumers' wishes. Our major concerns are the closure of rural maternity units, the lack of facilities for general practitioners and community midwives to care for their patients at birth and the undue pressure exerted on women to prevent them giving birth at home. Our particular interest is the care of women believed to be at "low risk". We note that this is a major interest of the Health Committee. We are also concerned with all aspects of primary maternity care, including preconception advice, antenatal care, and continuing support of mothers and babies after birth and in early childhood.

2. Discussions concerning maternity care have been distorted in the past by attention being paid to opinion and not to scientific evidence. Unfortunately, evidence on many issues is lacking. Where this is so we believe extra attention should be paid to women's wishes (as exemplified by consumer surveys). As professionals we do not believe we should dictate the pattern of care where science cannot support such a pattern. In submitting this our own evidence we have tried to distinguish between recommendations for which objective evidence does and does not exist.

3. *Preconception care*

3.1 One of the most important influences on the outcome of pregnancy and the health of growing children is the health of both parents prior to pregnancy. Much of the improvement in the outcome for mothers and children is generally agreed to have originated in improving social standards. There is a clear association between socio-economic class and perinatal health. It is not known how such influences operate, but it is likely that such factors as housing, education, nutrition and harmful influences in the environment are important. Health professionals can have only a minor impact on these factors. However these factors can be affected by government and the Select Committee need to address such areas. Professional care can have only a much smaller influence.

3.2 The idea of preconception care, as advice provided to women by health care professionals in order to intervene at the earliest possible opportunity is attractive. However there is very little evidence to show that intervention prior to conception for most women has much effect. Even if a programme of advice were thought to be desirable there is a limit to the number of women who would make use of it, since a substantial number of pregnancies are unplanned (even allowing for a number of women who choose termination). Despite professional advice more young women smoke than ever before.

3.3 The one exception is in the prevention of congenital rubella, where a programme of immunisation, together with testing the immunity of women of child-bearing age has largely eradicated the disease. Such a programme falls within the remit of primary care. Since many women are seen by general practitioners for contraceptive advice before conception, it can also be incorporated into existing patterns of care.

3.4 Women in certain special groups may benefit from advice given at or before the time of conception. These include women with diabetes mellitus or chronic kidney disease, and those at risk of having children affected by inherited disease such as thalassaemia and sickle cell disease. For these minority groups there is a need for specialist advice, and it is important that such services are universally available throughout the UK.

3.5 *Recommendations.*

Government can have a much greater effect on the health of young people than health care professionals can. We recommend:

(a) a much tougher stance on tobacco sales and advertising. This would probably have a bigger impact on health than any other single action. A voluntary control on tobacco advertised in young women's magazines has not worked. Similar measures would help alcohol abuse.

* Submitted under the former name of the Association for General Practice Maternity Care.

(b) greater emphasis in schools to be placed on education concerning the value of human relationships. Though we have no evidence for this, we believe it might reduce the number of teenage and particularly unplanned pregnancies especially if young women can develop a greater sense of self worth.

(c) better control of harmful influences in the environment including chemical emissions and radiation.

(d) greater attention needs to be paid to the effect of social disadvantage on perinatal health and research into how such efforts are mediated should be encouraged.

(e) healthy foods should be made relatively cheaper.

(f) pre-conception advice from family doctors should be encouraged. Practice leaflets should encourage the uptake of such a service. We do not recommend the encouragement of specific pre-conception clinics in general practice.

(g) specialist advice for certain groups of parents should be made widely available eg for genetic counselling and pre-pregnancy care of diabetes and kidney disease.

(h) contraceptive manufacturers could be persuaded to insert leaflets giving pre-conceptual advice eg the importance of rubella immunization and stopping smoking.

4. *Antenatal care.*

4.1 Introduction. Despite the frequent claims made on its behalf, much antenatal care is of questionable value. It is a powerful example of medical practice going from innovation to universal aceptance without any proper evaluation of its effectiveness. The result is that pregnant women are now offered, or expected to submit to, a variety of procedures, of which some are known to be effective, some may be so and others seem to be of no benefit whatever. As we have stated above (para. 3.1), most of the enormous improvement in maternal and child health in recent years is almost certainly due to improving social standards.

4.2 *Content of antenatal care.*

Most women in the United Kingdom are healthy and will have healthy babies regardless of antenatal care. At the same time pregnancy is a time of considerable uncertainty and anxiety for many women. The aims of antenatal care are threefold:

(a) prevention of avoidable morbidity

(b) treatment of symptoms and problems associated with pregnancy

(c) emotional support, reassurance and education.

While the medical profession has concentrated extensively on prevention of morbidity, less attention has been paid to emotional support and reassurance.

It is important that professionals do not do harm to healthy women by causing anxiety through either inappropriate advice, such as complete prohibition of alcohol, of inappropriate investigation, such as assessment of fetal wellbeing by frequent ultrasound scanning late in pregnancy. The available evidence does not allow us to state with certainty what components or pattern of care antenatel care should comprise. However, we do recommend that future research in this area should give equal status to the measurement of emotional outcomes for the women, as for any benefits in prevention of morbidity.

4.3 *Place of care*

If antenatal services are to produce any benefit at all for pregnant women, they must be accessible, acceptable and appropriate. In the 1970s numerous surveys pointed out the difficulties presented to many women in attending hospital based antenatal clinics in terms of the distances to be travelled, the long waiting times and the feeling of being processed through a machine rather than being treated as individuals. Various studies have shown the positive effects of ensuring that women receive most or all of their care in community settings, and these initiatives have very often been set up in areas with disadvantaged populations. One benefit of such schemes has been the opportunity to provide care tailored for local needs, such as occur in areas with a high proportion of patients from ethnic minorities. We recommed that such schemes should be extended to cover the whole country.

In particular we should like to draw the Select Committee's attention to the "booking visit". This describes women's attendance, early in pregnancy, at a clinic in order to "book" for delivery in a particular unit. For most women that means booking for delivery in a specialist unit under the care of a consultant obstetrician, and consequently the booking visit takes place in a hospital clinic. This may mean that it is delayed until almost halfway through the pregnancy, and the major interview and discussion concerning women's wishes for pregnancy and labour is likely to take place in unfamilar surroundings, with a doctor or midwife they have never met before nor will even meet again. With better integration of community and hospital staff, and modern information technology networks it should be a simple matter to organise for women to be "booked" from community based clinics.

If the majority of antenatal care is to be provided in community settings, then those providing the care must have direct access to diagnostic facilities such as ultrasound scanning.

Such a change would have the added advantage of removing a substantial volume of work from specialist clinics and leaving them able to provide better, more personal care for those women, such as those with diabetes mellitus or with rhesus antibodies, who are genuinely at increased risk and likely to benefit from closer attention from specialist obstetricians. As midwives and general practitioners already work within the community and much work is needlessly duplicated, shifting antenatal care into the community should save money.

4.4 *Carers and continuity of care*

There is no evidence to support any recommendation that any particular professional group has intrinsic advantages over any other as providers of antenatal care. Earlier recommendations that all women should see a specialist have no foundation. At best it may be wasteful use of scarce consultant resources; at worst a "specialist opinion" may, in reality, be given by a junior member of staff with less than six months' training in obstetrics. For most healthy pregnant women antenatal care can be entirely provided by midwives and general practitioners, and the skills of these two groups can be complementary. How the work is divided between midwives and general practitioners will be a matter for local discussion. The particular skills that individuals bring to the task may be the result of their training, or their own personal interests and experiences, or may be determined by the wishes of the pregnant women themselves.

One complaint frequently made by women attending antenatal clinics is that of having seen a different person at each visit. Although there is no evidence to show any objective benefit produced by seeing the same carer at each visit, it should make it easier for women to discuss their worries, and consequently for the carers to give appropriate explanations and reassurance. Consumer surveys show that women prefer care from one person they can get to know and trust. Applying the standard of continuity does not necessarily favour one professional group over another.

Midwives are particularly suited to providing antenatal care if they are also going to attend in labour ("domino" deliveries). A few general practitioners will attend in labour; for the majority who are concerned only with antenatal and postnatal care, continuity of care antenatally, apart from the immediate gains, can represent a foundation for long-term personal care for families. Specialists cannot provide continuity of care for all pregnant women. This is another argument for them to limit their care to a small number of high risk women, for whom they can give personal continuity of care.

4.5 *Records*

One method for integrating care is by patient held records. Experiments have shown that patients welcome the opportunity to hold their own records, that they feel more in control of their care, and that the system encourages better trust between woment and their carers. If held by women, the records are more often available when required than if they are held by the hospital. We recommend that this becomes standard practice throughout the United Kingdom.

4.6 *Summary of recommendations*

(a) All policies regarding antenatal care should pay as much atttention to women's needs for emotional and psychological support as to the prevention of avoidable morbidity.

(b) For healthy women at low risk, antenatal care should be provided in community settings. This should be the great majority of women—probably more than 80 per cent. In particular, arrangements should be made for women to be booked for delivery from a community based clinic.

(c) Community based clinics should be supported by open access to investigation facilities and information technology links to specialist units.

(d) Specialist clinics should be reserved for those women at high risk. These women will then be able to benefit from continuous care from a specialist which is rarely the case at present.

(e) All pregnant women in the United Kingdom should hold their own pregnancy records.

Supplementary memorandum submitted by the Association for Community-Based Maternity Care*

CARE AT BIRTH, POSTNATAL CARE AND PAEDIATRIC CARE

CONTENTS:

5. *Introduction*

The Association for General Practice Maternity Care encourages primary maternity care, i.e. care provided by midwives and general practitioners. It was formed in 1989 to support choice in maternity care, particularly choice of place of birth. The Association believes that most maternity care should be community-based. Membership comprises approximately two thirds general practitioners (GPs) and one third midwives, with a small group of much-valued consultant obstetricians. We have built up important links with consumer groups such as the National Childbirth Trust, the Association for Improvement in Maternity Services and Maternity Alliance.

We are therefore in the rare position of being a mixed group of professionals with a prime interest in maternity care having close links with consumer bodies.

The major interest of the Association is care at birth—who should provide it, where, what care is effective and whether it is sensitive to to women's wishes. We are glad of the opportunity to place our ideas in front of the Health Committee. The evidence presented is an overview of the detailed examination of primary care contained in our booklet "The Case for General Practice Maternity Care"[1]. We hope members of the Committee will find time to read this booklet, as it discusses the care of normal pregnancy and birth in detail.

6. *Care at Birth*

We note that central to the Committee's inquiry is the management of normal pregnancy and birth. This subject is the main interest of the Association.

6.1 *Historical background*

In the 1950s most babies in the UK were born at home or in community hospitals. A series of government reports: Cranbrook, Peel, Short and, most recently, the Maternity Services Advisory Committee (Munro) has encouraged the centralisation of maternity care. We accept that these committees believed such policy would benefit women and their babies, but this policy was based largely on opinion—particularly of hospital-based staff—and not on scientific evidence. We hope the present committee will note the words of Archie Cochrane (former head of the Medical Research Council's Epidemiology Unit):

> "It is surprising how successive committees have been content to accept trends as something God-given which must be followed, instead of demanding a more rigorous analysis of causality."[2]

* Submitted under the former name of the Association for General Practice Maternity Care.

6.2 *Place of birth*

There is abundant evidence that with careful selection of women, and co-operation between primary and secondary care, most women, can be cared for just as safely in primary care setting—home, isolated GP/midwife units, and GP/midwife units attached to, or integrated within, specialist units. We are aware that many hospital-based staff find this evidence hard to believe, particularly as regards home and isolated units, and prefer to hold to the apparently commonsense view that birth *must* be safer in a unit with full facilities (a view, incidentally, still put forward by the Department of Health). This view is not confirmed (though neither is it denied) by the evidence. The maternity statistics for the UK were most thoroughly examined by Campbell and MacFarlane from the National Perinatal Epidemiology Unit in Oxford, who concluded:

"There is no evidence to support the claim that the safest policy is for all women to give birth in hospital."

and

"The policy of closing small obstetric units on the grounds of safety is not supported by the available evidence."[3]

Since this most important report, a large and detailed study from the Netherlands, the Wormerveer study,[4] has shown that a policy encouraging delivery at home or in small midwifery units is compatible with very high standards of care. We are aware again that hospital-based staff in the UK choose to discount this evidence if it does not fit with their beliefs. Such an attitude is unscientific.

6.3 *The limits of technology*

We do not know why the results of care in settings such as home and small rural units are as good as they are, but suggest it may have something to do with whether the labouring woman feels safe and in control. This may have more to do with being in known surroundings with known carers whom she trusts, than the availability of full facilities. It is known that a woman's sense of well-being can have a major impact on the progress and outcome of labour.[5]

We believe that the obstetric service has focused too much on technology as the answer to perinatal health and has, in parallel, paid too little attention to the economic, social and psychological background of the parents. An example of this is electronic fetal monitoring in labour. The large Dublin trial showed that such monitoring used routinely had no impact on perinatal mortality[6] or the incidence of cerebral palsy.[7] It might be more appropriate to spend money on midwifery staffing so that no woman had to be left unattended in labour, rather than on expensive machinery of doubtful benefit.

6.4 *The advantages of primary care*

Care at birth is unique in health care, in that specialists now have overall responsibility for 94 per cent of deliveries.

One per cent of women deliver at home

One per cent of women deliver in isolated units

Four per cent of women deliver in attached/integrated/GP/midwife units.

It is likely that returning more women to primary care at birth would show benefits:

(a) It is known that such care leads to less unnecessary intervention such as induction and episiotomy.[8, 9]

(b) We also know from consumer surveys that many more women would prefer primary care in such settings than can at present have their wishes fulfilled.[10, 11] Such surveys are supported by the bulk of individual letters sent to consumer bodies.

(c) A third and very important advantage of returning the care of most women at birth to midwives/family doctors, is that it will free specialist obstetricians to care for those women who would benefit from their attentions. We do not underestimate the crucial role of the obstetrician in maternity care, but feel his/her expertise should be targeted at those who need such care. These women constitute the minority. The recent report on the Confidential Enquiries into Maternal Deaths[12] highlights the dangers of junior hospital staff carrying too high a level of responsibility. We do not believe the solution to this is necessarily an increase in the number of senior specialist staff. It would be more appropriate to return the care of most woman to midwives and family doctors. That this process can succeed was recently demonstrated by overstretched obstetricians in Berkshire.[13]

6.5 *Cost*

Comparing the cost of home birth v. birth in an isolated rural unit v. specialist unit is not easy. Costs to the family are frequently omitted. Assumptions are made about the ability to transfer to the centre. Support of local units can be considerable and may be lost. If women are cared for by primary carers with lower intervention rates, it is hard to believe that savings will not occur. Unfortunately, managers look at short-term costs and have seen the closure of small units as a rapid source of short-term savings. This policy has left large areas of the UK without maternity units and without midwives or doctors competent to deliver a baby—a curious paradox in a civilised country.

The government has been quick to grasp the idea that general practitioners, by providing a greater range of care, may save the health service money. We suggest this approach could be applied to care at birth.

6.6 *The declining role of the GP*

More than 90 per cent of GPs no longer undertake care at birth. Similarly at very few births is the family doctor in attendance. Is there any role for the family doctor at birth?

GP withdrawal from care at birth largely results from government policy centralising care at birth. Where hospital staff were available, GPs felt redundant. Attendance at birth is very poorly rewarded (less than the fee for fitting an intra-uterine contraceptive device) despite great responsibility, the potential for litigations and long periods away from other GP work. It is therefore no surprise that GPs opt out at birth. Does this matter?

6.7 *The place of the GP*

We believe it does. The GP is the only professional involved in maternity care who is likely to have long background knowledge of the woman and her family. This relationship continues after birth with care of the woman and her growing child. The surveys quoted indicate that women appreciate the presence of their family doctor at birth. Because of the different way GPs are reimbursed compared with midwives and hospital staff, GP behaviour can be influenced by the way certain activities attract fees.

In certain circumstances, the family doctor is very important at birth—in particular in rural units and at home births, where there may be no other immediate medical help for women who reject conventional hospital care. Even in hospital settings it may be that appropriately trained GPs may be a more suitable support for commumity midwives than junior hospital staff. As numbers of junior hospital staff will decline, this role becomes potentially more important (as exemplified by the recent experience from Berkshire.[13])

We recognise that the prime carer at birth should be the midwife, but believe that the GP may be an effective support to her.

This can only occur if changes are made in the way future GPs are trained and in the way in which they are reimbursed.

6.8 *Training*

The majority of GPs are unlikely to return to care at birth. For them, a 6-month SHO post in hospitals is inappropriate. They would benefit from a training programme largely based in the community, for the minority, training in intrapartum care will be important but should not be centred on the management of abnormal labour as this deters GPs from future involvement. Midwives should play a greater part in the training of GPs so that the future GP recognises that labour is usually normal. These GPs will still need exposure to abnormal labours and obstetricians will therefore continue to play an important role in GP training. Much midwife and GP training could, with benefit, take place together.

6.9 *Conclusion*

The majority of women, given good selection, can be safely cared for without specialist involvement. Evidence from rural GP units and from the Netherlands suggests this is between 70 per cent and 80 per cent of women. Such care would probably be preferred by women, result in less intervention and might well be cheaper, there is no evidence that it is less safe.

This form of care should be available at home and in isoloated units, as well as units attached to specialist hospitals. Such care would be improved by encouraging team midwifery (where a small group of community midwives providing antenatal care can also continue the care at birth). The separation between hospital and community midwives should be broken down.

The family doctor could be an appropriate medical support to the midwife if suitably trained and encouraged. The impact of specialist obstetricians on the practise of normal midwifery may have been to undermine the important role of the midwife.

6.10 *Recommendations.*

1. The policy of centralising care was not based on scientific evidence. There should be an immediate halt to the closure of further "isolated" units. (These units are not isolated for the women who use them.) It may, in certain areas, be approrpiate to re-open or build new rural units.

2. Home birth has been fiercely discouraged without scientific evidence. For some women it may be a reasonable option and they should be supported, not harassed by their carers. Flying squads have fallen into disuse and it would be unrealistic to re-form them. Paramedics working in ambulance teams should be trained to manage obstetric transfers to hospital.

3. All specialist hospitals should have facilities for "low-tech birth". This may mean a separate, though attached, unit, as it is rare for integrated units to retain their sense of identity and philosophy that birth is usually a normal process.

4. Midwives—not obstetricians—should be seen as the "core-workers" in maternity care.

5. Obstetricians do not need to see all pregnant women (as previously recommended by earlier Committees). They should be free to devote greater attention to women at high risk who need them, and would greatly appreciate their expertise.

6. General practitioners could become the medical support to midwives. This is already the case in rural units, many home births, and in some integrated and attached units.

7. The training of future GPs and midwives should become linked. This would foster trust and co-operation.

8. Most GP training should take place in the community. Even GPs who will undertake care at birth should have community-based training, but there will be a need for training to be extended to incorporate hospital experience. This extended training needs to be flexible to allow GPs to take up intrapartum care later in their careers (eg women doctors returning after raising their own families).

9. The remuneration of that minority of GPs who undertake care at birth should be separated from the other maternity fees. It is a concern of a minority of doctors only, and will therefore never be presented as a priority in evidence to the Review Body. The fee should be greatly increased, but only for those who can show continuing experience after relevant training.

10. Local maternity care policy should be defined after consultation with all groups of professionals and consumer representation. It is clear that Maternity Services Liaison Committees have in many areas either never been formed, or have been ignored. Policy-making has been dominated by hospital specialists. A properly functioning MSLC should be mandatory in each district.

Policy should be:

(a) based on scientific evidence of effectiveness

(b) sensitive to women's wishes

The present government purports to support choice in maternity care:

"Will I still have a choice about where my baby is born? Yes."

(The NHS Reforms and You, pp. 3 and 18).

The Committee should recommend that the Government live up to its promises.

6.11 *References*

1. Jewell D, Young G, Zander L. The Case for General Practice Maternity Care.

1990. Temple Sowerby CA10 1RZ.

2. Cochrane AL. Effectiveness and efficiency: random reflections on the Health Service.

1972. London. Nuffield Provincial Hospitals Trust.

3. Campbell R, MacFarlane A. Where to be born? The debate and the evidence. p. 58.

1987 Oxford National Perinatal Epidemiology Unit.

4. van Alten D, Eskes M, Treffers PE. Midwifery in the Netherlands. The Wormerveer study; selection, mode of delivery, perinatal mortality and infant morbidity.

Br J Obstet Gynaecol 1989; 96: 656–662.

5. Klaus M, Kennell J, Robertson S, Sosa R. Effects of social support during parturition on maternal and infant morbidity.

Br Med J 1986; 293: 585–587.

6. MacDonald D, Grant A, Sheridan-Pereira M, Boylan P, Chalmers I. The Dublin randomised trail of intrapartum fetal monitoring.

Am J Obstet Gynecol 1985; 152: 524–539.

7. Grant A, O'Brien N, Joy M-T Hennessy E, Macdonald D. Cerebral palsy among children born during the Dublin randomised trail of intrapartum monitoring.

Lancet 1989; 2: 1233–1235.

8. Klein M, Lloyd I, Redman C, Bull M, Turnbull AC. A comparison of low-risk pregnant women for delivery in two systems of care: shared care (consultant) and integrated general practice unit. I Obstetrical procedures and neonatal outcome.

Br J Obstet Gynaecol 1983; 90: 118–122.

9. Rosenberg E, Klein M. Is maternity care different in family practice? A pilot matched pair study. J Fam Prac 1987; 25: 237–242.

10. National Council of Women of Great Britain. Are we fit for the 90s? London N1 8JU p.5.

11. Taylor A. Maternity services: the consumer's view.

J R. Coll Gen Pract 1986; 36: 157–160.

12. Report on Confidential enquiries into Maternal Deaths in the United Kingdom 1985–87.

HMSO London 1991.

13. Street P, Gannon MJ, Holt EM. Community obstetric care in W. Berkshire.

Br Med J 1991; 302: 698–700.

7. *Post Natal Care.*

7.1. Post natal care suffers from being often inflexible and based on tradition, not evidence of effectiveness. Women become confused by conflicting advice. As with other parts of maternity care, continuity of carer would improve the service. We support the creation of domino schemes and midwifery teams. Early discharge home must be accompanied by adequate community midwifery and medical support.

7.2. Most postnatal care already takes place in the home, yet most teaching remains hospital-based. This should be changed.

7.3. Family doctors provide continuity, yet they are paid fees to attend only to 14 days after birth. This period of time is ridiculous as many problems associated with the post partum period occur much later, e.g. postnatal depression, perineal pain, sexual problems. It is equally unfortunate that the continuity of care from midwives, now becoming more widely available, ends abruptly with handover of care to the Health Visitor. We believe women and their families would benefit from the midwife continuing to be involved until the baby is one year old. It would be more appropriate for the Health Visitor to become involved at that age.

7.4. *Recommendations.*

It should be recognised that postnatal care takes place mainly in the community, in particular in the home. Teaching about such care should take place mainly in these settings.

Family doctors should be encouraged to continue close involvement—if wanted—with the family for months, not weeks.

Midwives should provide care of the mother and child until the child is one year old, when the Health Visitor should be involved.

Much postnatal health is not affected by professionals, but results from social circumstance,

e.g. education affecting attitudes to breast-feeding housing and poverty affecting home life and diet smoking.

It is Government's responsibility to alter these factors to improve maternal and child health, especially in deprived areas. Infant mortality relates closely to social class. We are perturbed that this rose in 1989.

8. *Paediatric Care.*

8.1. The Association feels it would be presumptuous to make many comments about paediatric care, except insofar as it affects primary care. In particular, we do not wish to comment on neonatal intensive care, except to ask that the Committee should question the cost-effectiveness of such care for *very* small babies of < 500g.

8.2. Basic resuscitation of newborn babies should be able to be undertaken by all midwives and doctors involved with care at birth. It is dangerous to confine this skill to paediatricians who may not be immediately available. Midwives are present at all births. GPs undertaking intrapartum care need to become proficient at resuscitation. This does not necessarily mean a specific 6-month paediatric post, but experience which could be incorporated into the extended obstetric training we feel such GPs need.

8.3. Routine care of the newborn does not require specialist paediatric involvement, yet discharge of women from hospital is frequently held up in waiting for routine paediatric permission to leave hospital. This task could more usefully be done by the midwife, thereby freeing paediatricians to spend more time on those babies who would benefit from their skills.

8.4. It would be beneficial if more paediatricians were community-based and thus built up more co-operation and trust with midwives and family doctors. Children live in families and most illness in children is treated at home, not in hospital.

Memorandum submitted by Mr Richard Porter

MATERNITY SERVICES IN THE BATH HEALTH DISTRICT

Summary

Bath Health District Maternity Services are *community based.* This is felt to be the correct way to provide services for a rural community where the furthest reaches of the District are in excess of 26 miles from the District General Hospital. This policy is extremely unusual, and its success raises interesting questions about whether such an approach could or should be adopted in many other Health Districts.

Introduction

Bath Health District is more or less semi-circular in shape. Unfortunately the District General Hospital in Bath is positioned at the centre of the original circle, rather than of the District itself. Furthermore, although Bath is the largest conurbation in the District, only 17 per cent of deliveries are of residents of Bath itself. The remainder would have to travel distances which might be as much as 27 miles to attend the Consultant Obstetric Unit. This is of course by no means an unusual phenomenon in rural Health Districts. What is unusual is Bath Health District's response to the problem.

Historically the Bath District has had a tradition of delivering babies in Community Hospitals. Such a policy has been made more feasible by the size of some of the other towns in the District, such that deliveries in these units range from 110 to 600 per annum. During the 60s, 70s and 80s, when numerous other Health Districts were closing Isolated Maternity Units, Bath did not follow the trend and in 1988 Bath DHA took the radical step of declaring that it supported the continuing existence of these units and wished to see an expansion of the numbers of deliveries taking place within them, in order to make them logistically and financially more secure.

Current Provision

Ante-natal care

Most ante-natal care is undertaken, as in many Health Districts, by District Midwives and General Practitioners and clearly takes place outside the Consultant Unit of the District General Hospital. However, in addition to this, approximately 25 per cent of all ante-natal *appointments* in Consultant Obstetrician clinics are for clinics held in Community sites—away from the District General Hospital. Furthermore 75 per cent of all routine booking scans are performed in Community Hospitals. The underlying ethos is that of taking the facility to the community, rather than vice versa.

Ante-natal care patterns fall into four groups:

(1) Women who have shared care (GP/Obstetrician). They may attend as few as two Obstetician Antenatal Clinics (OANCs) but the upper limit depends naturally on the complexity of the case. These are the majority of cases (c. 55 per cent).

(2) Women who attend an OANC once only in order to confirm a booking for delivery in a GP Unit (isolated or integrated). Once that is done the remainder of their antenatal care is outside the Obstetric Unit. (Women from this category are occasionally transferred to group 1 if indicated). (c. 30 per cent).

(3) Women whose pregnancies are uncomplicated, with satisfactory Obstetric histories, who book for GP care and never need to attend an OANC. (c. 14 per cent).

(4) Women who have predominantly OANC care because of major problems (a tiny group, perhaps one per cent).

Most women thus attend an OANC very few times in a pregnancy and many of these visits are in the nature of a formality. It is therefore logical that many of these clinics do not need to take place in the main Consultant Unit, and we recognise this by providing three clinics per week in outlying sites, serving the seven isolated maternity units and one local Health Clinic. 25 to 30 per cent of *all* appointments in OANCs are in these clinics. The clinicians in these clinics are either a Consultant alone or a Consultant plus a Clinical Assistant. Far greater continuity of specialist care is therefore provided, as is a high degree of direct access to Consultant opinion.

Deliveries

Approximately one third of the more than 5,000 deliveries in the District take place in seven peripheral (isolated) maternity units at a distance of between 11 and 26 miles from the Consultant Maternity Unit in Bath. Of those who deliver in the Consultant Unit more than half are transferred at the earliest possible opportunity to the isolated units to complete their post-natal in-patient stay.

The decision about suitability for delivery in the isolated units (IMUs) is made according to a list of criteria which has been drawn up after consultation between Obstetricians, GPs and Midwives. It is considered appropriate that all women be seen at least once in their Obstetric career—optimally in their first pregnancy—by an Obstetrician—but this is not mandatory. If there is no doubt that the woman is appropriate for delivery in the IMU she does not need to attend an Obstetrician ANC at any stage.

Letter to the Chairman of the Committee from Mr Richard Porter

Re: Provision of Maternity care in "low-tech" units

I hope that you will excuse my sending you what may be considered almost a post-script to the recent deliberations by the Health Committee, but I fear that the recent controversy over the plans (or rather the arbitrary alteration to the plans) for a "low-tech" Maternity Unit in Bournemouth show once again the startling lack of intellectual substance in the debate surrounding this issue—an issue which you would, I feel sure, agree is of major importance for the future of British maternity care. I believe that you are aware of the details of the argument.

As you will see from my letter to the Secretary of State I am concerned to do what I can to remedy this, by collecting and analysing the data that we already generate but do not have the means to handle. If you feel that there is anything that you and the Committee can do to facilitate this I would naturally be most grateful.

Please let me know if there is any further information that you might require. I hope very much that we can make progress in this matter.

Letter to the Secretary of State for Health from Mr Richard Porter

Re: Obstetric Services in "low-tech" Units, with particular reference to Bournemouth and Bath

I know that you have been involved earlier this year in communications with MPs local to Bournemouth who have been concerned about the controversy surrounding the proposed "low-tech" Obstetric Unit in Bournemouth, and that Mr. Stephen Dorrell, Parliamentary Under-Secretary of State, will be meeting (if he has not already done so) these local MPs to discuss this issue. I am writing to you now to reiterate a point that I had made last year to Mr. Roger Freeman, when he attended a presentation (co-ordinated by Maternity Alliance) by myself and others at the House of Commons.

As you know, there is considerable dispute about whether it is appropriate to provide patterns of Maternity (and particularly intra-partum) care that differ from the currently almost universal "high-tech" large-unit model. As is clear from the dispute over the proposed "low-tech" Maternity Unit in Bournemouth, concern is expressed about outcomes in specific groups of women, in particular nulliparous women. The striking feature about many of the opinions that are expressed is the extreme paucity of evidence put forward to support opinions that are often disproportionately strongly held. I imagine that this is a phenomenon that you may have come across once or twice before, in different contexts, as Secretary of State for Health!

The reason why I am writing is to draw to your attention the fact that we in Bath Health District already deliver 1600+ women per annum (more than 30 per cent of our total births) in Isolated Maternity Units which are emphatically "low-tech". We do so (since 1989) under a unified policy for admissions and management of labour. (Of particular relevance to the Bournemouth debate is the fact that we do—with confidence—deliver nulliparous women in our Isolated units). This represents approximately 15 per cent of the total numbers of deliveries in such units in this country. I, as the Consultant Obstetrician with overall responsibility for these units, and as Maternity Services Director for the Provider Unit, am inclined to believe that this, seemingly

bizarre, pattern of provision is a successful and highly appropriate way to deliver maternity services to our population. We lack, however, the facilities and expertise to put this "hypothesis" to rigorous test. The points that I would like to make arising out of this are as follows:

(1) This is the largest number of deliveries in such "low-tech" units in the country. It therefore provides the best opportunity that we have for studying "low-tech" maternity provision. Although the numbers will obviously never be vast. and will certainly never approach figures that are obtainable from the Netherlands, they do have the major advantages of coming from one "practice" and of being *British*—rather than *Dutch*—figures.

(2) Although it is the current controversy surrounding Bournemouth (and most of the concerns raised there can be easily "tested" by analysing our activity/data/outcomes) that has spurred me into writing to you, it is clear that this is far from being simply a local issue. Indeed the answers that may be provided by analysis of the activity in Bath Health District will be of major importance in the current national debate concerning the provision of Maternity Care.

(3) I would wish to propose that a definitive prospective study should be set up to investigate the provision of Maternity Care in the Bath Health District and the outcomes arising from it.

(4) I would suggest that the funding for such a project, since it is of such major public health policy importance, should come from central funds. We certainly have no way of funding this sort of study from local sources.

These suggestions had, as I mentioned earlier, already been put to Mr Roger Freeman last year. He was extremely interested in the proposal, and had asked me to liaise directly with him. Sadly, the initiative lapsed when he moved to Transport. I do very much hope however that you will agree with me that this is a matter of major importance, particularly in the light of the recent enquiry of the House of Commons Health Committee into Maternity Services. With your support we may make some progress in providing reliable figures for this vital debate, which so often seems to be conducted in some quarters on a froth of unsubstantiated opinion.

I look forward to hearing from you.

August 1991

Examination of Witnesses

DR GAVIN YOUNG (General Practitioner, Cumbria) Chairman, DR DAVID JEWELL (Senior Lecturer, Department of Epidemiology and Public Health Medicine, University of Bristol), MRS MARION MCKENZIE (Midwifery Sister, Hythe Hospital), MR RICHARD PORTER (Consultant Obstetrician, Bath) AND DR SANDY CAVENAGH (General Practitioner, Brecon), Association for Community-Based Maternity Care, examined.

Chairman

1395. If the Association for Community-Based Maternity Care can take their seats I should be very grateful. Who will be the lead spokesman for your Association?

(*Dr Young*) I shall introduce them, Mr Chairman, if I may.

1396. If you would, Dr Young, I should be grateful.

(*Dr Young*) I am Gavin Young and I helped to found this organisation in 1989. I am a general practitioner in rural Cumbria in Temple Sowerby. With me I have Dr David Jewell, who is a Senior Lecturer in General Practice at the University of Bristol, Dr Sandy Cavenagh who is a General Practitioner in Brecon and has done a national survey of isolated maternity units, Mr Rick Porter, is a consultant obstetrician in Bath who over sees seven isolated units in the Bath district and Mrs Marion McKenzie, who is a Midwifery Sister at an isolated unit in Hythe in the New Forest. I would say two things about that. The first is that I believe we are unique in that we are a multi-disciplinary group who have come in front of you comprising a midwife, GPs and an obstetrician and, secondly, we share some of your interests in that we are primarily concerned with the care of low risk women.

1397. Thank you very much for that introduction. I think Mr Porter is aware that in a week's time he will be looking after us, not professionally, when we visit Bath. I think Dr Cavenagh from Brecon will be aware that we are also coming very much into his area during the visit to South Wales and we look forward to it. Can I kick off? You have recently changed your name from the Association for General Practice Maternity Care to the Association for Community-Based Maternity Care. May I ask why this subtle change has been adopted?

(*Dr Young*) Am I allowed to tell you a little bit about why we arose?

1398. You can tell us the nature of your organisation as well at the same time.

(*Dr Young*) We started as a group of general practitioners who were perturbed that there was a loss of choice about where women could have their babies and loss of choice about style of care about how women were being looked after. We were aware of women's concerns about that and we met and decided that the number of isolated units had become so small and the pressure against home births so intense that we wished to do something about it as doctors. We rapidly realised that midwives were crucial to our organisation and rapidly midwives joined us, I am happy to say, despite our name which might have appeared slightly off-putting to

[Chairman *Cont*]
midwives. About a third of the membership is midwives. We became increasingly uneasy about the term "general practice" because though it was not "general practitioner" it appeared to concentrate on a particular professional. This became even more apparent when we went to the Netherlands and all the Dutch midwives looked at our stand and turned up their noses and said, "What is this funny lot? Are they against midwives?" It was at this point that we thought it was important to change the name because we were talking about a style of care not about which particular individual delivered it.

Mr Sims: You will have heard Professor Alberman a few minutes ago referring to satisfaction. I wonder what are your criteria by which to judge the quality of maternity care?

Chairman

1399. Dr Jewell, the academic.

(*Dr Jewell*) The answer is that first it has to be effective in terms of what it is trying to do. What we are trying to do is to produce healthy mothers and babies at the end of pregnancy with the minimum of unnecessary intervention and the minimum avoidable morbidity. We have heard the people before saying—and we agree—that nobody measures morbidity and we do not know what the links are between care and morbidity, but we think that it is important to pay attention to post natal depression, which may be very much linked with the process of care, and which has considerable morbidity for mothers and babies, the amount of perineal pain that women suffer, which may have a considerable effect on their psycho-sexual problems later on and perhaps breastfeeding rates. We also think it is important that the experience should be good for women emotionally and one of the most important things about that is that they should be involved in terms of the decision making that is going on and that they should feel they are part of that and that the care should be accessible to them. It is no good trying to provide care if it is difficult to get to and it is a problem both in urban areas and in rural areas for some women. Finally, if we could decide exactly what we wanted to do, it would then be relevant to decide how it was most efficiently delivered in terms of its costs.

1400. Mrs McKenzie, would you like to deal with that question because you are a woman and we are men? Your other colleagues are men. Satisfaction of birth lies with you rather than with us.

(*Mrs McKenzie*) Yes, I think midwives can give good care in the maternity situation. How we judge the women's appreciation of this is on a one-to-one basis in the post natal period afterwards. We are, as you know, allowed to visit up to 28 days, although most of us through sheer necessity of numbers only visit to 10 days and perhaps it would be a good idea if we could visit for longer. We would then get a better picture of the woman's appreciation of her care. There have been various surveys and various maternity units have produced their own questionnaires to the mothers to try to evaluate the service they give and then hope to analyse those and improve their services accordingly.

1401. Can you answer me this question? Do you think a woman is going to enjoy the birth of her child—if it is a normal delivery, and most of them are—more in her own home or in a small GP unit or in a larger district general hospital?

(*Mrs McKenzie*) I think this must be her choice. It should not be a choice that is made for her by a midwife or a GP. Some women will feel much happier at home and will do better for that. I trained in the days when it was all home deliveries and I love home deliveries, but I would not insist that my women should have home deliveries just because my experience of it is good.

1402. I am not saying just your experience or that of the women that you were looking after. Professor Alberman used the word "satisfaction", as Roger Sims said. Is a woman more likely to get satisfaction out of the birth in one situation as against another?

(*Mrs McKenzie*) I think the women who have experienced home birth will say that they get more satisfaction from that and indeed from GP units as well, because it is very similar, but if a woman is made to have a home delivery when she does not want one, she will not be satisfied with her care.

Mr Rowe

1403. I think the advantage of being able to choose seems to me to be overwhelming, but have we any practical thought of having the resources available? At the moment there are concentrated resources in centres where changeovers and teams can be arranged and all the rest of it. I just wonder how realistic you think it might be to have a switch over to your kind of care on a wide scale?

(*Mr Porter*) I think you have hit the nail on the head there. I speak from a position of a district where 32 per cent of our women in 1990 delivered in isolated maternity units, to use the jargon, and 5 per cent delivered in our integrated GP unit. What I can say is that it is possible for it to work, but whether it is possible to induce this dramatic shift is something that worries me greatly because it will be a revolutionary shift. I suppose you could say that given time there could be some form of evolution, but it will not be easy. I do not think there is any doubt about that. It will require a major change in mind set, but we shall not achieve it if we do not try it.

1404. And in resources, would it be more expensive?

(*Mr Porter*) I am not 100 per cent certain about that. I know that you will have had expert opinions on the costings before, but it will be quite interesting to discuss figures when you come down next week.

Chairman

1405. What has been pushed in one direction and that is what has happened. In years gone by home deliveries were the order of the day so the pressure that has been brought to bring about a 99 per cent delivery in district general hospital could be reversed could it not?

(*Mr Porter*) Yes, I hope so.

Sir David Price

1406. Carrying a stage further the reply that you all agree on, to give the mother choice, but she has to be able to make an informed choice. We all agree on that. What I am not clear about is whether the advantages of maternity care being provided by the primary health care team has been put across adequately. I know of your work, Dr Young. The work of you and your team is well known to me. But I do not think generally this is so, or am I wrong? I certainly get that impression, that it has been very much that a mother risks her baby if she does not get to the obstetric unit. That seems to me to be the received wisdom at the moment. Having gone through the process of small little maternity units being closed down and all the younger GPs saying that that is absolutely right and only one or two of the older members saying that perhaps it is not, but anyway they are retiring a year later.

(*Dr Young*) Without wishing to make myself very unpopular in front of you, which I may, I should say that in part that is due to the decisions of previous Committees which have been advised, perhaps over heavily, by a hospital based specialist and have been led to the opinion that birth outside large hospitals was very dangerous. As you have heard from two women better placed than I am to speak about it, even if the evidence is not in the opposite direction, there is certainly not evidence there and it is very unfortunate that so many small hospitals were closed on such amazingly scant evidence. Unfortunately the Department of Health, as far as I can see will still not take a stand and say that perhaps these units need protecting.

Chairman

1407. But is that not really the fault of the general practitioners who so often fail to use the units and the beds that were there for them?

(*Dr Young*) I accept that criticism. That is fair and I think one has to look at the reasons why general practitioners have opted out of maternity care. Can I tackle that one?

1408. I wish you would.

(*Dr Young*) It is a cause of great sadness to me as a general practitioner. As you know you have received very little evidence from general practitioners and perhaps have gained the impression that none of us is interested. I would certainly wish to redress that. If you look in the 1950s there was major involvement by family doctors in maternity care. What has happened ever since then is that as it became increasingly hospital based general practitioners have been deterred from doing it, I think largely by their experience of training. We know from a paper in the BMJ just this very week that something like 22 per cent only of general practitioners coming out at the end of hospital jobs feel that they wish to do intrapartum care. I think that is a terrible indictment of present training, that the vast majority of those training for something should be put off doing it. I have likened it in a stupid moment to parachute training. "I have done enough of this and it is terrifying and I do not wish to do any more". I think that needs changing. We are coming on later to money, so I believe, but government can affect what general practitioners do, as you will know only too well recently as we have been made to do a lot of things. There has been considerable adverse pressure on general practitioners to continue maternity care. They have been told from hospitals that this is a very risky business and that they must not get involved. We have been warned that litigation will ensue. This is something that really is not for general practitioners at all. Unfortunately most people have swallowed the message, particularly as we are training not in the environment we are going to work in. We are trained in hospital by hospital based specialists who do not have the same experience and will not have the same experience we have when we go out and we can discuss training later.

1409. Before Sir David goes on, can I ask Dr Cavenagh, who is perhaps compared with you, Dr Young, an old wrinkly and would fall into an older category of GP, what he would like to add to the question that Sir David has put and perhaps the reply that Dr Young has so far given to us?

(*Dr Cavenagh*) I have presided over this decline.

1410. Personally?

(*Dr Cavenagh*) No, not personally, but my practice career has exactly parallelled this slide of GP interest and the corresponding but unrelated slide in perinatal mortality. The reasons are exactly as they have been outlined. They are multiple. They are complex. They are correctible. The question is whether we wish to correct them. This, I imagine, is what your Committee is going to do, Sir. We know there has been powerful evidence from the midwives that we are dispensable and that it would be best left to them and the specialists to deal with the whole thing. Our perception is that acting as a group in a combined way we bring something to the art or whatever of maternity care which, acting in our separate ways, we cannot bring to it. That is the message we really want to try to get across.

Sir David Price

1411. Can I follow that by going back to my earlier question and asking if we are going to get the balance a bit better, may it not be necessary in a bigger way to revive the whole concept of what we used to call the cottage hospital and now is called the community hospital, I believe, of which maternity was always the centre, but by no means the total activity. I would argue this case very strongly, it went across the board, the whole practice of medicine and particularly when you persuade consultants to come out and hold some of their surgeries there, provided there is sufficient population base, rather than the patient always having to go into the district general hospital, and building up so that you get a total medical environment, GP-run, which the community identifies with. Therefore the concept of having your baby there is a nice safe thing to do. That is what the old system—in my very limited experience—was in my part of the country. It was clear. Then a lot of the mums there were got at and the people largely responsible were the young GPs, who said "Look, your baby is at risk. I cannot tell you that you have a risk, but play it safe. You have nothing to lose, and, look, we have a lovely new obstetric unit in such-and-such a district general hospital. You go along there".

[**Sir David Price** *Cont*]

(*Dr Young*) I would be very happy to see more small units set up in the country. I do not know about resources and whether that would detract from the centre. It would inevitably do so, but whether it would be cost-effective I do not know. I hope it would. There is certainly clear evidence that general practice commitment to maternity care is higher in rural areas where they have small units and where they do not feel marginalised by specialists.

1412. Would you not yourselves as GPs where you have such a unit, not only put in maternity cases there? One thing I am particularly keen on is respite care and the whole area of care in the community. We will not go into that today, but I feel extremely strongly that this is an essential link in developing medicine, but also getting people post-operatively back home earlier in the local environment generally, and also I should have thought for minor casualty and so on, particularly if the units have elementary diagnostics that can be done with the improvement in micro-electronics. There is no question of that, but it tends to be resisted by some of the specialists who do not want to dissipate. They use sometimes slightly questionable figures about minimum critical mass and all that. We went through it in local government and we are now getting it in medicine.

(*Dr Cavenagh*) If I could perhaps respond to that for a moment. There is no doubt that the concept of the small hospital is in a various state of imbalance at the moment. There are districts that are still closing their small hospitals. There are other districts alongside that are developing them. The whole thing is very irrational. What nobody has looked at logically is the way the small hospital can support the big hospital and this has not been adequately done, except, oddly enough, in Finland where they have shown that it works, that it is cost effective and that by putting resources into small hospitals in a satellite relationship to your big hospitals you do a lot of comparatively economic care thereby saving the expensive central facilities.

Chairman

1413. But on that very issue how is the peripheral cottage hospital going to fare under trust status within the National Health Service?

(*Dr Cavenagh*) It will depend whether its local practitioners hold the budget and then they will call the clout and then things will happen. The logical way to go is probably to go the whole hog, hold the budget, have the hospital as a trust and so forth. But that is perhaps outside what we are really here to talk about today.

1414. How will you respond, Mr Porter?

(*Mr Porter*) Wiltshire is going trust. There are four isolated maternity units. We actually call them neighbourhood maternity units. We have got this thing about "isolated". To call them isolated makes them feel isolated and we know that they are not isolated. And we have four other small hospitals within the catchment of 230,000. We foresee going trust as supporting ourselves. In other words, we are protecting ourselves.

1415. Are they going to become trusts as neighbourhood units or are they going to go—

(*Mr Porter*) As a trust within the Wiltshire health care NHS trust.

1416. A single district trust?

(*Mr Porter*) Yes, as part of the country. We think that acting together as this big unit of eight small hospitals it will give us a great deal of power and protect us from the power of the centripetal force into the centre.

Sir David Price

1417. If we as a Committee were to recommend an increase in GP units for maternity care, do you think your colleagues in general practice in sufficient numbers would support this, or do you represent a daring and dashing minority?

(*Dr Cavenagh*) This depends on your next question, which I believe is how the process is to be encouraged.

(*Dr Young*) A straight answer to your question at the present moment would be no, but, as I have said, one needs to understand that general practitioners did not withdraw from maternity care rubbing their hands in glee. They were pushed out of it and many of them feel very unhappy about it.

1418. Do you think though, going back to a point you made earlier, that part of answering my own question is that it is necessary to get at the medical schools?

(*Dr Young*) Yes. Do you wish us to discuss training now?

Chairman

1419. But to answer Dr Cavenagh before you come in on this, if this Committee in its report—and who knows yet what will be in it—made a recommendation along the lines that Sir David has just outlined, would that be providing any form of encouragement, cajoling, momentum which might create the situation that Dr Cavanagh would like to see?

(*Dr Young*) Yes, it would, but two other things would have to happen too. One is that there would need to be a major alteration in the way we are trained, as I have discussed. I would like to see much more of that handed over to normality so that midwives were closely involved with the training and assessment of future general practitioners who were going to work in obstetrics. That would be an improvement. I think more of our training should be based in the community. For those who were going to do care at birth it would be necessary to have continued hospital experience.

1420. Can I briefly intervene there and put this question to you? If GPs were therefore trained on a midwifery rather than obstetric model, would this not constitute even more duplication of skills than already exist? Or would it be beneficial?

(*Dr Young*) I did not suggest they should be trained on a midwifery model. I said that midwives should be heavily involved with their training, but they would need extended training from hospital specialists too. The primary grounding should be in normal maternity care which at present it is not alas and it should be based in the community and the teaching could come from general practitioners and from

[**Chairman** *Cont*]
midwives. There should then be further extended training in hospital.

Chairman: Mrs Audrey Wise has been very patient.

Audrey Wise

1421. So now I shall ask several! The Department of Health say that women can exercise choice about place of birth at least at present. Four of you are practitioners in the field. Do you think the Department of Health is right when it says that? Can women at present effectively exercise choice in relation to where they have their babies?

(*Dr Young*) Sorry, I am going to dominate this a bit and then let Marion in as it is a subject of great importance to me. No, simply. I think there is abundant evidence from women all over the country that their choice of where they deliver is limited in obvious and in subtle ways. One of the sad ways it is limited is by general practitioners exerting pressure on women against home birth. I say that with regret, but it is true and I should like to see something done about that to put it right. We can suggest ways later. The Department of Health has done nothing to support isolated units. It has allowed them to be whittled away, knowing full well the evidence about safety was lacking from the beginning. I personally think it is disgraceful that they have not come out and said that the evidence for it was lacking and that they would stop doing it. The brief answer is, no, I do not think most women have much choice at all. They are pressured against home birth. They are pressurised against small units, often by frightened general practitioners and if not by them then by obstetricians in hospital.

1422. You have touched on my next question. It seems to me that in relation to general practitioners there are two quite separate issues. One is the relationship they have to women as GPs, the women who seek their advice or make the first reference when they think they are pregnant and the fear which is inculcated. You say that you might suggest ways in which that could be dealt with. The other question about how far and how GPs should themselves take part as practitioners in the birth process is a separate question. If you would like to suggest any ways of removing the malevolent effect of many GPs in their advice they give to women patients on this, that would be helpful.

(*Dr Young*) I would support and I believe the Association would support the suggestion put forward by the RCM that women should be allowed direct access to midwives. I do not know that my own college would support that, but I am not here representing my college. We feel that would be an advance and if a woman has an obstructive general practitioner she should have the right to overcome that obstruction. Having said that, I would prefer a situation where the general practitioners were better informed, better trained and non-obstructive so it never had to happen. But I know at present some GPs are obstructive and women should be able to avoid this obstruction. Similarly midwives should be allowed direct access to obstetricians when they need it instead of having to go through a difficult GP. I should like to stress however, that the ideal we would look for is collaboration and that is why five of us are here, all of us witness to the fact that it is possible for these three groups to collaborate, contrary to opinions you may have received from other sources. I think those are the major ways and the retraining of general practitioners. I would like choice and I hope women would be able to realise what their general practitioner was like beforehand. If they found he was being obstructive and difficult and misinforming them then they must have access to a midwife who may be able to get them less biased information.

1423. So you would not be averse to the proposal that a women who considers that she is pregnant could make a first direct reference to a local midwife?

(*Dr Young*) No, provided it was "could" rather than "must".

1424. You would say that she should be able to choose where she makes her first reference?

(*Dr Young*) I think there is abundant evidence from consumer surveys. I think you have heard some from the NCT that many women value close contact with a general practitioner and it would be a tragedy if that was forced out and there would be a further loss of choice. I would like to see choice extended.

1425. Looking at the process further than that, I am exercised in my mind about problems of duplication because one of the terms of reference this Committee gave itself was to consider cost-effectiveness and the best use of professional skills. While we have some good GP evidence—and one is reluctant to say, "Never mind, you can be done without"—I believe that there is a genuine problem of duplication. What suggestions can you make to avoid waste of resources in having the co-operative relationship that you would like?

(*Mrs McKenzie*) Antenatally I think we can share care and that should be discussed locally among the mother, the GP and the midwife. It may be the mother's choice to have all GP care. She may not like her midwife. Equally she may not like her GP, in which case she should be able to choose all midwifery care. But I think the majority will choose to have both, but not together. It can be discussed between the midwife and the GP at what stages each should see the mother. Then there would be no duplication at all.

1426. Can I supplement the question by asking when you advocate GP involvement are you thinking that this would be a general situation, the GPs as a whole would, should and would want to be involved more than they are? Or are you thinking that there should be space left for those GPs who are interested in this particular field?

(*Dr Young*) Antenatally the vast majority of general practitioners would like to continue involvement and I have no survey evidence for this, but my suspicion is that the majority of women would like their GPs to make contact, so I am talking about the bulk. If you are talking about care at birth, that will remain a minority.

1427. How far then do you think you can get continuity if you have people involved in the antenatal care who do not take any part in the birth and therefore do not, in a sense, have to take responsibility perhaps for some of the advice they have given, or see how it works out?

[**Audrey Wise** *Cont*]

(*Dr Jewell*) The thing about continuity, to use a phrase that people thoroughly overwork, it depends how you define it and what you mean by it. We are all involved in intrapartum care. When you talk to GPs who are not involved in intrapartum care and you say, "Why do you bother to do this apart from the money?" They will say, "Actually it is important to us to see this woman because we are going to look after them as a family". The continuity that matters to GPs is a continuity partly for that woman within the context of her own family and the rest of her health at the time, but also over a long time. One still meets GPs who have delivered more than one generation of a family.

Chairman

1428. Do you agree with what Mrs McKenzie said a few minutes ago that while you look for this co-operation—and it is interesting to see you here crossing a number of specialties and professions—that a GP and a midwife should not both be present at the birth?

(*Dr Young*) She did not say that.

(*Dr Jewell*) I thought she did.

(*Mrs McKenzie*) I did not mention the birth. I was talking antenatally. If you would like to say "at the birth", I do not think it is necessary. But if the woman would like to have her GP present then we will call him.

1429. I then put the question, if both were present who would be the ultimate decision-maker, the GP or the midwife?

(*Dr Jewell*) It is interesting. I can only answer that from my own personal experience. It has never been a problem. I have worked with two very good community midwives and it never arises. It is the kind of question which I almost do not understand. In both cases these midwives are perfectly capable of doing almost everything without me and in both cases they appreciate my being there. I am not entirely sure what I do there. I provide support. I can resuscitate the baby if necessary. I can hold the mother's hand. I can do various things, but my presence there seems to be valued by both the woman and the midwife.

1430. I then put the question, because it will enable you to continue and I am not interrupting you in mid flow to cut you off. What could a GP do, therefore, at a delivery that a midwife could not do that would justify his attendance along with the midwife?

(*Dr Jewell*) The additional skills that one could bring. If this were an examination paper the question would be what are the additional skills? They are limited. One would hope that GPs who undertake this kind of care can acquire skills in terms of instrumental delivery—if it were needed, particularly for GPs who are working some distance from district general hospitals; that is not my position—or an ability to resuscitate the babies.

(*Dr Young*) I do not know whether I can butt in. I have had to use forceps on occasions in the unit which as yet midwives cannot do. There is no particular reason why you could not train midwives to a much higher level, but in the present state they are not and there are certain skills which I have that the midwife does not have, such as instrumental delivery. Dr Cavenagh is doing caesarian sections, but that is pretty bizarre. There are not many of us doing that. There are skills there. If we are talking about maternal satisfaction and her experience of it, there is evidence from a good paper by Beverley Chalmers in South Africa and evidence from a paper in Guatemala that the social aspects of care of who is there, how they are trusted and what women feel about the women looking after them has some outcome on the labour and her feelings about it. If she wants her GP there and feels, however useless this may on the surface be, that this person is supportive to her and makes her feel calmer and better, I do not think one should be asking them to be removed from the scene.

1431. You have been associated, Dr Sandy Cavenagh, with the word "bizarre", I cannot think why, by Dr Young. Would you like to add anything to what he has said?

(*Dr Cavenagh*) I should like to say that the concept of care that we are promulgating means that the expectant mother is in contact with a small team and which she gets to know. With the best will in the world, a professorial unit admits that in pregnancy a mother will experience 29 carers. That I think is rather a big team. But the small team has advantages in confidence, in relaxation and continuity. The other thing that I think you were leading on to was the division of GPs into some sort of sheep and goats. Straw polls, when I have been examining candidates in the diploma examination, which is GPs about to take an interest in obstetrics, indicate that about 10 per cent plus really want to be interested and involved in hands on obstetrics. That is a small figure, but there are 1,800 candidates and 1,200 diplomas awarded annually, and it is a potential contribution to the obstetric labour force of 100 to 200 doctors a month which would be very significant.

Audrey Wise

1432. Does it seem that one of the ways in which you could be involved is almost like a stage between the full scale obstetrician, loads of intervention, high tech and the midwife working on her own, so that it was not that rather stark choice which was on offer, but that you could have rather more intervention where it was needed but less than the purely obstetric model. Does that make sense? Is that what happens in a GP unit?

(*Mr Porter*) The thrust of some of these questions is trying to define very accurately a role for a being, an entity called a GP who wants to work in a GP unit. I do not think it is as easy as that. I think that different GPs will have different views of what they want to do. There is a role here for the provider unit for whom midwives will be working to try to define a package which they consider to be the appropriate package of antenatal, intranatal and post natal care for the women who are coming through this provider unit. Then phase II of this is to go round the individual practice and say, "This is the package that we consider to be necessary. How do you see yourself in relation to this package? What do you want to do? How often do you want to see them? What sort of share of the care do you want? What is your view of your role in the system?" I do not think it is necessarily appropriate for the provider unit actually

[**Audrey Wise** *Cont*]
to dictate to a very heterogenous population what they should be doing. I think this is one of the most important things that we should be getting away from, is this stereotypical view of maternity service provision, the idea that what works in Brixton works in Bolton, works in Bath. It just does not wash.

1433. It has been put to us quite strongly that a major influence in GPs wanting to be involved in the antenatal care and not wanting to be involved in the birth itself—we understand why that is—is because they are paid for this and they are paid a fair amount so that with the number of women likely to be pregnant in any one practice it is an important contribution to income. Do you think that that statement has any validity? If you do, do you think that there could be any merit in replacing that system—which may involve GPs for the wrong reasons—with a capitation fee based on the number of women of child bearing age in their practice so that their income was not adversely affected, but it did not influence their intervention in ante-natal care.

(*Dr Young*) I thought you might ask me that. Antenatal fees are an anachronism now. Given that GPs are paid by a highly complex mechanism where if you do a bit more of this you get a bit less money for doing that, it frankly does not really matter if they are removed. I do not think that I or any of us is qualified to speak about GP remuneration. Nevertheless the RCM has joined in and I do not think they were either, so I will have a go too. I personally would not object if antenatal care fees were removed. Many of my colleagues I am sure would and I am sorry about that. I do not think they understand personally. I think the fees could be spread out in other ways. I do not think money is the thing. It is really whether GPs should be encouraged to continue to do something. I think they will continue to do antenatal care even when they do not receive a fee for it, I would hope. I think the midwives' suggestion of shifting to some capitation fee would be acceptable. I would find it less easy to accept about intrapartum care because it is a much higher commitment with a responsibility and will require extended training. I think this Committee could do something to support general practice, if it wishes to see it remain, by addressing that problem.

1434. I do not think the RCM has made that suggestion in relation to intrapartum care. It seems to me, unless I have got it wrong, that the payment for intrapartum care is not such as would persuade any GP actually to undertake it.

(*Dr Young*) It is kind of you to say that. Really I would like to turn the whole thing on its head and say that the fact that 6 per cent of general practitioners are still prepared to take this inconvenient, occasionally dangerous, very time-consuming job on for no money at all is a credit to the general practitioners who do it and shows the level of their enthusiasm and emotional commitment. Most of you will know that we are paid more money for fitting a coil which can be done in a matter of moments, if all goes well, whereas attending a birth can be a very protracted business.

Chairman

1435. What is the payment? Let us get it on record.
(*Dr Young*) For a birth £34.50. Sandy has a line on this.

1436. And the remuneration for fitting a coil?
(*Dr Young*) It is slightly more.
(*Dr Cavenagh*) It is slightly more, £42.75, and for our emergency treatment fee, which we can earn by putting a bandaid on someone who is passing by our surgery, is just about half that. So it is a ludicrous state of affairs. But I think we want to emphasise that this is not a wallet job. We are not reaching for the wallets. We are looking at the future and recruitment of the people who are needed to the service as we hope it might go. If these young enthusiasts, the 10 per cent, are to be brought in it has to be worth while for their practices to bring them in. The practice involved has to recruit another half partner to do the obstetric work somehow, because this chap will not be available to do general medical services round the clock like his colleagues. He will be away doing the obstetric work. This is really what the whole possible turning round of the decline depends on, I believe. The scope is already there. Appointments can be made as clinical assistants and as hospital practitioners, which would cover any work these people do in obstetric units. Whether that could be extended in some way to cover their domiciliary work is another matter. But unless there is a major incentive for the recruitment of these people we are facing extinction.

Audrey Wise

1437. A number of you come from rural areas. There is Cumbria, New Forest and Brecon. Would you like to tell us of any special problems or needs that you think apply to rural areas, because I do not think we have had too much evidence on that aspect?
(*Mrs McKenzie*) High risk women who must be delivered in the consultant unit at the moment have to travel a considerable distance to the consultant unit. Some of the consultants do come out occasionally once a month. It would be nice to have more consultant visits to stop the women having to travel. We have funded our own scanner, but the women in other peripheral units have to travel also long distances, just to have a scan sometimes. Local scanning services could be encouraged too.
(*Dr Young*) Medically I think we would wish for good support from the centre. That is not universally so. Happily I can put it on record that the unit in Carlisle is very supportive of our peripheral unit, but that is not always so. If there is an isolated unit it would be better if the centre accepted graciously instead of wishing that it would go away. I would like good medical support from them. There is a real pressure to train ambulance staff up as paramedics for the transfers because at the moment that is not universally so throughout the country and some of these women are, whatever your selection procedure, going to need to be transferred. It would be better if the ambulancemen were trained up to the level to cope with that. I think that should be done as a matter of urgency, particularly as the Royal College of Obstetricians and Gynaecologists has, in my mind correctly, said that flying squads are probably not the

[**Audrey Wise** *Cont*]
appropriate way to move people. It would be better to get the ambulance from the outside to bring them in, rather than take somebody from the centre to collect them.

1438. What about Brecon?

(*Dr Cavenagh*) We would echo the Cumbrian situation. The problems are exaggerated for the rural patient who is attending a DGH. It means on the whole that more services tend to develop on the spot. This is the converse of it. We in Brecon represent the lunatic right hand fringe of activity in terms of the amount we do.

Chairman

1439. Bizarre and lunatic. You are attracting some attractive adjectives.

(*Dr Cavenagh*) We are at the end of a spectrum and it is a pretty wide one.

1440. Can I just put a quick question to you, Dr Gavin Young, to respond to on behalf of you and your colleagues? We understand—I may be wrong—that an impasse has been reached over the joint report by the three Royal Colleges. Can you tell us what the position is as you see it and perhaps what the position of the Royal College of General Practitioners is?

(*Dr Young*) Yes, I can. I seem to have spent most of the day saying that I feel sad about this, that and the other. Here comes another one. I was involved in the early stages of this report and wished it well and hoped it would have been laid in front of you by now. The sad news is that my own College did not accept it in its present form on Saturday and I have to put in front of you that I dissociate myself from my College about that. I would have approved it as it is now. I am sure the Committee will understand that the temperature has risen greatly between the RCM and the RCGP since comments passed to your Committee which left general practitioners feeling that we had spent 40 years being told: "Obstetrics is far too dangerous and needs specialists and you clear off out of the way and leave it to us". So we cleared off and now we are being told from the other end by midwives that it is so healthy and normal that we can clear off and leave it to them.

Chairman: Can I make this observation, by way of intervention? I think it is a great pity that the Royal College of General Practitioners took this evidence that was given to us quite freely and openly—which is what the purpose of this Committee is—and has taken it in such a way that it has apparently adversely affected this joint report. I must make this point because I think it is important to get it on record. When we ask people to come before us, we put extremely difficult questions sometimes to them, questions which clearly are provocative and in some ways controversial, but we expect them to give honest, direct and full answers. We solicited that information. We drew it out of the Royal College. It is not that they were wanting in any way to pre-empt any report that the three Royal Colleges were going to put together. I think it is very unfair, although it indicates the importance of the work of this Committee.

Audrey Wise

1441. I think it is probably worth putting on record or asking you if you are conscious of this, that the RCM in making the suggestion it did was concerned not to be adversely affecting by its other proposals the financial situation of GPs. They wanted to remove the financial question from this arena and that is why they made that suggestion.

(*Dr Young*) Can I come back on that and finish my argument? I do not think it is the finances that upset us, it is being told that we have a negative impact on pregnant women that is upsetting. It was not really the money. As regard the three party report, I am very sad that my own College has not signed it. I believe they should have signed it. I have to dissociate myself from it, but there we are.

Chairman: I think this has been an excellent Session of evidence. I thank you, Dr Gavin Young, all your colleagues and your Association for coming to give evidence to us. What you have said will be borne very seriously in mind by this Committee in the drafting of our report. Thank you very much indeed.

Supplementary Memorandum Submitted by the Association for Community-Based Maternity Care

After the Association gave oral evidence to the Health Committee on Wednesday, 11th December, you asked for a breakdown of the membership of the Association which I enclose. The units are maternity units, most of which will be rural ones. Unit membership allows midwives to attend meetings. Associates are lay organisations or particularly interested lay individuals.

Breakdown by Membership Type	
General Practitioners	176
Midwives	84
Units	38
Associates	20
Obstetricians	8
Trainees/Students	6
Total	332

As you will see, the combined midwifery membership of midwives and units is over one third of the total.

We appreciated the interest shown by the Committee in our evidence.

December 1991.

TUESDAY 17 DECEMBER 1991

Members present:
Mr Nicholas Winterton, in the Chair

Mr David Hinchliffe
Rev Martin Smyth
Audrey Wise

Examination of Witnesses

MR JOHN WYN OWEN (Director, NHS in Wales), Chairman, DR MORTON WARNER, Executive Director, and DR BERNADETTE FUGE, (Senior Medical Officer, Health Professional Group, Welsh Office), MRS SHEILA DRAYTON (Nursing Officer, Welsh Office), MR DEREK ADAMS (Assistant Secretary, Public Health and Family Division, Welsh Office), and MR DAVID PRITCHARD (Assistant Secretary, Health Strategy and Review Division, Welsh Office), Welsh Health Planning Forum, examined.

Chairman

1442. As we are a little late through no fault of our own but that of British Rail, can I say how delighted the Committee is to be here in the Principality and to come to this very prestigious building, the City Hall, in the capital of the Principality in order to meet representatives of the Welsh Health Planning Forum which has in fact produced a paper which we felt it was worthwhile to pursue further. Perhaps it is not unique for the Principality to set an example which will then be followed in other parts of the United Kingdom and obviously we are delighted that you have been prepared to come here this evening to a formal meeting of the Select Committee, very occasionally, as in this instance, held outside the Palace of Westminster. We believe it is very good for Select Committees to come and take evidence in all parts of the Untied Kingdom and all my colleagues on the Committee with our specialist advisers are delighted to be here. You know the purpose of this visit, you know the subject of our inquiry therefore I myself will open the batting by putting initially a fairly general question to you. Could you explain to the Committee briefly the nature of the Welsh Health Planning Forum and how it fits into the National Health Service here in Wales and the programme of work within which the Protocol for Investment in Health gain: Maternal and Early Child Health was developed? I intend to ask three or four further questions but that is the opening question. Perhaps in order to help our shorthand writer you could initially identify yourselves. Perhaps you might do that in opening and then deal with the first question I put to you.

(*Mr Owen*) May I introduce my team. I am John Wyn Owen, Director of the NHS in Wales and also Chairman of the Welsh Health Planning Forum. Dr Bernadette Fuge is a Senior Medical Officer dealing with health services for women and children and a member of the Planning Forum's Protocol Health Gain and Resource Effectiveness panels. Mrs Sheila Drayton is a Nursing Officer dealing with amongst other things maternity services and a member of the same Protocol panels. Derek Adams is head of the Public Health and Family Division with the policy lead for maternity services. David Pritchard is head of the Health Strategy and Review Division with responsibility for NHS planning and review, including the work of the Planning Forum. Dr Morton Warner is the Executive Director of the Welsh Health Planning Forum. Can I begin by answering your first point which is in relation to the Planning Forum. It was set up in 1988 to give advice on the strategic planning of health services in Wales. It is a multi-disciplinary and a multi-agency group which includes clinicians, people with a management background and consumer interests. Its first products were two key documents, the "Strategic Intent and Direction for the NHS in Wales" and "Local Strategies for Health", which recommended a new approach to strategic planning. These were launched in November 1989 and have achieved significant interest in the rest of the UK, Europe and beyond. The first dealt with the overall direction of the NHS in Wales and included maternal and early child health as one of the ten health gain priority areas. These are areas where in the Planning Forum's judgment there is scope for improving health status and reducing premature death and enhancing the quality of life. We consulted widely on the work of the Planning Forum, and the Strategic Intent and Direction was endorsed by the Secretary of State for Wales in July 1990. Our district health authorities, working jointly with Family Health Service Authorities, were then asked to develop ten year strategies for health, assuming broad resource neutrality. The draft strategies will be with us by the end of this month and will set out how each health district intends to meet the challenge of Strategic Intent which is for NHS Wales, working with others, to take the people of Wales into the twenty-first century with a level of health on course to compare with the best in Europe.

1443. Can I stop you there because I think you might be almost anticipating, if not have partly answered my next question because obviously we are relating this visit entirely to deal with our inquiry into maternity services and we do not want to go any broader than that in the evidence that we take from you. So in respect of the Protocol for Investment in Health Gain; Maternal and Early Child Health, what precisely do you mean by "health gain" in this context?

(*Mr Owen*) We have interpreted it in NHS Wales as avoiding premature death, which is adding years to life, and adding life to years. These are the two main criteria we will apply to our future investment.

1444. That brings me on to the next question I wish to put to you, what then precisely do you mean by "investment" in this context? Why did you choose

[**Chairman** *Cont*]
what seems a rather loaded term to describe this work?

(*Mr Owen*) It is a general term we have adopted. By shifting our NHS resources—our investments—between prevention, promotion, diagnosis and treatment and rehabilitation, we believe that we can significantly improve the health of the people of Wales in each health gain area with the intention that it should converge with the best in Europe.

1445. Why?

(*Mr Owen*) In many areas we are starting from a very poor situation. Our tradition of health and disease and cancer and cardo-vascular—

1446. Leaving that side alone, particularly relating to maternity services, why did you say in some areas you are starting virtually from scratch or from a very bad situation?

(*Mr Owen*) It is not just a question of mortality rates but also an issue in terms of quality of life and the quality of services. In the original Strategic Intent and Direction document we identified the reasons why we thought maternal and child health was an area capable of yielding health gain.

1447. Would any of your colleagues like to comment, particularly Dr Bernadette Fuge?

(*Dr Fuge*) You will note that one of the areas we have decided to address in the Protocol is perinatal mortality as we lag behind some of the best performers in Europe in this area, particularly in relation to low birth weight and congenital malformation. These are the big issues we should address.

1448. Would your colleague care to make any further comment?

(*Mrs Drayton*) I agree with Dr Fuge that low birth weight is the area that perhaps presents the greatest scope for action. We are aware that our rates do come a little behind those in some other European countries.

1449. But basically I think the difference is that you have just given the answer that it is low birth weight. Dr Fuge also mentioned perinatal mortality. I know there is a connection between the one and the other but is it not more important to concentrate on low birth weight than merely a statistic under what is headlined "perinatal mortality"?

(*Mrs Drayton*) In exploring perinatal mortality we came to the view that in developed countries the principal factor associated with poor foetal outcome is low birth weight and low birth weight is associated with smoking and social problems. Therefore, we saw this as being a key area which needed to be addressed. We were very much aware that within Wales we had addressed poor foetal outcome in terms of providing services for those neonates born with, for example, specific medical conditions, but perhaps we had not focused before on the issue of low birth weight, how we could mitigate it and whether it could be prevented.

1450. Thank you. Can we move on to my final question before I pass you across to my colleague, David Hinchliffe. Can you tell the Committee where did the impetus come from for the rethinking of maternity services? Was it from the professionals involved, some are here giving evidence to us this afternoon? Was it the managers, or dare I say, was it the politicians?

(*Mr Owen*) Perhaps I can describe the way in which the Forum goes about its work as that would explain how we have ended up with this particular approach. For each health gain area, we formed panels from the NHS in Wales with a broad range of interests. The first has a focus on health gain and considers the way in which best medical scientific and other advice would indicate current activities and also directions. Another group looks at the service from the customer, consumer, patient, woman or family point of view. A third looks at the current deployment of resources and the scope for reallocation. We are looking for consensus within each of those groups. We also engage an appraiser who provides an external perspective in relation to the panel's work. An attempt is then made to pull all of these strands together. But at the end of the day, in terms of this particular Protocol, it was the health gain component that chiefly influenced the way in which some of our recommendations have come through. Clearly, there were differences of opinion and emphasis between the various groups; but one of the things we put a high price on is getting agreement and ownership to the principal recommendations. I believe we have been able to secure that in Wales; and the BMA, the Royal College of General Practitioners as well as the Welsh Medical Committee have welcomed the advice in the maternal and early child health Protocol, apart from one or two comments about some of the service targets about which perhaps there may have been some misunderstanding. We therefore have a general consensus that this is the way in which we would like these services to develop in Wales.

1451. By whom were those concerns expressed?

(*Mr Owen*) The ones in relation to the service targets?

1452. The service targets that you said were misunderstood.

(*Mr Pritchard*) The response involved is not to hand, but we could let your clerk have the letter later on. I can, however, confirm the Director's general point that all of the bodies he referred to welcomed the Protocol and it very helpful and illuminating. From memory, it was not the targets that they were complaining about, but perhaps the pace of change was judged a bit challenging.

1453. I really repeat my question to you. Who or what was the instigator for this change, for this review? Was it the politicians? Maybe I am trying to get credit for my own kind.

(*Mr Owen*) It goes back to the way in which we have been trying to manage the NHS in Wales. If I can put the Planning Forum in the proper context. When general management was introduced in Wales one of the things that I asked the Secretary of State of Wales to provide was a statement of policy and priority for the Health Service. In other words, "If you want the service better managed, what is it that you actually want to achieve?" We put a very high premium on efficiency; but also said that we wanted the services in Wales to be effective: that was a much more complicated and difficult question. It was in that context that the Secretary of State agreed that we should set up a Planning Forum to help address the

[**Chairman** *Cont*]
theme of effectiveness. It was the outcome of the Forum's first efforts that led us to identify the ten health gain areas where we thought a shift in the current pattern of investment between the various levels of health care invention would enable us to move Wales up the league table to be amongst the best performers in health and output terms.

Mr Hinchliffe

1454. Could you tell us whether there was general agreement at the outset that the organisation of maternity services required reform and can you identify what were the major shortcomings that were picked up at that stage in the existing services?

(*Mr Owen*) If we go back to the Strategic Intent, the Planning Forum's launch document identified for each health gain area the main justifications for selection and what we want to achieve. Picking up the points my colleagues have made about some of the characteristics of the health of the population in Wales, we identified a focus on maternal and early childhood health as a way of improving the health potential of children by reducing disease and death during the time of pregnancy and early childhood; that was the aim. The justification we published at that time was that infant mortality accounted for 6 per cent of lost years of potential life for males and 4 per cent for females. In addition, attitudes and patterns of behaviour which affect current and future health are formed in childhood: nutrition, smoking, dental care, alcohol and safety behaviour. There is also considerable scope for prevention of disability, particularly amongst children of lower socio-economic group families. Children are also major consumers of primary health care resources, including prescribed drugs, so the need to emphasise maternal and early childhood health was clear.

(*Mr Pritchard*) The emphasis is not on maternity services as such. We are trying to turn the equation round and say what are the health challenges, look at where we are now in terms of the health status and then try to work backwards to see what health services you need to improve health. The old-style approach to planning had been to ask the question, "What maternity services have we got now and how can we make them better?" In our judgment that missed the point. As I have said, the focus should be on improving health, with service issues only being considered later.

(*Dr Warner*) I would like to expand on that a little. I am a relative newcomer to the National Health Service, but have a background of working closely with the World Health Organisation. Their approach has some similarity with our own. They would say rather than concentrating, perhaps as the Health Service has in the past, on just saying, "Let us deal with the supply side," and rarely looking at the needs, we should begin our planning by assessing the needs of people. This approach is echoed in "Working for People" and ultimately the new NHS Act. While we have to begin with the needs of people, but then crucially we do not accept that the interventions that we have always done are necessarily the best ones. There will be many good things that are worth continuing, but we have to scrutinise everything we do closely. In Wales, this process has been seen to be more than just a useful exercise. Our clinical and managerial colleagues have joined us in this task, I think with a degree of willingness, as they use a similar approach, have an interest in science, and in looking at the evidence. The Health Service has for quite a long time been enmeshed in an activity culture, enmeshed in the supply of services. We have taken this brief time out to look at the key issues, and at what interventions are possible and most effective. Our findings are summarised in the Protocol and offered as a guide to good practice to purchasers. It provides them with a sense of what they might purchase to achieve the best results in terms of health gain.

(*Dr Fuge*) Could I also say something about our people-centredness approach. We have explored what people want from the service. We have not been content to simply accept present practice. We want to know if this is appropriate for the people of Wales.

1455. Can you say how you have actually gone about doing that?

(*Dr Fuge*) We set up a people-centred panel with representatives of consumer groups and voluntary organisations. A whole chapter of the Protocol is devoted to this issue. Health gain has been our main theme, but people-centredness is another important one.

1456. So you are satisfied that the information upon which you based your changes in fact reflected consumer feelings on the issues that we are concerned about?

(*Dr Fuge*) Well, it was a consensus document at the end of the day.

(*Mr Pritchard*) What the document tries to do, and what the entire series of Protocols attempts to do, is blend the consumer perspective with professional judgement in a way that we believe has not been attempted before.

1457. One of the points that has come out very clearly in this inquiry so far from the evidence that we have taken is that there are very marked differences in approaches and I am sure you are well aware. We certainly only today witnessed some very different views on a particular approach on a visit we had previously in the Wiltshire area, which you may be aware of, in the areas we are concerned with. When you looked at the various organisations who represented the Health Service, how did you actually assess whether they represented the broad thinking rather than a narrow line on the issues that we are concerned about? Can you actually mention some of the organisations that were involved?

(*Dr Warner*) Perhaps I can pick up on that point because I was involved in the structuring of the panels. As the Executive Director of the Planning Forum I have been involved with the development of the local strategies our districts have been preparing and you may have talked with some of those involved. When we were constructing the people-centred panel we canvassed a wide range of people to identify which voluntary sector bodies and self help groups had an interest in this area. The people we finally involved are listed at the back of the Protocol. I believe that the issue of representation is a very difficult one. How do you achieve an appropriate representation of the broad mass of the population? We have taken the approach which says, "Let's get

[**Mr Hinchliffe** *Cont*]
those groups involved in the process which have a special interest." We recognise that they often come with an agenda and certain biases. The encouragement has been to get those biases on the table so that they do not become covert agendas and then to press for evidence of the hardest type from their organisations or other places, to achieve the best view we can. But it would be wrong to talk in terms of broad representation, just as it is perhaps inappropriate to rely entirely on data coming through such bodies as community health councils.

Chairman

1458. You have given the impression that the impetus behind this has been mainly management. Certainly you used the word "we, we, we". I am just wondering how much input to all this came from general practitioners, the obstetricians and gynaecologists, perhaps also very importantly the midwives in addition to what I perceive to be a management-driven exercise, certainly initially.

(*Mr Owen*) If you look at the membership of the Health Gain panel, you will see who was involved in the work. What I was trying to describe was the management framework within which we are trying to take the policy agenda forward. We are very clear that in Wales we have to take the agenda forward not only with our professional and managerial colleagues, but also with the consumer and the community interest. The composition of these various Protocol panels reflects this judgement and approach.

1459. That really does not quite answer my question. How much initiative was taken by the profession in this whole exercise. It is one thing appointing them to panels or asking them to be represented on panels, but it is quite another for them themselves to have perhaps been part of the impetus behind this initiative and behind what is done by the Forum?

(*Mr Owen*) As far as the Forum is concerned I can guarantee you that the participation of the members is very forthright and uninhibited. My colleagues can talk about the ways in which the various panels have operated; but in my mind they have a very important part to play; and if you look at the membership of the overall Health Planning Forum, there is no doubt about the way in which professional groups contribute to that.

(*Dr Warner*) Can I add to that and suggest that in the early days, if you recollect this was the third of our Protocols, we were feeling our way as we went along. For the first one, on cancers, there was, to use your term, a "management drive" to get it under way. But there was also an attempt to get professional groups to suggest people from within the appropriate body or bodies with an interest in the area, who would be prepared to invest time in the initiative. By the time we got to the Protocol on maternal and child health, the one you are discussing, we found professional people wanted to be on the panels. They knew about the process. It was no longer new. There was an awareness from the professional press and elsewhere. Professionals now see it as a part of their responsibility and role to get engaged in this work. So I believe that the drive now comes as much from the professionals as from management.

(*Mr Pritchard*) This is reinforced by the fact that the person who chaired the Health Gain panel on maternal and early child health was Professor Brian Hibbard, Professor of Obstetrics and Gynaecology at the University of Wales College of Medicine.

Mr Hinchliffe

1460. Coming back briefly to the consumer involvement in this, can you give any examples where perhaps representation from a consumer group or consumer groups led you to respond by changing the approach that was being taken at any particular time?

(*Mrs Drayton*) Yes, I think we can. Each of the panels, and there were three, produced a technical document. There is one by the people-centred planning. Within that document there are chapters on "Participation in planning", "Appropriate facilities", "Quality services delivery", "Responsive staff" and "Informed choice". The final item very much influenced the way in which the Protocol was written. The Health Gain panel also recognised informed choice, but possibly not to the same extent and in the same way. So when we brought the documents together this issue was very much to the fore. Other issues featured, of course, but that was a very significant one.

1461. Mention has already been made of the changes that took place last April in the structure of the Health Service. To what extent was your work driven by the need to tie in with those changes?

(*Mr Owen*) The work of the Planning Forum started before the Prime Ministerial review of the NHS, so allowing us to be clear about what district health authorities and also local authority social services had to do by way of needs assessment before then considering how best to meet those needs. The planning and reform strands therefore came together well in Wales to offer opportunities.

1462. Can you give us any examples of ways in which perhaps you have found through this process of the work you did, major areas of waste or misuse of resources through the efforts that you made in this respect?

(*Mrs Drayton*) I am not sure we can identify major areas of waste. There were a couple of issues. One was about reallocation of expertise and the other about the reallocation of volume. I can give you an example of both. Women with high risk pregnancies require obstetric care and the Confidential Enquiry into Maternal Deaths recommended a higher level of obstetric input. We recommend continuity of care. Clearly both would be possible if we thought about appropriate levels of expertise for appropriate degrees of complications. This points to women without complications being cared for by midwives, women with minor complications being cared for perhaps by midwives and general practitioners, and women with severe complications enjoying the greatest degree of continuity of care probably from consultant or registrar obstetricians. So that is about reallocation of expertise. In terms of reallocation of volume the maternity service has developed a number of routines, for example, antenatal care. In

[**Mr Hinchliffe** *Cont*]

1982, the Royal College of Obstetricians and Gynaecologists Working Party on Antenatal and Intra Partum Care suggested that five or six antenatal visits should be the norm for women without complications. In the case of primigravidae, an additional three visits were suggested. There is considerable evidence to suggest that most women are asked to attend clinics more regularly than that, so there is excess use and perhaps some women really need far less ante-natal care. This would release resources to provide a greater degree of continuity of care and expertise for those women with greater needs, for example, in the area of lower birth weight. So it is not waste but perhaps the need for reallocation of resources that has been identified.

Audrey Wise

1463. I was very interested in the scope of expertise in your panels. I would like to ask a question which really relates to this variety of expertise. Could you indicate what were the major areas of disagreement which emerged from the various groups represented on the Forum, for instance obstetricians, GPs, midwives and there may be others.

(*Mrs Drayton*) I would rather say that at the beginning there were perhaps different emphases and different approaches from doctors, general practitioners, midwives and obstetricians. Not surprisingly, each group approached the task in what might be called their professional way; and so obstetricians and perhaps consultant paediatricians felt more technology and perhaps more resources would greatly enhance their ability of care to specific groups. Midwives were anxious that their skills should be fully utilised. GPs felt the need to remind us that they are the lynch pin of the National Health Service. The way in which we overcame these difficulties was to focus on health gain. Therefore, for the first two or three panel meetings there was a need to keep coming back to the issue of health gain. So, whereas traditionally one might have said, "If we had more of this or more of that service or input," every suggestion was tested against "Will it achieve health gain?" This was the focus which enabled us reach agreement. The second criterion which helped us to achieve agreement was that the recommendations should be founded either on consensus statements or research evidence. That again tested our views and we began to work together and gained a better appreciation of each other's point of view. We were also helped greatly by the Oxford data base. There were some sticking points; but we reached a consensus; and although the Protocol is itself a consensus and a compromise on everybody's part, and there may well be individual views that go a little further one way or the other, we have moved significantly forward in achieving the Protocol.

1464. I think the Committee are impressed by the Protocol. It is really why we are here and we are of course no strangers to the disagreements which can arise between professionals and between professionals and some of the users of the service and so we are particularly interested in how you overcame these problems?

(*Dr Warner*) Could I pick up on this. We have spoken of the Health gain panel, but the people-centred panel also played a vital part as ideas from both groups came together towards the end. We had the two panels running in parallel as we did not want the consumer interest to be overawed by the professional side, as perhaps often happens. But the issue that became central to the people-centred side was informed choice. The notions which come out, which are discussed in the last chapter of the Protocol, are giving mothers more choice and control. This people-centred emphasis could be strengthened by offering a range of service options particularly, when it links in with the Health gain This would suggest that the evidence is not always so concrete that one has to have all mothers under the care of consultant services. That was one part. The other part was the cost related to medical consensus. We now have babies who can survive a lot longer despite low birth weight, but other babies who are clearly going to have big problems. The informed consensus brought into the open the difficulties that were there, but without pretending we can do everything for every child, for every baby. We thought it was useful to open that issue up and the people-centred panel was very strongly of that view, and that influenced the overall report in which we tried to balance the professional and the people-centred vantage points.

1465. It is often claimed that the maternity services now offer women choice and you—personally I think correctly—say this is just not happening to a sufficient degree. I am wondering—choice is often interpreted as "Yes you can choose, as long as you choose what I think is best for you," and I wonder if you came across this particular attitude to choice and whether you had it put to you as though there was a contradiction between the interests of the mothers and the interests of the babies and how you resolve that particular way of expressing the matter.

(*Mrs Drayton*) Yes that point did actually arise and I can remember one of the draft chapters stating it quite clearly. But when we tested the idea against published evidence, and against the health gain model, it did not stand up well. Therefore, we acknowledged that there can occasionally be conflict between the choices of the mother and the well-being of the foetus, though those occasions are exceedingly rare.

(*Dr Fuge*) I think in medicine generally we are beginning to move away from a paternalistic attitude to one of partnership. We are becoming much more interested in whether we can satisfy patients. We want to be left with patients who enjoy good health.

1466. Of course in maternity women are not just users or consumers, they are participants, are they not? Do you have the expectation that by enabling them to be more effective participants perhaps we can improve outcomes in the broadest sense?

(*Dr Fuge*) I am sure that is true. Patient satisfaction is most important for continued health and in the bonding of mother and child.

(*Mr Pritchard*) Before birth, lifestyle issues are obviously a key factor and unless you have got the mother's attention—if I can put it that way—the best medical care in the world is not going to help overcome some of the hurdles.

(*Dr Warner*) The emphasis given is on treating pregnancy and childbirth as a normal event and not an illness. We say this right at the beginning of the

[**Audrey Wise** *Cont*]
Protocol. Most mothers and babies come through pregnancy and early childhood with few, if any, problems. Where there is a cause for concern there is a need to act quickly. We wanted to start off on the premise that it is a normal and participatory event which should be responded to in that way.

Audrey Wise: Exactly like this Committee does.

Chairman

1467. Before I pass the questioning to Martin Smyth, are you saddened by the impasse that has occurred with the three Royal Colleges in England in respect of progress here in the maternity service field, that is obstetricians, gynaecologists, general practitioners and midwives. As you know there has been an informal group that has been working together but an impasse has been reached. Do you think they have got anything to learn from the example here in the Principality?

(*Mr Owen*) I do not think I am well-equipped to answer that question.

1468. Dr Fuge?

(*Dr Fuge*) I personally feel very saddened and I speak as an ex-GP. I believe that we should be aiming for a safe outcome for mother and child and that all specialities have a great deal to offer. We have under-utilised skills both in midwifery and general practice. For example, here in Wales we have over 1,600 principals in general practice of whom 1,500 are on the obstetric list. You will know from your experience that this means there are 1,500 principals who have had post-graduate training in obstetrics. It would be very sad if these people were not encouraged to use these skills in a more effective way.

1469. Who is responsible for the impasse, the Royal College of Obstetricians and Gynaecologists?

(*Dr Fuge*) There is a working party looking into the training needs of general practitioners. What happens at present is they go through their post graduate training and then are not able to use their skills, skills which are probably going to be needed in the future. We also have a great problem, as you know, in staffing hospital obstetric units where they are having a difficulty with recruitment.

1470. So it is the Royal College of Obstetricians and Gynaecologists or the Royal College of General Practitioners?

(*Dr Fuge*) I am not qualified to answer that but I would imagine there is a tension between the two which they will have to sort out between them.

Chairman: A sensitive political response.

Rev Smyth

1471. We have already had a definition of your understanding of "health gains". Can we explore with you for a short time what are the main opportunities for health gains that you have identified. For example, what balance have you sought to achieve between the emphasis on social or public health initiatives and the more narrowly defined medical initiatives?

(*Dr Warner*) I can take you through a number of the areas. We went through the process my colleagues have described where we tried to bring the material together and it forms a concluding chapter we have characteristically referred to as "Seizing the Opportunity". We gave it a bi-line, "Safety and Quality". The key issues that emerged we called "objectives". In some cases we have brought ideas together, social issues and medical issues. In other instances we have identified those things that we is believe need to be done at by districts in their purchasing role, and by providers. For example, we have identified opportunities for mothers and their families to exercise more control during the pregnancy and child birth. In health gain terms, we would like most women to describe it as a positive experience with a mechanism being established to measure progress. That is, if you wish, a social sort of issue. I think the other issue which arises is the one between perhaps what is needed at an individual level and what is needed at a population level. We have always said that the Protocol is a population-based approach. Many of the targeting activities are based on populations achieving certain levels of satisfaction and certain levels of health for mothers and children. But equally I think there are other areas where we are trying to allow for the fact that individual care ultimately is of paramount importance so we are not in these Protocols trying to in any way say that individual clinicians must behave in a certain fashion because they must quite clearly be free to make the sort of decisions which only they can make as the point of contact. So we do not see that as official. We see these as a guide to best practice but there will always be certain situations that are outside of that fact and if it comes down to a question of individual safety, individual quality of care, then we do not in any way want these documents to be challenging how individual clinicians would act in a particular situation, but they do not highlight the need for further education from time to time.

1472. I can understand the concept of not wanting to mandate an individual clinician on individual issues but we are trying to tease through the measures of your Protocol which is to give guidance and historically means medical advances did not actually come because of medical discoveries but came into being as a result of public service initiatives, pure water, and I am asking now looking at the health care of your mothers and children in a light of one answer but at an early stage you identified higher risk for low birth weight babies. Have you put an emphasis on raising the standard of social provision or are you stressing the medical input?

(*Mr Pritchard*) It would be worth emphasising the focus of these documents. Quite clearly they are prepared for use principally by the NHS in Wales.

Chairman

1473. Is that not virtually all health care?

(*Mr Pritchard*) The NHS does not, of course, have direct leverage over such issues as housing or water quality. But it can act as a local advocate for improvements in such areas. The Protocols are designed to be business-like documents for NHS clinicians and managers to influence affairs locally. So therefore it would not be appropriate for this sort of document to seek to directly influence a wider arena. That would have required us to have been given a much broader remit.

[**Chairman** *Cont*]

1474. Where do you wish in maternity services to apply additional resources? You have been a bit thin on giving us the specific information and I think it is important to our inquiry to know, as a result of the work that the Forum and the working panels have undertaken, how you wish to apply additional resources. Please be specific.

(*Mr Owen*) If you take paragraph 316 we say there has been a consistent decline in perinatal mortality rates, though some areas have failed to improve. Also, the disparity between health outcomes in different groups is well-documented, with marked differences between the best and the worst. The aim must be to try and improve the rates for socio-economic groups IV and V. We then identify ways in which, by better targeting of health service staffing and other resources, we might make some improvements in this area. My colleagues might like to be more specific.

(*Mrs Drayton*) The simple answer to your question is that there are two areas that the targets address. One is for best effective practice to be gauged against research-based data, and here the Oxford perinatal database is very helpful.

1475. Can I just intervene there—I am sorry I am doing rather too much intervention—because certainly when we visited them recently they indicted there was no longer any firm evidence to suggest that mothers were safer and their babies were safer by having a birth in a district general hospital under an obstetric, gynaecology unit, ie within a hospital under an obstetrician and GP units and even home deliveries were considered to be very safe. Are you therefore reinvesting in peripheral hospitals and neighbourhood hospitals and encouraging home confinements?

(*Mrs Drayton*) I think you will find the point made within our Protocol.

1476. Will you explain this to us briefly because I want to get this not only in the document in black and white but actually in our oral evidence in black and white.

(*Mrs Drayton*) That would take a little while to find the specific paragraph. If my colleagues would be good enough to go on.

(*Mr Pritchard*) I will do a bit of filling-in, Chairman. You asked whether there would be extra investment and what that might imply for total spending in this area. The judgement of those who developed this Protocol is that there is adequate investment in maternal and early child health in Wales. We do not need any more resources. What we require is better targeting and better use of the resources that we got. That is a very clear judgement that has come through from the evidence, from managers, clinicians and consumer groups.

Rev Smyth

1477. Does that include health education and the whole question of targeting teenage pregnancy?

(*Mr Pritchard*) On teenage pregnancies, in so far as these may lead to low birth weight babies, yes, that is included. What we have done is to identify a range of services to support our health gain proposal, we have not just stopped and said "We will reduce infant deaths, for example, by X per cent by 2002." The Protocol has gone further by identifying service targets which we think, if local health teams pursue them, offer a decent chance delivering health gain. The service targets point to where more and better things could be done within the existing budget. For example, we suggest that in an effort to reduce still born births purchasers should, by 1993, look at ways of ensuring that at least 95 per cent of women attend ante-natal clinics in accordance with the guidelines. The Protocol includes over 20 service targets which highlight areas where we feel investment or more effort could have a beneficial impact.

1478. Going back to where earlier it was identified as some women have three consultancies and some have five consultancies and there may be those having too many and therefore they should be reduced. Are you going out now to the various hospitals and GP units and so on and saying, "For particular types of women you really only need one or two consultations," and have you listed specifically those targeted who need to have more consultations—arising out of your answer.

(*Dr Fuge*) As we said this document is not prescriptive. It is advisory and will be picked up by our local strategy teams which will have similar panels to our own Protocol. It will be for districts to continue the debate we have opened up.

1479. Has that been hopeful or hope so, bearing in mind we ourselves face the problem when we bring out reports of getting people to read them and to act upon them, what sort of thrust are you giving, not just leaving it to people to chose their own little bit but to try to go forward to improve the Health Service?

(*Mr Pritchard*) What we have insisted on, and this has not been universally popular in Wales, is that all health authorities should by the end of this month have produced the first set of local strategies for health based on these documents. I think it would be wrong for us at the Wales level, as Bernadette Fuge has suggested, to prescribe what should happen in each district. Even within Wales, local circumstances vary considerably from Powys through to Mid Glamorgan or where we are today. So what we ask is for local clinicians, consumer groups and others to take these documents away, extract the key measures, test them against their local circumstances and come back with firm proposals for action. Welsh Office Ministers will agree by April whether local responses have been satisfactory or not. Their response will be tested against the advice given in the Protocols.

1480. Am I right in concluding back to my first question that the Protocols and guidance you are taking you are not emphasising social and public health initiatives but more the medical initiatives and that is where you are putting your priorities?

(*Mr Owen*) We are setting service targets for the NHS to deliver but clearly it has to work with other agencies. For example, we have identified that there is some work they can do with the education services.

Chairman

1481. I will put a specific question to you, Mr Wyn Owen. Would the Welsh Office give support to any local service willing to open an non-consultant unit

[**Chairman** *Cont*]
and would the Welsh Office be prepared to put resources into such a development?

(*Mr Owen*) You mean a medical consultant unit?

1482. Yes, I mean basically a GP, a peripheral neighbourhood unit.

(*Mr Pritchard*) A lot depends on if the local strategy can demonstrate a consensus among local clinicians, managers and consumer groups that a sensible pattern of investment for the future would be one that included more GP maternity beds or whatever. We would then need to make a judgement whether that was a safe package of care. However, we would need to guard against second-guessing local judgement and if there was a strongly held view that we felt was professionally sound and cost effective, we would probably back that judgment.

1483. Can I just press because perhaps Dr Fuge would want to come in on this and also Mrs Drayton. Surely if such a proposal came forward it would be professionally supported by general practitioners, by midwives and no doubt also by those who you have not made great reference to and that is the women themselves and the choice that they are supposed to be able to exercise and the satisfaction that they wish themselves to get out of maternity services and being pregnant. So to an extent how would you sitting here in Cardiff overrule a proposal that came to you fully supported by general practice, midwives and the consumers in a particular area?

(*Dr Fuge*) At the moment our GP beds are very under-utilised as you probably know. We have 104 GP beds which have about a 28 per cent occupancy. I think in reply to your question we have to see what the future holds. That is the current situation.

1484. At the moment basically it is the accepted wisdom of the establishment that practically all women should give birth in a obstetric unit so to an extent is it surprising with that pressure which has now been built into the system that so few of the GP beds are occupied or their occupancy rate is so low?

(*Dr Fuge*) Surely this is the value of a document like ours.

1485. I am grateful to you for saying it.

(*Mr Owen*) I think we have found an earlier reference, do you want it now?

1486. I am sorry about overlooking the fact that you had been working.

(*Mrs Drayton*) Paragraph 365 makes reference to the fact that the Oxford database "flags practices which should be discontinued in the light of the available evidence. These include many which would potentially release resources, among them insisting on universal institutional confinement". Paragraph 365 is within "Framework for Investment", and for health authorities to consider. One of the points I would make is that these are recommendations. One of the key recommendations for example is continuity of care and another is good practice. The way in which health authorities achieve these changes is to be determined locally using the guidelines. Our talk of reallocation of volume and targeting is one way of achieving our goals.

Chairman: Thank you. I am most grateful to you.

Rev Smyth

1487. I think we might make it plain that one of the reasons why we are questioning you, is you have a Protocol and it will be listed in the addenda in our report but people will read the report and therefore we have things on the record as well as comments, which is much more helpful. Where do you identify the potential to use professionals involved in maternity care more effectively. Have you taken an overview?

(*Dr Fuge*) I identified general practitioners who were qualified in obstetrics and whose skills were currently under-utilised. As I indicated, there is scope to use these people for hospital care and to keep their skills going.

1488. Using them in hospital care?

(*Dr Fuge*) As clinical assistants.

(*Dr Warner*) There is an interesting issue here. We have a high proportion of general practitioners who have the obstetrics qualification; but one of the points raised at a Planning Forum meeting by a Professor of General Practice was that as a number of GPs had not had the opportunity of using their skills for a considerable period of time, there would need to be some investment either at a post-graduate level or through the Royal Colleges to get those skills up again. In fact, as we have shown in the Protocol, there would need to be a reversal of the trend that has been in evidence for some years. But there would be a cost we would have to look at and it would have to be looked at quite broadly.

(*Mr Owen*) That was a point made very strongly at the Planning Forum Meeting when we considered this particular Protocol.

1489. Am I right in inferring that in examining the provision you would not come down on the side of those who are arguing now that every delivery should be in the place of a high-tech unit. You see a role for the GPs and the general hospital as well as provision in the community?

(*Mrs Drayton*) Yes.

(*Mr Owen*) Yes.

Audrey Wise

1490. Pursuing the point about the further training first of all for the GPs, do you think that there should be a requirement for a regular refresher training for GPs on the obstetric list just as there is for midwives?

(*Dr Fuge*) I suspect that this is why the majority of GPs do not participate in intra-partum care. They lose their skills and are unhappy to carry out intra-partum care; but as you know the majority of GPs do provide ante-natal and post-natal care. So, if there were training programmes it could interest more GPs in intra-partum care.

1491. Do you think there should be a requirement for a regular up-date, a regular refresher in order to remain on the list?

(*Dr Fuge*) Developments are going that way anyway with post-graduate education, with GPs updating themselves in all areas. I am sure that this is an area the Royal Colleges will look at.

(*Mr Owen*) There is also the development of medical audit which plays an important part in maintaining standards. We make a very clear

[**Audrey Wise** *Cont*]
connection in Wales. Not only are we interested in medical audit in hospitals and in general practice but also the relationship between audit in general practice and that in hospitals, with a direct connection into post graduate medical education.

1492. How do you see your document being used? If I can just give an example with another question. On the paragraph that was quoted number 365, after the sentence about stopping on insisting on universal institutional confinement you go on to say districts are urged to subscribe to the Oxford database as a way of securing access to up to date research findings. Do you think they will take your advice? Will you be monitoring it to make sure that they do? If they do not will you have any sanctions on it?

(*Mr Pritchard*) Referring back to what I said earlier, we have asked districts to submit local strategies for health drawing on the Forum's published Protocols. It will be clear from the sections on early maternal and child health whether or not they have subscribed to this and to advice in the Protocol. Indeed, local strategies will need to pass a number of tests, and we will be looking at whether districts have referred to the best information available. We will be able to judge that. We will also be having meetings with local strategy teams to discuss their plans, and no doubt issues such as this will arise.

1493. Obviously it is a key issue because it gives a good deal of guidance on what should and should not be done. To return to the targeting question, you have peppered through this document references to the differences in social class and its relation to outcomes. You have said they should be targeted. I think you have slightly undone that, if I may say so, in paragraph 317 where you have said, "An approach built explicitly on eliminating different outcomes of different socio-economic groups presents problems. Defining social classing or assigning individuals to a class is difficult." Now I think perhaps you have given an opportunity for those who wish to drive a horse and cart through your exultations to target that. What sort of tests will you apply as to whether in fact adequate targeting on socio-economic grounds is going on?

(*Dr Warner*) It is a question at which point you enter the debate. One could perhaps try to target social class groupings by saying, "We know a particular housing estate, Penrose Estate or whatever it is, tends to be dominated by residents of a certain social class". But we believe that this is not as helpful as saying "Let's define those sorts of women and families who are at risk." There are a number of ways you can do that. Local strategy teams and practitioners need to work this through and identify those people at risk without relying on socio-economic analysis as such. The approach would be to identify the risk issues first and responding to the risks by focusing on the target areas. What we would anticipate is that those people who are in socio-economic groups IV and V are likely to emerge as those who have the greatest risk. This would be in line with many research findings.

1494. If I can press you, because for example using that approach you may well come to the conclusion that this or that women or group of women is at risk because of smoking. Now further examination of her circumstances might show that a contributory factor to her smoking is the degree of stress in her normal life, perhaps because of bad housing. Now do you envisage it being satisfactory to say, "You are smoking and should not smoke," or even discuss it with her in a much nicer way than that or to what extent to you think medical and health professionals should enter into the social debate, for instance giving advice to government?

(*Mrs Drayton*) The issue is low birth weight. You referred to social groupings; and it is true of course that one of the primary factors associated with low birth weight is social groupings and smoking. What we have done in this Protocol is thought about—

Chairman

1495. What about diet?

(*Mrs Drayton*) The evidence is a little equivocal. There is work to show that diet does have some relationship but not as strong a relationship as with social problems and smoking. We have thought about how the Health Service could best assist people at risk from low birth weight. The evidence suggests that low birth weight outcome can be mitigated by the provision of continuity of care and a higher degree of support. Through that mechanism a carer will come to know the woman well, and the woman will hopefully develop a counselling relationship with her carer who may be able to influence her lifestyle and direct her in appropriate ways to address other problems broader than health. Within the Health Service we can at least move towards continuity of care to give that woman a degree of support.

Audrey Wise

1496. I think that would be very valuable and I would not seek to belittle its importance at all but there is implicit in your answer a concept that it is open to the decision of the individual woman and is it not the case that there may be aspects relating to her social and economic situation which are not amenable to action by her but are much more problems of society and should health professionals not sometimes raise their voices? One answer mentioned local advocates. Now do you envisage any of your health professionals actually seeing themselves as local advocates in a rather broader sense ons social matters and what would your reaction be as the NHS if they have?

(*Dr Warner*) I think we can say that we have seen this already and that support would be our response. It came up when we were dealing with the issue of cancer a year ago. You brought up the issue of smoking. I have certainly had meetings with various public health authorities. They said that if you are taking this approach you are starting to suggest that we should be advocates for public health, My response was, "Yes, why not?" When it came to the Cancers Protocol, there are some words in there that I think are more than mildly encouraging for health authorities to act in support of local authorities as they try to deal with sales of tobacco to under age children and that sort of issue. This is a general notion, and perhaps we can respond to this as you have also talked about housing as another example.

[**Audrey Wise** *Cont*]
One of the things that the Protocols have done and the local work on local strategies is also a start—and I emphasise start—is to break down some of the bureaucratic barriers that have existed between the Department and the district and local level. So whilst these documents have come from the Health Service we find for example that it might be on one occasion that it is the district health authority that is in the lead on a particular area. In another, it will be the Family Health Services Authorities and in a third, for different reasons, social services or a local authority environmental health department. They are now starting to come together to consider how they can initiate action across the board. Our hope must be that you start to see better co-ordination between local agencies, recognising the fact that poor housing for example and respiratory illness have some connection. If you are going to reduce some of the respiratory illnesses amongst children you require better housing. I am looking at my colleagues to see what the Welsh Office response is, but certainly at district level we are starting to see integration occur in a way that we have not before.

(*Mr Owen*) The report of the Director of Public Health Medicine is going to be addressed to both DHAs and FHSAs; this and the fact that he Director of Public Health Medicine has an independent perspective means that he or she is a key individual in informing the debate on these issues.

(*Mr Pritchard*) One of the strengths of the approach we have developed in Wales is that local strategies for health, driven by the NHS, are being developed alongside the community care an s social care plans that county councils and district councils are preparing. Within that framework, both housing and education also figure. A whole range of issues can now come together. That is the strength of the process.

1497. From what you have said it seems as though it is a little early for us to be asking what has been the response to the Protocol since you are only just expecting the replies. Have you got any feel for what might be happening, whether there is any resistance to any particular line of thought, for instance?

(*Mr Owen*) It is a little too early to answer that. Do not forget we have been issuing guidelines in the form of these Protocols through this year. For health gain areas where we have not done substantive work we have given health authorities some less robust advice, so while we have asked districts to look at all ten health gain areas, we have encouraged them to major on the ones for which protocols are available, including maternal and early child health. I have to say there has been a lot of pressure to put the exercise off for a year or more to allow for a greater degree of refinement at the local level; but I believe that driving the NHS in Wales to look a the health needs of the population and saying, "Yes, it is not going to be perfect this time round, but at least we have made a start and begun to learn." We expect there to be an iterative process between the Directorate and my colleagues, with health professional groups and people at the local level to see how this exercise can be developed further over the coming years. One thing I can assure you as the Director of the NHS in Wales, is I believe that this is a fundamental part of our new way of doing business. Yes, we will learn as we go through the process; but we will be learning with our colleagues at the local level. We believe that ownership at the all Wales level is important; but ownership at the local level is essential. Some of the results of this exercise are going to be uncomfortable for us, for if there is local ownership of a solution, as the Chairman has indicated earlier, what would happen if that did not fit with the Centre's perspective? Then I think we have to think through these issues, but all the while recognising that while the thrust of our approach is for greater devolution, greater ownership, and greater debate within the community about priorities and the difficult choices that will need to be made if we are going to shift the pattern of investment to achieve health gain.

1498. Your report is often quite forthright and I notice particularly for instance in paragraph 198 you talk about cleanliness and the frequent complaint about the lack of provision and the cleanliness of sanitary facilities. Suppose your district says, "Yes, well we realise this but we have had to cut back on cleaning and we cannot afford any money to make more provision of sanitary facilities without more cash." What sort of answer will they get?

Chairman

1499. First of all would they do it and it that likely to be anything more than a hypothetical question?

(*Mr Owen*) I come from a hospital administration background and one of the things I have an almost total obsession about is cleanliness in hospitals. Therefore, I would regard cleanliness as an important standard of performance. I am not necessarily convinced that it costs money; it requires management effort to get it right.

Audrey Wise

1500. If this was the answer that came back, you would envisage some sort of mechanism for jointly deciding whether that rejoinder was justified or not or what would you do?

(*Mr Owen*) I would be looking to district health authorities as purchasers to make sure they have got a quality service, which includes clean places. That is something I would expect them to achieve.

(*Mr Pritchard*)The issue could be picked up in contracts with service providers. In Wales, every contract between purchaser and provider must include at least four quality measures. I cannot tell you exactly what they are, but as the system develops the measures will get sharper and sharper. The question is going to be, "If you want us to put services your way you are going to have to meet certain standards." Obviously the other way of looking at it is through the Patient's Charter which is again about raising standards. This is how the various elements of the system come together; health gain backed up by a sharp specification of conditions.

1501. What if it is true that they did not actually have the resources. How would it be established that was the reason for the shortfall in this or other ways that they were not fulfilling your Protocols. How would you do that?

(*Mr Owen*) I believe anyone who says they have not got the resources to keep places clean ought to go and manage something else.

[**Audrey Wise** *Cont*]

1502. In that case I think quite a lot of Health Service managers nationally ought to do that, certainly in England. I will say nothing about Wales because you are doing that quite effectively yourselves, but certainly in England. I notice that you say that the "Know your Midwife" scheme proved to be 25 per cent cheaper in the particular costing you did. On page 55 you have got a reference to that. I was interested in that because that suggests you are doing comparative costings and our experience is that there is rather a dearth of costings. Is that the kind of way you feel resources would be released for other things, more use of schemes like that?

(*Mrs Drayton*) This was taken from a one year study of that particular scheme and I cannot therefore generalise on that figure as it is just an example. I would like to come back to the reallocation of volume and the reallocation of expertise. Really, if we thought about how we organise our services we might get a better service closer to meeting women's needs and possibly with better outcomes through a change in organisation; but it will require considerable organisational change.

Audrey Wise: On that same sort of line, in one or your paragraphs you mention the problem for midwives being the unpredictability of the work load. I wondered if you thought that a change in organisation so that women follow mothers through—it has been expressed to us that staffing of mothers rather than staffing the wards could even out that unpredictability—so that if there was a group of women who were at a early stage then you would not need to keep holding the midwives, saving an unused labour ward but you have more midwives seeing them through from the beginning. Do you think that could help on this unpredictability?

Chairman

1503. In short an integrated midwifery system?

(*Mrs Drayton*) More or less. We have published a number of studies but I do not think we have that information.

1504. Surely it would be a better use of midwives and their time?

(*Mrs Drayton*) What I was going to say is that we have to move towards a small group of midwives or individual midwives taking responsibility for a case load, a given number of women, with obstetricians taking similar responsibility rather than everybody being minimally involved in the care of a large number of women. So that is the organisational element. In my experience this may require a few additional midwives initially.

Audrey Wise

1505. One last point—a different one. In your Protocol on breast feeding, your target is by 1997 each district should increase the number of women breastfeeding to six weeks to at least 75 per cent. Why did you choose six weeks as the time, since there has been some research that breastfeeding for three months shows a health gain over the next two or three years in the health of the toddler. Why did you chose six weeks?

(*Mrs Drayton*) I am sure that would be better but one has to start from a position of very little data at the present time. We have information on how many people commence breastfeeding but not much information on how many are still breast feeding at six weeks and this is a compromise. It represents something that we feel we shall be able to collect at an early stage.

1506. What sort of steps do you envisage being taken to meet that target?

(*Dr Fuge*) We have a National Breastfeeding Initiative in Wales which is Welsh Office funded and we have a worker who is liaising with our health authorities. The Initiative will continue to move forward.

(*Mr Pritchard*) Basically what we are highlighting in the Protocol is what is what we would like to achieve. It may be that we need to reflect on whether the appropriate period should be two months, or three months in the light of later information. The targets are indicative; but the challenge has been thrown down to local teams and consumer groups. We offered districts a number of strong hints in our service targets as to how they can start the process; but they have to fill in most of how to achieve the health gain targets, if I can put it that way. That is what we are all about.

1507. So when you talk about a National Breast Feeding Initiative of course that is not going to be part of our report. For people reading it, it does not mean very much.

(*Dr Fuge*) Except that is a focus.

1508. Yes but what sort of things would you single out as being likely to help you to achieve this very important target.

(*Dr Warner*) One of the things we mention in paragraph 345 and in the service targets at the top of page 59, is that we are looking for district health and family health service authorities to develop their own Protocols, their actual Protocols on breast feeding, amongst other things. This will ensure that advice is consistent because, as one looks around, one finds a great deal of advice, some of which clashes. I think the notion of the national programme is one that good information should be in a consistent form. The notion of having local Protocols giving advice and then going on to establish good practice and continued support and encouragement is that there will be local conditions that cannot be envisaged, if you like, from the central level where the health gain Protocol begins. The notion is very much that we will be looking for analysis down to this local level and ideally to community level within districts, as the practices within particular communities may demand peculiar particular local responses. We may be talking about Protocols within the districts to respond to each particular community's needs. I think the essential part of the action for that must be at the end of the spectrum covered by districts. The initiative and the encouragement for it is in the Protocol, as is the evidence to support the necessary action.

Chairman

1509. Thank you very much. I have just one or two more questions I would like to put to you. One is very specific and perhaps, Dr Warner, it is yours. What have you identified as the most effective way to organise and resource special care and intensive care for ill mothers and neonates or perhaps Dr Fuge or Mrs Drayton. This is to us again, in light of the questions we have had, also very important. What would you identify?

(*Dr Fuge*) If I can pick up on the neonates. First, we had our own perinatal mortality initiative which covered the period 1984 to 1986. This was followed by a survey looking at perinatal intensive care services in Wales chaired by Professor Eric Stroud and which identified areas of care.

1510. So what is the most effective way of organising this care?

(*Dr Fuge*) What Professor Stroud identified as desirable for Wales is a regional centre supported by sub-regional centres. His report is with our Ministers and we await their decision

1511. I am grateful. That is a very specific response and just what I wanted. Can I finally put to you the Department of Health have not apparently considered it appropriate to issue guidance as detailed as yours in England. Could you comment on this? Why do you think your approach will have more impact and do you think that it can therefore be replicated in England or perhaps you might indicate to what extent you think your work is specific to the Principality?

(*Mr Owen*) I am not sure how far I can comment on the scene in England; but what is important about our approach is that we have addressed issues as they appear to key people and some of the consumer groups in Wales. We have worked with professional staff and consumer interests. We have looked at research and other evidence. We have tried to make sure that we have ownership of what it is we want to do at the Wales level. We were fortunate to secure a grant from the Nuffield Trust to develop and test the same approach at local level. There is no point in us developing guidance that is not well matched to local requirements. We have tried to ensure that whatever we recommend works at district level. We would hope that the result of our work is not so unique that it might not have a wider interest; but it is a very important process that we have gone through. I do not believe that people can simply lift our document and then implement the recommendations without going through a broadly comparable process. However, as we have looked at evidence of best practice, I would hope that key elements of our work would be sufficiently robust to stand the test on an England, European or even wider basis.

1512. Thank you very much. Could I finish in thanking you, Mr Wyn Owen, and your colleagues for giving up considerable time at this late time of day to give evidence to us to fit in with our very busy programme. So to each and every one of you on behalf of the Committee, thank you very much indeed. Can I finish with a request that you could in writing by the New Year provide some information on the results of the submissions of local health authorities which we have talked about. The question was put to you and you gave the response that it was too early to indicate precisely what the reactions and responsibilities were going to be. Would it be possible to put it in by the New Year or early in the New Year to help us with the drafting of our report?

(*Mr Owen*) I think early in the New Year. We would like to have Christmas and the New Year off!

1513. I hope your New Year Holiday is not too long so that you can actually submit it to us in plenty of time for those who are advising us and in drawing up for the Committee a draft report for our approval and consideration.

(*Mr Pritchard*) Yes.

Chairman: Once again can I thank you very much. It has been a great pleasure to have this formal meeting in this wonderful Council Chamber here in the City Hall in the capital of the Principality. Thank you very much indeed.

APPENDIX

Memorandum submitted by the Welsh Office

1. Reproduced below are relevant "headlines" on maternity issues from the Welsh Health Planning Forum's Protocol for Investment in Health Gain: Maternal and Early Child Health. The responses are those of district health authorities and family health service authorities in Wales in the eight local strategies for health submitted to the Welsh Office. In addition, manpower and training issues are considered as these emerged as an interest of the Health Committee.

Opportunites for mothers and their families to exercise more control during pregnancy and childbirth through informed choice should be extended.

2. All eight local strategies for health address this issue, and acknowledge the tension between the need to ensure a safe service and allowing an element of choice. More than half aspire to move towards the informed choice model. The remaining strategies do not indicate a movement to this model at this stage.

3. The local intentions identified will be subject to dialogue with and scrutiny by the Department. The debate on this issue is at an early stage and positions could shift in the light of the consumer preference surveys commissioned by some authorities, and discussion with the Department.

Women's physical and emotional health should be protected throughout pregnancy and childbirth

4. Half the submitted strategies aspire to achieve such improvements through ensuring continuity of care. The remainder indicate a tension between the views of professionals and the public, influenced by the existing mode of service delivery. However, a number of the health authorities in the second group are carrying out consumer surveys to inform future policy-making.

The number of children who are stillborn or die soon after birth can be reduced through sustained and targeted effort.

Prevention and management of congenital malformations or handicaps can be improved.

5. As recommended by the Planning Forum's Protocol, each local strategy targets low birth weight as a key factor and recognise the need for initiatives to deal with the prime causes. Initiatives proposed include health education, pre-pregnancy advice, link workers and ante-natal screening, mainly targeted at high risk groups. Improvements in neonatal care facilities, in line with Stroud recommendations, are identified by five strategies.

Health authorities should work to provide a fully coordinated network of services to support the health of mothers and children in the early years.

6. The Protocol's targets on breast-feeding are relevant here. All the submitted local strategies recognise the importance of offering consistent support and encouragement to mothers to breast feed. The majority have launched initiatives which include improved education programmes and ensuring staff give consistent advice and support.

Manpower and training

7. Three of the strategies refer to extending existing "Domino" schemes. A further three flag the need for the refreshment of skills amongst GP obstetricians and midwives. One strategy proposes attaching midwives to primary health care teams.

Conclusion

8. The Protocol appears to have had a significant and positive influence on thinking about the nature of local maternity services in Wales, although, as expected, the eight local strategies for health are draft in nature and vary in their level of development. Further substantial development will take place in 1992, and the strategies will then be subjected to regular review and updating in later years.

February 1992

THURSDAY 16 JANUARY 1992

Members present:

Mr Nicholas Winterton, in the Chair

Mr David Hinchliffe
Sir David Price
Mr Andrew Rowe
Mr Roger Sims
Audrey Wise

Examination of Witnesses

MRS VIRGINIA BOTTOMLEY, a Member of the House, Minister for Health, DR DIANA WALFORD (Deputy Chief Medical Officer), Medical Director, NHS Management Executive, DR JOHN MODLE, Senior Medical Officer (Maternity), MR JOHN SHARPE, Assistant Secretary, Health Promotion (Administration) Division, MISS JOAN GREENWOOD, Nursing Officer, Midwifery, Department of Health, and MR BRIAN EDWARDS, Regional General Manager, Trent Regional Health Authority, examined.

Chairman

1514. Minister, can I welcome you yet again before the Committee. We are, as you know, coming to the end of our inquiry. We will shortly be drafting our report and there are a number of matters that we would still like to tidy up with you. Can I, in welcoming you, also welcome all the members of the public who have come but perhaps also our second group of witnesses, who may also be in the room. Minister, the first question I wish to put to you is this: in 1990 the Chief Executive of the National Health Service Management Executive, Duncan Nichol, stated in written evidence to the Public Accounts Committee that "there is no statistical evidence to show whether GP maternity units are less safe than those in District General Hospitals". Would you this afternoon, Minister, as we come to the end of our formal evidence in this lengthy inquiry, concur with this conclusion?

(*Mrs Bottomley*) Chairman, thank you for inviting me back to tidy up various matters. With your permission, before addressing your first question I wonder if it will be in order for me to bring you up-to-date on a couple of other matters.

1515. That would be very helpful. By all means.

(*Mrs Bottomley*) I want to announce to you today that we have appointed Lady Shirley Littler to chair the National Advisory Board that will lead the confidential enquiry into still-births and deaths in infancy. As you know, there has been a really remarkable improvement in the survival rate, the perinatal and infant mortality rates, over the last ten years, but there remain something like 11,000 deaths between the 20th week of pregnancy and the end of the first year of life. A great deal of thought and care has gone into this confidential enquiry, which will be the first of its type in the world. We know the success of the confidential enquiries into maternal deaths and we believe that much can be achieved from that. Lady Littler, who was formerly the Director General of the Independent Broadcasting Authority, will carry this important work forward in respect of stillbirths and deaths in infancy. A lay chairman has been chosen, because it is important that the Board has professionals and lay members on it to make maximum progress. The other area which I wanted to bring to your attention is that the Secretary of State has today answered a Parliamentary Question spelling out the initial work of the Clinical Standards Advisory Group. As you know, that body was set up to monitor and advise on the quality of care under the reforms. It announced a number of tasks. One of those which it announced, one to which we have referred in previous evidence but it has now been announced formally with the other areas of activity, is that the Advisory Group is to advise on the standards of care for women in normal labour. Their investigations will include variations in clinical protocols for, and practice in, the management of women having their first child in a representative sample of labour wards in NHS hospitals. We expect that investigation to embrace the question of the location of delivery and the nature of and necessity for intervention—two areas which I know are of great importance to the Committee. Having made those announcements, perhaps I could come back to the question which the Chief Executive, Duncan Nichol, answered about the statistical evidence on GP maternity units. Certainly I can say again today that there is no further formal evidence about the safety of the GP units as opposed to the district general hospitals.

1516. So basically you concur with that conclusion?

(*Mrs Bottomley*) I concur with that conclusion.

1517. If that is the case, quite clearly this report that we will be producing will be very important indeed because there are a lot of people, I am sure you will accept, who are becoming very critical of the present way that our maternity services are operating and the apparent lack of choice that mothers are given. Would you accept that?

(*Mrs Bottomley*) Yes.

1518. In the absence of any evidence to prove that GP maternity units are unsafe, quite clearly they have justification for that concern?

(*Mrs Bottomley*) Chairman, what the Committee would seek is formal, statistically convincing evidence. I must report to the Committee that there is no clear, overwhelming statistical evidence on that front. But that has to lie alongside commonsense and, indeed, professional judgments about what is the safest way for a woman to give birth. Those, of course, are the issues that are enshrined in the Maternity Service Advisory Committee's advice to the Department and throughout the Health Service. But I believe that this Committee and your inquiry,

[**Chairman** *Cont*]
Chairman, has identified an issue of great concern to many women in this country and it is one which I think as ministers we would want to reinforce. Now that we have done so well in reducing the perinatal mortality rate—because that is a remarkable achievement in ten years. That has been in a way many people's focus. Indeed, this year, as the Chairman will know, the NHS has had to set targets for the regions for how they plan further to reduce those figures. We must now be sure we are also addressing the question of choice and particularly the question of the mother's involvement in the birth plan. This week the Secretary of State made reference to a new report from the Management Executive, guidance called "Local Voices" talking about setting up focus groups and how we can better listen to and respond to the interests of the women who are giving birth. I will leave a copy with the Committee, if I may.

1519. We would be very grateful. Can I put a further quick question before I pass on to David Hinchliffe. In response to a Parliamentary Question put by Harriet Harman in July 1990—and I refer to the Hansard for that, column 705—the Department identified research it had funded on the relative safety and costs of delivery at home, in consultant obstetric units and in general practitioner maternity units. Perhaps you could briefly advise the Committee what use has the Department made of the findings of this research when formulating policy, because you have announced to us today that further inquiries, further reports, further committees are going to sit on this matter? Are we merely putting off a day when the system is, in fact, going to be changed or are we merely, as it were, setting up further inquiries to delay the changing of the system?

(*Mrs Bottomley*) I can say no to your last point, but the National Perinatal Epidemiology Unit, which we fund to approaching £500,000 a year, is of great use to the Department, and, indeed, the work to which you refer, Chairman, is something to which we have regard. It remains the case, though, that our evidence is that up to 20 per cent. of women in labour are transferred to a hospital consultant unit. I was trying to make clear to the Committee that there is no overwhelming evidence, unequivocal evidence about the relative merits of different settings and some of the evidence is conflicting in some ways. What we are stressing to health authorities as they make their plans to provide health care which is more sensitive to the wishes of the patients—and the Patient's Charter is of fundamental significance—is that they must listen to and consult with the women involved. Many women are saying that they wish to have a birth where there is less medical intervention. We are extremely interested, not necessarily in the GP units but in the midwife-led units. There are a number of very encouraging midwife-led units, frequently placed often in a district general hospital, where the midwife has the right of admission to the beds. I think we need to talk more effectively with the users of the service about what it is they are seeking and how we can best get those three priorities to which I referred when I last came to the Committee straight: the overwhelming importance of the safety for the woman and for the child, value for money—always a very significant factor—and then choice. Choice is something that under the new regime, with the Patient's Charter, with the work going on in the Management Executive, that I believe we have to make much more progress in making sure we are really providing what the mother wants and not necessarily responding only to the different professional rivalries involved.

Chairman: Minister, you allow me to pass the questioning at a very appropriate stage to David Hinchliffe who wants to raise the matter precisely of a woman's choice.

Mr Hinchliffe

1520. Minister, when you gave evidence before you recall I raised with you a specific case and we had correspondence about that particular case. Mrs Unwin, the person concerned, is here today and I believe you have had a chance to have a word with her briefly. In your letter of 9th January in response to the details I sent on to you about her particular case, you make the point that it is Government policy to encourage women to give birth in a hospital unit where a range of supporting services is available to cope with an emergency. Can I ask you, following on that point, if there is any reliably objective statistical evidence to show that births at home are either more or less safe than those in hospital?

(*Mrs Bottomley*) Once again, Chairman, there is no overwhelming information to support or refute the thesis made by Mr Hinchliffe. The case he brought to my attention has caused me concern because, although the woman involved had the right to have her baby at home, and she had found a midwife who was prepared to deliver the child at home, she felt under pressure not to accept that commitment. If the GP involved had not wished himself to take a responsibility, there would have been other GPs in the area who would have been prepared, I expect, to offer that service. I want to make clear that women should be able to have their babies at home. We have one of the most developed midwifery services in the world; we have seen a very significant increase in the number of midwives in recent years. They are professional, highly trained, competent experts in the whole process of birth and we should use those skills. Now, as to the particular case which Mr Hinchliffe raised, it seems to me there is a need to make more clear that women who wish to give birth at home are entitled to do so. We must talk with health authorities as to how they can make that right of the woman more explicit. As to the information about the safety of home deliveries, I think the research to which I would point, Mr Hinchliffe, is the independent midwifery study which the Department is funding through the Royal College of Midwives, which I believe will be able to throw further light on this particular aspect.

1521. Can I just pursue Ruth Unwin's case because I think you have picked up a very important issue arising from that. That letter you wrote to me about her case said "Women are encouraged to discuss the options for place of delivery with their GP and midwife". Now, certainly in Ruth Unwin's case that did not happen, and she has advised me that it has not happened to her peers who have had similar experiences in recent times. Do I take it from the answer you gave and from your comments that you perhaps believe there is a need to look at more

[Mr Hinchliffe *Cont*]

formalised procedures to ensure that this might happen, to remind GPs, to remind those involved in the birth process, that that is a right and should happen? Do you see a need to change existing policies on that point?

(*Mrs Bottomley*) I am sure the whole spirit of the Patient's Charter on making information more available to the users of services is extremely important. We produced only recently a leaflet about the Health Service and its availability for women—I have forgotten the title. Two and a half million copies have gone out because women want to know what is available. Gone are the days when patients were passive recipients of health care; they want to be partners in health care. May I just add that the document I mentioned is called, "Your Health; A Guide to Services for Women".

Chairman

1522. We know all that, but can I perhaps ask you to answer David Hinchliffe's question. Do you need to have some more formal instruction given to health authorities to bring this situation about? Perhaps you want to bring in Mr Brian Edwards who has come from the Trent Health Authority and is helping with the implementation of the Patient's Charter. If it is to be meaningful, there has to be some backbone to it and people do not want just to talk about it, they actually want real choice.

(*Mrs Bottomley*) Health authorities are expected to make known the availability of services and the work that is going into their purchasing to implement and work towards the health of the nation. The strategy is to make clear their assessment of the health needs of the local community and through precisely the documents and initiatives which I described earlier of "Local Voices" subtitled "The Views of Local People in Purchasing for Health" to make sure they do have that dialogue at a local level about the availability of services. I certainly make it my business to make sure that there is awareness that women are entitled to give birth at home.

1523. What about formal authority, something the mother can get hold of and say "I have a right which I want and am going to get"?

(*Mrs Bottomley*) Do you want to add anything, Brian?

(*Mr Edwards*) I think we can learn from the experience of Mrs Unwin that we really ought to have allowed her a better opportunity to ask for what she wanted and made it in a way in which she did not feel she had to struggle to get that right. I hope as part of the work we are doing on the Patient's Charter we can do something to make sure people can have easy access to have their legitimate concerns dealt with and responded to quickly. That is what was missing in this case.

Mr Hinchliffe

1524. A final point on Ruth Unwin's case, though she may want to comment herself: one of the issues to which the Minister has already referred and which she mentions in her letter is the issue of the availability of GPs prepared to offer an obstetric service. In her case she was registered with a practice with seven GPs (a fairly large practice I would have thought even in this day and age) and registered with that practice as a child of 8, so she had a family connection there. It seems to me unreasonable that she should be asked at a fairly critical time in her life to move to a completely different practice. The question I would welcome your comments on, Minister, is this: should the DHS have a duty to ensure that within each practice there is a GP prepared to offer the kind of service she wanted at that stage, to avoid the need at a critical time in a patient's life to move to a different practice?

(*Mrs Bottomley*) I think that is a difficult question, Mr Hinchliffe, because there are a number of duties that GPs have and other ones which are optional. To require the GPs to perform particular tasks when that team of GPs felt that, maybe because of the way they trained, maybe because they had had a particular experience at some stage in maternity matters, they did not wish to take on that responsibility, would be, I think, to take a coercive approach which would probably be unwise. But I think what is important—and I recognise the point about the woman having been with that practice for a long time—is that simply for the responsibility for that maternity episode the women is able to use another GP in the area whilst maintaining her link with her home practice. But I suspect this is not a matter for Ministers or even the Department; I think it is one of the issues which the work that is under way between the Royal Colleges will help to address. The principles which the three Royal Colleges hope to address are important, as is also the work on training being discussed by the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists. But what I want to emphasise is that I think the Committee and Mr Hinchliffe have performed a valuable role in giving prominence to a case where, in spite of the procedures, that particular women did not believe that she was able to resist the advice she was being given. We must make sure that informed consent and the participation of the patient in the birth plan are far more explicit and certainly on the basis not only of this Committee's Report but of the considerable degree of activity that is being carried forward in the whole question of maternity services. I believe the time has come for a change of emphasis and a change of emphasis which more highly respects the views of the mother and makes fuller use of the role of the midwife.

Sir David Price

1525. I have three quick questions following up the subject of place of birth. First, is there any reliable objective evidence to show that births in peripheral units cost more than those in district general hospitals? Secondly, what is the Department's policy on the contribution that GP maternity units can make to the future provision of maternity care, and on what evidence is it based? Thirdly, in the light of the steady and continuing reduction in the number of such units, do you have a policy concerning their continuing existence, because, of course, if more of them are phased out it will make the choice we are all agreeing on that much harder to fulfil?

(*Mrs Bottomley*) The question of the cost of any unit depends on its occupancy and the use that is made of it, so that if we have a peripheral unit which

[**Sir David Price** *Cont*]
is well-used it will be cost-effective. If we have a peripheral unit such as I had in my own constituency, where for one reason or another women had stopped using the peripheral unit because they wanted to go to the district general hospital, then that unit may be less cost-effective. That is the difficulty.

Chairman

1526. I think you would accept that we may not accept that statement that women wanted to go to the district general hospital. They were directed and probably given no choice.

(*Mrs Bottomley*) Chairman, I entirely accept that the decisions that women make and have made will be largely influenced by those to whom they turn when they are having a baby—their GP and the local midwife—and I entirely accept that if we are talking about a different emphasis then that involves work with the different professional groups who are giving the advice. I have to tell you that when women make those decisions they do not necessarily look to the guidance of the Department of Health and much less to the Minister for Health. They tend to go to the GP whom they know and trust and the local midwife. The question for us is the concern of many of the experts that the safest way for a woman to give birth is in a place where she has access, in the needs of an emergency, to a specialist team. But that is one factor. It is an important factor. Cost-effectiveness is another factor but so is choice and as we make very clear in the letter to the General Medical Services Committee, (perhaps I can give you the reference at another time): "Ideally, GP maternity facilities should be integral or adjacent to consultant units." I have to say I think they should be renamed GP or midwife-led maternity units because I think the significance of the right of admission of the midwife is something we will see develop. "In some localities, however, geographical factors will require the continued availability of GP units distant from the consultant units." That is the position and I would not like the Committee to feel there was a rigid rule from the centre. If I can make one further point of clarification—because I know the Committee has been working very hard on this subject but so also have we in the Department, trying to think how we can better respond to the needs of patients across the range—when the Maternity Service Advisory Committee's reports were written there was, I think, a more centralist style in the Health Service. The style and the ethos of the service that we have established is very much one that we want to be more responsive to local needs and local diversity and local choice.

Sir David Price

1527. There are, of course, I think you would agree, two ways in which one can do this. One, you can have the GP/midwife unit adjacent to the obstetric unit so that you get the best of both worlds, or it can be in an entirely separate location and this is the traditional cottage hospital/community hospital situation. So one does not necessarily preclude the other, but you have not answered my final question—I am sorry I am rattling these out—about how you feel if they go on closing down the peripheral units so that it will not be possible to exercise choice if they do not exist?

(*Mrs Bottomley*) Indeed. Chairman, I hope I addressed Sir David's point. To the extent that there is no hard-and-fast central edict on this question, each case has to be judged on its merits and if there is a proposal for a closure then what we would be looking at is the question of patient care, of cost-effectiveness, of safety and of choice—all those different elements. But if what Sir David or the Committee want me to reinforce is that it is false to allege that because it is a GP unit by definition it must be unsafe, I agree. I think each case must be looked at and a decision made by that local health authority as to how best it can advance patient care in that district.

1528. I wonder whether, to help us evaluate this better, you would feel like supporting a research project in the Bath area, where we discovered in our visit there were more deliveries in GP maternity units there than anywhere else in the country. It would seem it might be worth an in-depth study just to evaluate the pros and cons?

(*Mrs Bottomley*) What I can report to the Committee is that Mr Rick Porter is going to meet with officials from the Department shortly to discuss his work. My understanding is that 30 per cent. of those births take place in GP beds and elsewhere. I am sure there is no justification in a rigid, monolithic blueprint as to how women should give birth. It will be different in different parts of the country. There will be different patterns, and so long as we safeguard the question of safety, cost-effectiveness and, above all, choice, I think we should feel much freer to develop new initiatives. Certainly I think his initiative sounds very interesting. One of the other areas I am interested in is whether the King's Fund with the £6.2 million* they are putting into nursing development units can identify with their initiatives for the following four years whether there are any midwife-led units that would interest them in the future.

Chairman

1529. Before I pass on to Roger Sims, on a point of information only, Minister, how many GP maternity units have you saved when a health authority is applying to close them?

(*Mrs Bottomley*) I am unable to give you that reply but I would be very happy to let you know in writing.

(*Mr Sharpe*) This issue came up before, Chairman, you may recall.

1530. I think some things are worth repeating.

(*Mr Sharpe*) I was offering a few helpful remarks, I recall, in our first session about the arrangements whereby proposals to close units came through the system for final decision by the Secretary of State. On that occasion you asked how many were saved and we promised to go away and find out and we found out and I think we wrote to you, Chairman.

1531. But I would like it on record in an open session. That is why I have asked the question.

(*Mr Sharpe*) The answer, Chairman, was one.

**Note by witness:* This figure should be £3.2 million.

[**Chairman** *Cont*]

1532. I think that puts the whole matter in a proper context.

(*Mrs Bottomley*) Can I come back. I know the question was about GP-led units, peripheral ones, I believe. I simply want to emphasise to the Committee the further consideration I think we should give to the development of midwife-led units within the district general hospitals because, although I made it clear that there is not overwhelming statistical evidence on the question of safety, the fact is that there is a very strong professional belief that women need to have access to the emergency team. I think we can distinguish that from what I also hear, which is a very strong wish for women for the low-tech, non-interventionist, midwife-led birth patterns.

1533. Sometimes they like the more relaxed atmosphere of a smaller peripheral GP maternity unit rather than the tense activity of a district general hospital.

(*Mrs Bottomley*) Indeed.

Chairman: What we are trying to do here is make the point that if choice is to be made available it should be genuine choice and as wide a choice as possible.

Mr Sims

1534. We have received a great deal of evidence, Minister, on the question of shared care and this leads us to believe that this method of sharing antenatal care between GPs and the hospital is not very efficient, is not very effective and does not meet the mother's needs. I wonder if you would care to comment as to whether you share that view, whether you have the same perception from the Department?

(*Mrs Bottomley*) I am concerned if the woman, as I said on the last occasion, feels as though she is at the centre of a demarcation dispute. There is a legitimate role for the GP, who knows the family, knows the family's medical history, for the midwife, who is the expert in birth and can identify difficulties, and for the obstetrician, who is the specialist and the specialist particularly for areas of medical complexity. The way in which those three professionals work together is of great importance and of great importance to the mother's peace of mind because in childbirth of all times the woman needs to feel confident and have peace of mind. I very much hope that the work that is taking place between the Royal Colleges will help achieve a clarification of the way in which shared care can operate most effectively. I have to say to the Committee that I think you have been able to identify areas of concern and areas where it may be important to have further clarification or a change of balance. I do not think it would be right to feel that throughout the country in every case there were such difficulties. There are clearly many units and areas where maternity services are working harmoniously and women feel that they are being very well treated and that shared care is working effectively.

1535. I accept that entirely, but the Minister will understand that it is the concerns we have had brought to our attention which we feel we ought to ventilate. On this particular matter shared care is relatively unusual and it remains one where GPs are paid on an item for service basis. Do you feel that is satisfactory, whether or not the fees involved are really adequate anyhow, and could you tell us to what extent the GP contract might alter?

(*Mrs Bottomley*) I think this is an area where we would want to look at any comments that the Committee made. Perhaps I could hand on to John Sharpe who is particularly involved in this area. We are clearly having discussions with general practitioners on a range of subjects concerning their contracts.

(*Mr Sharpe*) Chairman, when the general practitioners' new contract was being negotiated, one alternative was considered quite briefly and that was a capitation fee for women. At that time this was not an issue behind which there was a strong head of steam. There had been a long consultation period before the GP contract was renegotiated. During that consultation period, amongst many issues that came up about improving the range for general practice, that particular one did not come very high on the list for negotiation with the General Medical Service Committee. We glanced at the issue of capitation, then put it to one side. That was some two or three years ago and, if your Committee were to make recommendations, certainly we would be very happy to look at it again.

Chairman

1536. Could I slip in a quick one here? There is a strong rumour going round that the fundholders are going to be given the power to purchase maternity care. Is that correct?

(*Mrs Bottomley*) There are a number of areas where we are looking at the development of GP fundholding initiatives which have been extremely successful and popular. I think it is too early to give the Committee further information about whether or not that might be an area into which they would move. There are certainly pioneering enthusiastic GP fundholders who have hopes and aspirations of taking over almost every area of health activity.

1537. If that occurred it might prejudice the enhanced role both you and I and this Committee might like to see for the midwives.

(*Mrs Bottomley*) I think that would be one of the aspects which would need to be properly considered before any such plans were introduced. There are a great number of areas which have been tentatively considered, but I cannot report to the Committee that we are within foreseeable distance of introducing such initiatives.

(*Dr Walford*) This was one of the areas that we did consider in a small working group as to the possible development of GP fundholding, but it was concluded that in fact we had yet to bring it to a stage where one could come forward with any formal proposal. In particular, of course, having in mind too what this Committee has been saying to us, we took the view that it really needed much more extensive consultation, much more deep thought on the matter.

1538. And the advice of this Committee?

(*Dr Walford*) We wanted to hear what this Committee thinks about this possibility, which is at the moment simply one option of many that are being considered.

[**Chairman** *Cont*]

(*Mrs Bottomley*) I would like to draw the Committee's attention to the fact that the assumption of the Chairman's remarks is that a fundholding GP would be less likely to value the contribution of a midwife. I do not think that is self-evident. It may be that one of the ways it will become not only less self-evident but less sensitive is if we have better information on costing. When I last appeared at the Committee we talked about the whole question of cost in the relative forms of midwifery care. There are many, many cases where the steps that the women or patients wish to take are actually cost-effective as well as coinciding with choice. What I think, if I may speak on behalf of Mr Edwards, he would want to report to the Committee is that he has announced a research programme in Trent where they are looking at the costing of different forms of care for maternity services. I do think it will help people make rational decisions where they are not assuming aspects about different forms of delivery which are not substantiated by the facts. That is apart from the commitment which I also gave last time I came to the Committee of asking our team at Brighton, who are looking at different forms of team midwifery to see if they could give further advice on costing.

Chairman: I think the matter of appropriate costings is one of the reasons why this Committee and certain members of it are expressing constructive concerns about the rapid rate at which the reforms were progressing. You have actually in a way, I think, supported some of the views this Committee expressed.

Audrey Wise

1539. There is one proposal which has found favour with certainly some midwives, which is that women should have direct access to a midwife as the first port of call, as it were, when they become pregnant. Now, GP fundholders purchase of maternity care would certainly, I feel, pre-empt that and I would think inhibit that. Has there been any consideration in depth about direct access and will you make sure that you look at it before making any decision about fundholders?

(*Mrs Bottomley*) There has not yet been any consideration and I think I can safely say we would look at it before making any decisions on fundholders.

1540. Are you saying then that there has definitely been no decision made on the extension to fundholders of this right?

(*Mrs Bottomley*) I am considering the extent to which this is a "don't rule out" and "don't rule in" stage. I can assure the Committee no decisions have been made to extend fundholding to maternity services, but I am tentative about doing that because the Chairman might ask me about all sorts of other areas.

Chairman

1541. I do not intend to today.

(*Mrs Bottomley*) I would not like the Committee to think that when one is thinking of the future of fundholding I do not accept the presumption that it would necessarily be antipathetic to the interests of all midwives. I think I have made my position very clear on that.

Mr Hinchliffe

1542. We have heard during the course of our inquiries a number of references to the discussions that have been under way between the Royal College of Midwives, the Royal College of Gynaecologists and the Royal College of General Practitioners on the organisation of maternity care but we understand there have been some difficulties with this dialogue; it has run into some problems at the present time. We wondered whether you had considered in the Department the possibility of the Department offering a forum and basis for this dialogue towards the establishment of appropriate protocols for maternity services?

(*Mrs Bottomley*) The Department strongly support the progress being made by the Royal Colleges and hope they will reach a constructive conclusion. Clearly we have had informal discussions with the Colleges and are in regular contact with them. I have seen the Presidents of the Royal Colleges in the last three months, for example, and I am confident that they will come to a satisfactory conclusion. These are areas about which people feel very strongly; the different professional groups feel very strongly and the mothers feel very strongly. I think it is too early yet to feel any anxiety that they will not reach a constructive conclusion but there are sincerely held views from all the parties.

Chairman: Several months. That is only a brief time for discussions to be going on.

Audrey Wise

1543. Minister, in an earlier answer I understood you to say that midwives can have rights of admission to hospital, their own rights of admission. I find this puzzling in view of the fact that one of the requests which has been made by the Royal College of Midwives is that they should indeed have admission rights to NHS hospitals so that a woman can choose to combine midwife only care with a hospital confinement. My first question is, do they or do they not have this right, and my second question is, if they have this right, why has not somebody told the Royal College of Midwives?

(*Mrs Bottomley*) Mrs Wise, if I may I will give you a copy of the letter I wrote to Miss Ashton in October on precisely this matter, which makes it clear that the responsibility for admitting patients rests with the district health authority but that can be delegated to a midwife or a midwife-run unit and, indeed, we have examples at the Royal Berkshire Hospital at Reading, in Scotland (since we now know more about Scotland as our Chief Medical Officer came from Scotland) at the Aberdeen maternity unit. I think there are a number of others, but it is the case that the rights lie with the district health authority who can then delegate them. Indeed, in the vast majority of cases in the past it has been delegated to the consultant, but the Department has no objection at all to midwives having admitting rights, and I think Mrs Wise will see by the tone of my response that it seems that there are strong arguments in favour of exactly such units developing.

[**Audrey Wise** *Cont*]

1544. So does that mean that the Department has informed or will actually inform those responsible of its views that this is a desirable thing?

(*Mrs Bottomley*) Chairman, as I say, I have written to the General Secretary of the Royal College of Midwives making the position clear. I think when we consider the report of the Committee, if there are areas where clarification of existing arrangements needs to be made then we will certainly do so.

1545. Yes, but existing arrangements are all too clear in the overwhelming majority places and that is that beds are regarded as belonging to specific consultants and they decide who should be admitted and when and why and everything. So in view of that, do you not feel, Minister, that there should be some more positive action taken to make it quite clear what the Department's view is and that should not be left to the initiative of the Royal College surely?

(*Mrs Bottomley*) I will try and be brief if the Members of the Committee will try and be brief. Mrs Wise will know that, indeed, the whole development of the reforms in the Health Service are involving a rather different look at the way in which beds are used and the occupancy of beds, and there is quite a lot of discussion on precisely these subjects within hospitals. I think I can do no more than make the policy clear. It is the district health authority who have the rights and they delegate them then to whichever professional group or official they so deem.

1546. If a midwife wished to admit a woman to a particular hospital, could she do it? What would your attitude be if she appealed to you for help?

(*Mrs Bottomley*) At the moment it is the responsibility of the district health authority or trust and they will have their arrangements for admissions. Mrs Wise is entirely correct that the tradition in the service has been in the overwhelming majority of cases that it is the consultant who has the lead responsibility for admitting to hospital beds. I have identified a number of units where it is the midwives who hold that right. They do so not by edict from the Department of Health; they do so because they have arranged that in the local district, and it is a model which I think has merit. On considering the report from the Committee, and if it would be helpful for the Department to emphasise that position then we would happily do so.

Chairman: Excellent.

1547. We were pleased to hear of the Department's commissioning of the Mapping Team Midwifery Study. However, there are relatively few examples of such schemes and they do vary, as I believe the Minister herself said to us on a previous visit. Before that study appears will the Department be prepared to fund the establishment of further pilot schemes to enable their effectiveness to be fully explored? I should say we have some evidence that the provision of pump-priming money can make all the difference to the establishment of a Team Midwifery scheme.

(*Mrs Bottomley*) Chairman, I think what I have referred to is the work of the King's Fund and the Nursing Development Unit and the £6.2 million they have to fund 30 projects over the year* and it may be they would be able to respond to some such scheme.

1548. The 30 new projects, I understood that was nursing development?

(*Mrs Bottomley*) Nursing, health visiting, midwifery.

1549. Yes, so it is not 30 which would be available for this. We do not know. Is the emphasis being put on nursing?

(*Mrs Bottomley*) It is a matter for the team involved to consider which are the sort of developments they would hope to fund.

(*Miss Greenwood*) Could I say that I think Mrs Wise is interpreting the title, Mapping Team Midwifery, too narrowly. What the questionnaire will say—and it will go out to every head midwife in England and Wales—is: "What do you consider is being provided in the name of continuity of care?" so it is whatever that maternity unit thinks is their team scheme and "team" should really perhaps be in inverted commas. I hope that will explain things because we hope to have some sort of positive answer from each health authority, even though they may not call it a team scheme.

1550. To take a different point now, one of the issues concerning choice which has emerged in our evidence is the matter of how long women should remain in hospital after giving birth. Some women are very anxious to be discharged very early but some are not and there are circumstances in which it would be very helpful to a woman to be able to stay a bit longer in hospital. Does the Department have a policy about this, has it given any advice and to what extent are the woman's own wishes about length of stay respected?

(*Mrs Bottomley*) What I am fumbling for is the Patient's Charter because in the Patient's Charter Standard No. 9 says: "Before you are discharged from hospital a decision should be made about any continuing health or social needs you may have before you are discharged from hospital," so that is part of the Patient's Charter. Clearly there is a balance to be struck because hospital beds are primarily there for treating people who need medical attention but at the time of child birth—again I think I would be very sympathetic to the point that Mrs Wise is making—where medical, social and emotional needs very much tend to coincide, sending a woman home when she is ready to go home is obviously very important. Sending her home when she is not ready to go home can clearly have adverse effects, not only on her but the baby as well. So I hope that the commitment in the Patient's Charter and the guidance generally will make that clear—that, of course, together with the work that Mr Edwards has been carrying forward of ensuring that we listen to what patients want. Without being too personal, if I can say this, when I was a lady who gave birth in Lambeth, nobody ever asked me what I thought of the service, what I wanted of the service or what my experience was in the service. I believe there are now, with the focus groups and many other mechanisms, actually ways of saying to people, what was your

**Note by witness:* The current figures are £3.2 million . . . over the next four years.

[**Audrey Wise** *Cont*]
experience, what do you want, how could we improve it?

Chairman

1551. Before I pass the questioning to Andrew Rowe, I have a very small but I think important point. Do you not think that lying-in beds could well be provided in peripheral hospitals? For instance, Mr Porter in Wiltshire for whom we have a very high regard we met while on a visit organised through him and saw people who had come from the Bath General Hospital back to a peripheral hospital for a two or three day period of lying-in which was required and is very popular and can be very therapeutic and beneficial to a number of women who have given birth.

(*Mrs Bottomley*) Chairman, you are identifying the great range of women's wishes and desires. I was able to speak briefly before I came in to women who had given birth at home. You are now describing women who wish to stay in hospital longer. Overall the bed occupancy has improved and stay in hospital has come right down, but the advice has to be that we should not have hard and fast and rigid rules.

Mr Rowe

1552. Minister, to turn to the difficult question about the number of obstetricians required, some of our witnesses have said that if we have any more they will interfere more and the obstetricians themselves have said they are grossly overworked. You told us in December that the RCOG are in general content with the Joint Planning Advisory Committee's target for senior registrars and registrars but would consider a request for review. What criteria will you apply to determining whether the Royal College's claims are justifiable?

(*Mrs Bottomley*) It is up for review in November 1992. As Mr Rowe knows, there has been a very dramatic increase in obstetricians and gynaecologists. I have to say at risk of being thought to be sexist I do think one of the particularly welcome areas is the increase in women obstetricians and gynaecologists. We only have 12 per cent of consultants who are women at the moment. In the last three years for which I have figures there has been a 19 per cent increase in the number of consultants overall, which is not good enough, but, more encouraging, a 64½ per cent increase in senior registrars. I do believe, although this is no part of JPAC's consideration when they approve places, when we are thinking about women and their choice in these matters that more women consultants would be very popular and well received. We have also announced additional consultants as a result of the junior hospital doctor hours arrangements.

1553. The implication of your reply is the more the merrier, and I think that we are wondering whether in fact you would be prepared to look at whether obstetricians are currently being used appropriately. Will you listen to the arguments we have heard which suggest there are at least enough, if not too many, already?

(*Mrs Bottomley*) I am sure there are a great number of obstetricians' and gynaecologists' tasks to undertake. The tasks they undertake do not need to be ones for which there are other professionals who are admirably trained and competent to undertake. We should consider the whole of the infertility service and a great number of gynaecological conditions. There are complex questions about manpower numbers, but what I want to see, as I said, is each professional working to the maximum of their ability rather than the minimum of their ability. May I hand over to Dr Modle?

(*Dr Modle*) The last report of the inquiry into maternity deaths pointed to avoidable factors which included the availability, or rather lack of it, of consultants to deal with difficult labour ward problems. I think that is a factor to be remembered in considering this matter.

1554. It has been estimated that the cost of meeting the recent Pay Review Body's recommendations on out-of-hours pay will be between £1 million and £2 million next year for obstetrics and gynaecology alone. Will this be met by additional Treasury funding or will maternity services have to find the money from current budgets?

(*Mrs Bottomley*) There have been considerable extra resources put in as a result of the new arrangements on junior hospital doctor hours, not only the additional new 350 consultants and 150 staff grade appointments being made to help tackle that particular question. We have a task force in every region seeing how they can meet those needs of that particular area: it is too early to be able to respond to that figure with any sensible authority.

1555. If you do actually realise the reduction of junior doctor working hours to 72 hours a week for obstetric staff, how are you proposing to provide adequate resident medical cover without a large increase in staff or the closure of many small maternity units?

(*Mrs Bottomley*) It is an interesting question because it could develop in a number of ways. Because of the new junior hospital doctor hours question, there is no reason why you should not see a development, or it is arguable that much of the medical cover could indeed take place by GPs if that was the way it developed in some parts of the country. You would then have an obstetric team in the district general hospital. I just simply do not feel we are yet at a stage where I can make any informed comment about the way in which that would develop, except in so far as to say this: I am not sure whether Mr Rowe's concern is that the direction in which this Committee has been arguing maternity services should develop might be adversely affected. I do not believe the sort of initiative we have been describing in terms of the development of maternity services will be adversely affected by the very important new deal of junior hospital doctor hours.

Mr Sims

1556. We had some rather disturbing evidence about increasing concern that obstetricians might be practising what is known as "defensive medicine". I wonder whether you could tell us, Minister, whether you have any fears that this is producing a defensive approach to obstetric care. We have been told that some 85 per cent of consultant obstetricians have been sued at least once. Whether this is true or not I

[**Mr Sims** *Cont*]
do not know, but is this an area on which the Department has done any research? Have you been able to establish the causes?

(*Mrs Bottomley*) Work is being undertaken in consultation with the Royal Colleges about the whole question of what is called defensive medicine. There are sometimes cases in which "defensive medicine" means the clinicians are being absolutely sure they have taken proper professional responsibility for their patients; it need not be a negative matter. If, on the other hand, it means women are subject to intervention and tests, assessments which are unnecessary, then that clearly is unsatisfactory for the woman and, frankly, unsatisfactory in terms of the use of Health Service resources. I think one just wants to get that balance right. In maternity services when the term defensive medicine is used, it is sometimes confused with excessive intervention. So the use of epidurals or episiotomies and various other steps is not necessarily defensive medicine; it is just what some women or another professional would regard such practices as unnecessary intervention. So I think when it comes to the question of defensive medicine one wants to stand back and try to identify the different elements involved. When Mr Sims refers to the concern about litigation, I think that is a genuine concern for all involved in the development of health care in this country. As you know, the Secretary of State recently issued a consultation document on how we could help with the question of arbitration for medical negligence, but I fear this is a matter which will be of concern to health professionals, politicians and managers for many years ahead.

1557. That is a rather wider issue but I think there is a suggestion in some quarters that the difficulty of having complaints adequately dealt with perhaps leads to this situation?

(*Mrs Bottomley*) Although we have heard the concern I do not think we have clear evidence on that front.

Mr Sims: I do not think I can pursue that further at this stage.

Chairman

1558. Professor Hull, President of the British Paediatric Association has expressed a view, going back to the question Andrew Rowe put to you about a review of the junior hospital doctors' hours, that this could cause grave problems in the area for which he is responsible. I understand he believes that the number of paediatricians might have to double if a satisfactory service is to be provided. Would you agree with his assessment?

(*Mrs Bottomley*) Again it is too early at present to say precisely for the different specialties what the implications will be but I can say that of the early appointments that were made, of the 200 consultant posts in 1991/92 40 posts were allocated to paediatrics, which is a very substantial number. There is no doubt in our work on junior hospital doctors' hours, the groups who feel the greatest pressure are neonatal paediatrics, obstetrics and gynaecology and accident and emergency. When we talk about moving to a shift system of working rather than an on-call arrangement, those are the groups that we must first consider because they are overwhelmingly the ones who are still working what I regard as unacceptable hours. They are coming down but those are the groups and the task forces who are responsible for allocating these new posts (and a very sizeable amount of money has been put into tackling this priority area) are well aware of that.

1559. But clearly you take Professor Hull's concern very seriously?

(*Mrs Bottomley*) His concern. I could not with authority confirm his figures.

(*Dr Walford*) We have a very specific working party exactly looking at the problem of paediatric manpower, not simply in relation to junior doctors' hours but because even before the junior doctors' hours initiative we were conscious of the fact that we needed to re-examine the paediatric manpower position.

Audrey Wise

1560. We have had a lot of evidence, Minister, which causes us concern in relation to statistics. Some of the evidence came, in fact, from the National Perinatal Epidemiology Unit to which you yourself have referred, so can I ask you some specific questions about this. The Maternity Hospital Episode System, according to a reply to a Parliamentary Question from Dafydd Wigley last June, showed that the HES contained records for only about 55 per cent. of deliveries in England in 1989-90, and a subsequent reply to a Parliamentary Question asking for the same information for 1990-91 in December said that the relevant data files were not yet ready. Can you give us any preliminary indication as to whether there has been any increase in the proportion of deliveries covered in the Maternity Hospital Episode System?

(*Mrs Bottomley*) Chairman, I am in very great difficulties because I think the Committee understands I have to leave at five and I have a considerable difficulty. What I wondered was whether Mrs Wise would be happy for me to reply to her in writing or for Mr Sharpe to answer after I have gone. On statistics, the question at issue is that we all recognise that there have been teething problems in the early introduction of the information systems. It is a complex question. We need to improve the quality of the information that we have available and I shall hand over to Mr Sharpe if you would like him to address it now.

Audrey Wise: I am sure we would be quite pleased to have something in writing but not, of course, to me. I am not asking, as you will understand, Minister, as an individual but on behalf of the Committee. If Mr Sharpe has the information it would be quicker and neater to get that now.

Chairman

1561. Minister, I accept the restraints which you have. We were aware that you wished to get away just after five o'clock. I believe that the statistical questions we would wish to put could be dealt with by your or your Department by way of written answer to us but I would like to give my colleagues a chance, because I know Sir David particularly wanted to deal with matters relating to disability and follow-up, and ask whether there is any particular

[**Chairman** *Cont*]

brief question you would like to put to the Minister before she goes. I think other than that we do have, of course, a problem with our next witnesses. I think those that have come with them have been extremely patient!

(*Mrs Bottomley*) It is staggering, is it not? It says a lot for their GP, I understand.

1562. I think it says a lot for the mothers but that is by the by. Minister, can I then thank you very much indeed for coming. This was a much longer session than we anticipated. You can see it generates a great deal of interest. We will submit the remaining questions we wish to put to you for your written answer or the answer of your staff and obviously the sooner you can get those answers to us the better, but can I thank you and your staff very much for the time you have given us and the very helpful answers you have given to some perhaps quite difficult and controversial questions. Thank you very much indeed.

(*Mrs Bottomley*) Chairman, thank you very much indeed. We look forward to the report because, as I say, I think that it is time for a change of emphasis in the work of the Maternity Services. There is a great deal of activity at the moment and we look forward to the report.

Chairman: Minister, you look forward to our Report; we look forward with even greater anticipation to the governmental response.

Memorandum submitted by the Department of Health

The Committee requested further information on the following points:

1. HOSPITAL EPISODE SYSTEM

(a) *The Department's reply in its supplementary memorandum in December (Question 9) gave preliminary figures for Maternity HES coverage. Is there now any firmer evidence as to whether there has been any increase in the proportion of deliveries covered in maternity HES for 1990-1?*

Department's response to 1(a):

The indications are that for 1990-91 about 70 per cent of birth episodes and 60 per cent of delivery episodes will be covered. This is an improvement on 1989-90. The latest information shows that missing records are concentrated largely in two regions. If these two regions are excluded, the indications are that nearly 90 per cent of birth records and over 70 per cent of delivery episodes will have been collected for the rest of the regions. The Management Executive is in touch with the two regions in question to ensure improved compliance with the needs of the HES system. Until the data are processed, and examined in depth, it will not be possible to comment on the quality and completeness of the records.

(b) *Of the hospitals which did not contribute data to Maternity HES in 1989-90, how many (a) had the relevant items on local computer systems, but were unable to output data records in a format which could be fed into Maternity HES and (b) did not specifically collect the data items in the Korner minimum data set?*

Department's response to 1(b):

The Hospital Episode Statistics do not provide maternity data by unit. The lowest level of aggregation available is by individual District Health Authority. The Management Executive is aware of data deficiencies by district and is pursuing the individual problems with the appropriate regions during the course of regular monitoring meetings. The Management Executive is not aware of any inability to collect the required data at unit level. The problems identified are with the transmission of the data to district and regional information systems to provide centrally required data. These problems have been addressed and improvements achieved.

(c) *What are the specific steps that the NHS Management Executive have taken to improve the coverage of Maternity HES referred to in your answer to Question 9(c) of your December supplementary memorandum? Will it impose any sanctions against hospitals which do not contribute data?*

Department's response to 1(c):

The Management Executive has identified the need for further action in improving coverage of maternity HES. It will bring deficiencies to the attention of regions and continue to press for improvement. This is a priority issue in discussion between the Management Executive and Regional Directors of Information. Pressure to improve the quality of data will be further assisted by the needs of purchaser authorities to have adequate information to support contracting.

---

2. INFORMATION SYSTEMS IN GENERAL AND THE NHS INFORMATION STRATEGY

(a) *What consideration is being given to maternity information systems in discussions about the proposed NHS Information Strategy as announced in an answer to a PQ on 21 November, col. 314?*

Department's response to 2(a):

The discussions referred to in the answer to Mr Cook's parliamentary question are concerned with strategic issues and not with specific operational needs. As regards maternity services, as in other areas, it is for local NHS Authorities and Units to decide what information systems they need to help them maintain and improve the quality of care offered to their residents and patients. In support of work at the local level consideration is being given, through the NHS Management Executive sponsored Hospital Information Support System (HISS) initiative, to the options of integrating hospital departmental information systems including maternity systems.

(b) *Is there any quality assurance being done to ensure that one-off systems written for individual Trusts will collect the data to be contributed to national systems in a consistent way?*

Department's response to 2(b):

The Department, in consultation with the NHS, defines what national information is needed and in what format it should be provided. NHS Authorities and Units must then work with suppliers to ensure that the systems developed meet these requirements and local operational needs.

The appearance of NHS Trusts has not affected the situation. At present Trusts are largely still using systems developed by regional health authorities or major national suppliers who are fully conversant with the standards required.

---

3. CONFIDENTIAL ENQUIRY INTO STILLBIRTHS AND DEATHS IN INFANCY

(a) *What pilot studies is the Department doing to test the enquiry method before the confidential enquiry into stillbirths and infant deaths itself starts?*

Department's response to 3(a):

Before the Confidential Enquiry was announced in July 1991, the mechanisms necessary to enable work to be carried forward were the subject of study by a working group set up by the Chief Medical Officer. The working group considered all the evidence and experience available based on work already done in the field. The working group did not recommend pilot studies. It is for the National Advisory Body, which will be guiding the Enquiry, to decide whether any aspects of the enquiry method required further testing on a pilot basis.

(b) *In the absence of relevant data items for all births from maternity HES, what denominator data does the Department intend to use for these?*

Department's response to 3(b):

The National Advisory Body will advise Ministers on the data required for each category of deaths to be subject to confidential enquiry. It is not expected that problems with HES data will adversely affect the Confidential Enquiry.

---

4. THE RISE IN THE RATE OF TRIPLET AND HIGHER ORDER BIRTHS

What data are being collected to monitor trends in the use of ovarian stimulants and assisted conception to evaluate the implications for the provision of neonatal special and intensive care? In particular what data are being collected about the use of (a) in-vitro fertilisation, (b) gamete intra-fallopean transfer and related procedures?

Department's response:

The Human Fertilisation and Embryology Authority (HFEA) will be collecting data in order to monitor in vitro fertilisation, artificial insemination by donor, and GIFT using donor gametes. This will include information about the use of ovarian stimulant drugs in these procedures and about multiple births which may result from them.

Multiple births above three babies as a result of GIFT or IVF are much less likely. The HFEA issued a Code of Practice in July 1991 in which the Authority stipulated that "No more than three eggs or embryos should be placed in a woman in any one cycle, regardless of the procedure used." The HFEA will be monitoring this policy.

---

5. Disability and Follow-up of Very Low Birthweight Babies

(a) *Does the Department of Health plan to support the existing cerebral palsy registers and to encourage the development and ongoing maintainance of cerebral palsy registers in other health regions?*

(b) *What has the Department done to encourage efforts to improve and standardise the information collected on the Child Health computer system so that reliable data on disability will be readily available.*

(c) *Will the Department support alternative ways of collecting information on childhood disability, for example by sample surveys carried out at regular intervals?*

Department's response to 5(a), 5(b) and 5(c):

The Department is to discuss the future of cerebral palsy registers with representatives of the Spastics Society including Professor Eva Alberman, Chair of their Epidemiology Panel, at a meeting in early February 1992. Children of very low birthweight are one group who are at increased risk of subsequent disability, particularly cerebral palsy.

One of the issues we will wish to explore is whether the requirements under the Children Act 1989 for the identification of children in need and the maintenance of a register of children with disabilities might provide for more effective surveillance of such children.

Health authorities are required to collaborate with local authorities in assessing children in need. We agree that the Child Health System, which provides for computerised records to be maintained of the growth and development of all children within a district, can make a major contribution here. The system is now in use in 70 per cent of districts and the Department is supporting the extension of its use to meet health authorities' duties under the Children Act.

6(a) *Can the Department confirm that in its memorandum printed with evidence for 3 July (pages 186–7) and in answers to PQs (10 June, col 446, 21 June, col 324, 25 July, col 911) the Department showed that data provided to the Committee were based on only 55 per cent of births in England in 1989–90 and could not be used to produce tabulations for regions, or for districts. What was the coverage in 1990–91?*

Department's response:

The Department can confirm that data provided to the Committee were based on 55 per cent of births in England in 1989–90. Regional analyses of estimated percentages of some key data items have now been produced where possible and are attached (Annex H). It is too early to make a precise assessment of maternity

HES coverage in 1990–91, but indications are that about 70 per cent of birth episodes and 60 per cent of delivery episodes will be covered. Until the data are finalised, processed, and examined in depth, it will not be possible to comment on the quality and completeness of the data in these records.

(b) *What has coverage been since April 1991? Has there been any problem in getting data from trusts?*

Department's response:

It is too early to be able to assess the coverage since April 1991. Arrangements have been made for NHS Trusts to continue to submit HES data through the Regions in which they are located until April 1993 and there is no evidence of any specific problems with this arrangement. From 1993, data will be gathered through purchasers covering patients treated in both Trusts and other management units.

(c) *What has the Department been doing to improve coverage and what have been the results?*

Department's response:

The NHS Management Executive monitors the data provided by Regional Health Authorities and regularly meets with Regional Directors of Information to discuss the quality of the data. The difficulties surrounding the completeness of maternity data have been identified as a priority. This initiative has resulted in real improvements in most regions. Work has now been successfully completed in the area on linking maternity to other systems and an improvement will be evident when 1991–92 data are available.

Letter to Mr David Hinchliffe MP from Ms Ruth Unwin

As requested I write with details of my difficulty in obtaining a home confinement for the birth of my second baby.

When I had my first child two years ago, I was happy to accept the advice of my GP and community midwife to opt for a hospital confinement.

The labour and birth were both quick and straightforward but the experience was marred by the fact that I felt I had been bullied into having both an enema and pethidine. By the time the baby was born, I was so numbed by the drugs that I was barely able to appreciate it. The only good thing about the delivery was that, as the staff were so busy delivering 5 other babies the same night, my husband and I were left alone with the baby for over an hour after the birth.

Although I have nothing but praise for my treatment by staff on the post natal ward, I found the rigidity of hospital routine an intrusion into what should have been a very natural process: restrictive visiting hours which demoted the father to the role of spectator rather than a participant in the whole event and the strict adherence to meal times which made demand feeding the baby near impossible—I was frequently made to eat meals whilst listening to mine and other babies screaming to be fed. I also woke on two occasions to find the baby had been taken from my bedside to the nursery whilst I was asleep—somewhat alarming considering this happened less than a week after the abduction of the Griffiths baby.

Shortly afterwards my community midwife was relating to me the joy of delivering her niece's baby at home and said she would recommend me for a home delivery next time.

It was for these reasons primarily that I was so keen to have my second baby at home. I felt the whole process should be as natural as possible and wanted my son to be able to share to some degree the experience of birth. I also wanted to feel more in control of the situation rather than being a component in a production line.

However, when I requested a home delivery at my first ante-natal visit, my GP said the practice, New Southgate surgery, could no longer offer this service because none of the doctors—at least three of whom have been practising for over 20 years—felt they had the necessary expertise to provide cover. My GP, Dr Wroe, told me in theory I had the right to approach another doctor for ante-natal care but this would probably mean going outside the district because he knew of no other practice locally which would provide cover and because the two consultant obstetricians dealing with midwifery services did not favour home confinements. Going outside the area was not really a feasible option because I was having to take time off work for ante-natal checks. There was also the added risk that because my first labour had progressed so quickly—just under 3 hours—a GP and midwife from outside the area might not have reached me in time. This was yet another reason why I had not wanted a hospital delivery.

My GP also said one of the reasons GPs generally were moving away from home confinments was the fear of litigation should anything go wrong. I did offer to sign a statement accepting responsibility but he would not accept this.

Eventually I was persuaded to opt for a hospital confinement on condition I could go home the same day—a service not normally offered by Manygates because the hospital has no GP unit. My community midwife then advised me to draw up a care plan indicating I wanted minimum medical intervention and no drugs and my GP wrote to Manygates supporting this and stating that I would have preferred a home confinement.

In the event I went into labour at about 1 am and arrived at Manygates about 2 am, after a hectic rush to get someone to look after my son and someone else to take me to hospital (my husband was working away at the time). This time I retained almost total control over the management of my labour by refusing any drugs or other unnecessary intervention and the baby was born within half an hour of my admission to hospital.

I was admitted to the post natal ward for a short time, where the staff clearly felt threatened by my wish to go home and made every effort to treat me like an invalid—including offering me a wheelchair to go to the toilet although I felt perfectly well.

Finally, I managed to persuade them to discharge me and was home by 11 am.

I am convinced that my early return home and familiar surroundings had enormous benefits both physically and mentally. The baby was very rapidly absorbed into the family and routines were re-established much more quickly—something I felt was tremendously important for the older child. I also had the support of a community midwife with whom I had built up a relationship over nine months, who respected my opinions as I did hers, instead of being patronised and dictated to by staff to whom I was just one in a long line of new mums.

I appreciate that not everyone has either the blissfully easy birth or the kind of support which I had and it is important that hospitals are there for those who want or need the reassurance they offer but I feel very strongly that home births should be treated as a viable option.

I'm sorry this has been so long winded but you must appreciate I make my living out of making a little go a long way.

Thanks for your concern and I do hope your efforts will prove successful—though it's unlikely I shall be benefiting myself!

Letter to Mr David Hinchliffe MP from the Minister for Health

Thank you for your letter of 3 December enclosing one from Ms Ruth Unwin about the difficulties she experienced in obtaining a home birth. I am sorry you have not received a reply before now.

It is the Government's policy to encourage women to give birth in a hospital unit, where there is a range of supporting services available to cope with an emergency. But that does not mean that we wish to deny women the choice of home birth if they prefer it, and if no problems are anticipated. Women are encouraged to discuss the options for place of delivery with their GP and midwife. Not all GPs offer home confinements to patients on their list, and they are not obliged to do so. The decision is a clinical one and rests with the practice concerned. However, it is open to a woman to change her GP if she so wishes. Her local Family Health Services Authority (FHSA) will be able to provide a list of those GPs and practices who can offer home confinements. If a women is unable to find a GP who is willing to offer her a home confinement, she can still choose to deliver her baby at home under the care of a midwife.

Wakefield Health Authority's maternity services policy includes home delivery as an option, if the GP is on the obstetric list and is willing to offer the service. I understand that four GP practices within Ms Unwin's own area, and more than a third of the GPs within the larger area covered by Wakefield FHSA are willing to offer the service. The Health Authority will make arrangements for midwife-only care if a woman is unable to find a GP, and insists on a home birth. In such cases, two midwives will attend the delivery. In Wakefield there were 36 home deliveries in 1990–91, and from April 1991 to December 1991 there had been 31 so far. It is indeed unfortunate for Ms Unwin that her own GP could not offer a home confinement, and that she was not aware of the alternatives.

I have sought the views of Wakefield Health Authority on the points made by Ms Unwin about the care she received at Manygates Hospital. The Authority is keen to address any criticisms so that it can improve services, and is therefore grateful to Ms Unwin for her comments.

There are obviously some routines which need to be in place in a hospital setting, although I am assured that at Manygates they try to keep these to a minimum. The hospital is hoping to move towards open visiting for partners, and is considering the possibility of staggering mealtimes to be more flexible for feeding mothers. Wakefield's policy is to allow early transfer home where it is appropriate. The earliest transfer time is six hours and women who want to take advantage of this can do so. It is very good that Ms Unwin felt so well after her son was born. This is obviously not always the case and new mothers at Manygates are offered every care—including the use of a wheelchair. I understand that the hospital's staff regret that Ms Unwin found this offensive. They also regret that Ms Unwin felt she was patronised and dictated to. This was not intended.

In 1989 Wakefield Health Authority carried out some consumer research on its maternity services, and has acted on this. It proposes to carry out further research in the near future, to discover how mothers feel about

the services which are already available, what they need and how services can be improved. I hope this will reassure you and Ms Unwin that Wakefield is doing all it can to respond to the needs and wishes of women in the planning and purchasing of its maternity services.

January 1992

Examination of Witnesses

MS LINDA GARTLAND, MS DEBORAH HEDDERWICK, MS CRESSIDA NASH, MS HELEN ROBINSON, MS RUTH UNWIN, MR PATRICK TURNER and MR DAVID JOHNSTONE, Examined.

Chairman

1563. May I welcome our second group of witnesses. Perhaps as we come to the end of taking formal evidence into maternity services it is very appropriate that we should have women coming before us who have very recently given birth so that they can tell us first-hand of their experience and what they would like to see the maternity services provide in this country, where they are critical of them, where they are, as it were, praising them, and also why, in the cases of the witnesses that we have in front of us today, you chose to have a home delivery. We are very interested because our report would be incomplete without the sort of evidence and views which I have no doubt you are going to explain to us and put to us today. I am not saying there is any one of you who is the spokesperson for the group in front of us but shall we start with the one who has been mentioned, Ruth Unwin from Wakefield in Yorkshire. Could you tell us of your experience, your views of maternity services as you have experienced them yourself?

(*Ms Unwin*) I think the Members of the Committee have all had the letter which I sent to David, which outlines mainly why I wanted a home delivery for my second baby. When I had my first baby I was advised to have the baby in hospital. I was quite happy to do that because I did not know what to expect at all, but after the experience of being in hospital the first time I felt I would like to have a home delivery for the second one, primarily because going into hospital meant my husband was restricted to visiting hours and so could not come to see me so much and could not participate in the event of the birth so much. I also was unhappy about the way the staff had intervened when I was trying to get used to my new baby—things like taking the baby off to the nursery in the morning while I was having breakfast, that sort of thing. There were also certain things about hospital routine which I felt were restrictive; in particular the fact that, regardless of whether the baby wanted feeding, I had to take my meals at a particular time—the baby could be screaming for his meal and I could not take it with me and feed it, he had to be left in his bed. Those were the main reasons I wanted to have a home birth when I found I was pregnant the second time. I spoke to my GP who was, as David has said, my GP since I was a child and he immediately referred me for maternity services at the hospital and I remember the kind of stunned silence when I said actually I wanted a home delivery. He said, "Well, really our practice is no longer able to offer that. We don't feel the doctors have the experience to offer it".

1564. At that stage did he talk about the role of midwives at all?

(*Ms Unwin*) My midwife was there as well because I actually booked in for an antenatal visit and the midwife who was there had seen me through my antenatal care prior to the delivery of our first child. After he was born she said she would recommend me for home delivery but, as the midwife attached to the practice, she then had to change her stance so that she now as a community midwife does not actually deliver babies unless they are registered with the GP of another practice. So she goes in as a support midwife but does not deliver babies herself. I do not think, talking to her after the baby was born, that she was entirely happy about that but the situation is, as the midwife attached to that practice, that is what happens to her. So I had quite a lot of lengthy discussions at many visits with my doctor and midwife about this. The midwife said the only thing she could advise was either that I book into hospital for the minimum time, which is six hours, or "if you want to take the risk completely upon yourself you can wait until you know the baby is coming, ring for an ambulance and midwife, and that way you will get a home delivery". Obviously that was not satisfactory. I was in the event on my own when I went into labour because my husband was working away. We could not have done that. We had several discussions about the situation and said to my doctor I was going to write to the Family Health Service Authority in my area. He said there was not a GP within our district who would offer home delivery to a woman who was not already registered with the practice. Virginia Bottomley said in her reply that there are some GPs who offer the service to people already registered with them and I know that Stanley Health Centre, my local health centre, has done about 4 deliveries within the last year but only to people already registered with them. I did not want to change my doctor because I had been with that doctor for a long time and I could have gone to another doctor simply for that service; but that option is not open to you because no GP will take you on as a new patient. Whether there is home delivery in an area depends on the attitude of the consultants because I understand they have to authorise a patient transferring to another GP for maternity services only. I think that just about really sums up my situation. There were a few things I wanted to raise on Virginia Bottomley's replies.

1565. Can I give the other mums an opportunity to come in, then by all means do come back. I hope each and every one of you will say what you would like to see the maternity services in this country offer you.

(*Ms Hedderwick*) I had two different experiences with my eldest child and this baby. Both times I had opted for a home delivery and the first time I had a labour that was very prolonged and needed transfer to hospital, which happened practically, if not

[**Chairman** *Cont*]
emotionally, very smoothly, and she was born in hospital. That experience of the hospital really bore out the reasons why I had chosen to have a home birth and why I chose the second time to have a home birth. There were three main reasons. The first was to do with the atmosphere of home. I think birth is a very intimate family occasion and I felt that the family atmosphere and home atmosphere would be the right place to be born. I would be at my most relaxed there, it was better for me and my baby, and I would just be more in control of the situation. This was particularly not only during labour but in the time after the baby was born when we would have a chance to relax as a family with the new baby, my husband would be there, and we did find this very difficult in the hospital the first time. The first baby was born very late at night and the hospital staff were very keen to get me cleaned up and down into the ward and in bed. There was no provision for my husband to stay that night when I had just been through two days of labour. It was a very emotional experience and he was going to have to go home. In the end, because we stuck our necks out, he was allowed to stay that night, but unless we had really gone for that quite forcefully that would not have been the situation. Then the second main point was that, as has been discussed today, I wanted a choice about how my baby would be born; I did not want intervention of any kind that could be avoided if the birth was proceeding normally and I think when you are in your own home you feel more in control of the situation. I think a lot of women, and I particularly, feel that when you go to hospital you feel hospitalised, you are the patient in a submissive role, that sort of role that we grow up with in medical care for whatever reason where the doctor is the person who knows and the patient is the lay person who accepts. At home you can be on a more equal basis, you feel stronger about saying what you want and discussing intelligently with the medical care team what the pros and cons are in any given situation. I felt that at home I would feel I was, as I say, in a more equal position and, if things needed to be discussed in regard to intervention or medical care which might be needed, I would be in a better position to discuss that. In connection with that I also think that when you get to hospital then you are the responsibility of the hospital and the health of you and your baby is the responsibility of the people whose care you are under; so that care moves more and more towards the safety measures that have to be taken to ensure that that responsibility is taken properly and the baby is born safely; so you are always two steps more into the safety measures than you need to be maybe, and that is easier to avoid at home. The third matter really is this: alongside conventional health care I like to use alternative health care, particularly homeopathy, and I was in touch with a qualified homeopath who treated me during my pregnancy and was prepared to be on the end of the phone with me and had given me remedies that might be appropriate during the labour if things had not gone smoothly. I knew that if I was at home that it would be much easier to involve than if we were in hospital and my husband had to run out to a hospital and phone and find a phone and get the change ready and that sort of thing. So that was another side of the care, that I wanted to be accessible, and it was easier from home.

1566. By the way, a question I am sure is in the minds of all the Members of the Committee: have you enjoyed coming here today and do you think the questions we put to the Minister and her officials were relevant to this whole subject of childbirth?

(*Ms Hedderwick*) Yes, I did, particularly the thing about choice that has come up and the question about relative safety at home and in hospital, because as far as I have understood it, if you are somebody who has a low risk prospect at birth, if you have a healthy pregnancy, then it is as safe to be at home as it is to be in hospital. So I did find it very interesting and have enjoyed it. There were some questions that related to things where I did not know the background to the question.

1567. Again there will be another opportunity. Ms Gartland?

(*Ms Gartland*) This is my first baby. I initially went to my doctor and I did not ask her for a home birth. She asked me where I wanted to have it and the question basically meant which hospital and I felt if you wanted a home birth you had to fight for it and I did not feel I was a tough sort of person who could do that. So I was booked into my local hospital and I went to the booking-in clinic there and a antenatal clinic and it was grim; there were so many women there were not enough chairs for everyone to sit down.

1568. Should we ask which hospital that was?

(*Ms Gartland*) That was King's. It is very busy and you just go to see the various people who do the various tests. You go from one to the other and I did not really feel I knew what was going on and it is difficult to ask. But before the second visit I had heard of Domino, where you can just go in to have the birth and come straight out again and I thought I might be able to get away with it. So I asked the doctor who examined me at the hospital and he had never heard of it. I told him what it meant and he thought it sounded like a jolly good idea. So when they had all finished examining me and things I went to the receptionist and she passed me to the sister in charge of the antenatal and eventually I found a community midwife and spoke to her and she said, "Have you considered a home birth?" and I said: "I haven't dared ask anybody about a home birth," and she was so positive about it and I felt then that I could ask about a home birth. She told me what to think about and who to talk to and so I changed then from a hospital to a home birth and I just felt so much happier about the whole thing. I felt I was back in control and knew then what was going on. I enjoyed being pregnant very much and was looking forward to the birth and wanted it to be the best possible, to happen in the best way possible, and obviously be as safe as possible, and I did a lot of reading, which is what I normally do with anything, and I had no reason to think it would be more dangerous at home. I was very healthy; there is no history of obstetric or gynaecological problems in my family, and from then on the thing was totally different. Instead of having to go to the antenatal clinic the midwife came to my home and we had my checks in my flat, in my lounge, and I would lie on the sofa for her to examine my stomach and things and she knew me as a person, so that if I had been ill she would have looked at me and thought, you do not look like you did last time, there

[**Chairman** *Cont*]

is something wrong. I was *her* lady and we were going through it together. It was a totally different experience and the birth itself went really well in the end. But I nearly did end up in hospital and we knew all the time that we might have to go into hospital but we felt if we did we would know why and we would have gone willingly—anything to ensure the safety of the child and obviously me. About three days before he was actually born I went in and they were going to induce me because there had been a slight leak of amniotic fluid and there was a risk of infection. We thought that was it. We wanted a home birth and it had not happened but it was quite interesting talking to the midwives at the hospital because I was there all prepared to give birth and the drip was ready to induce me and everything and they were very nice but very different to the community midwives in their attitude to intervention and drugs and things, which I thought was quite interesting. In the end the leak had healed up and they sent me home, which made me feel I had been let out of prison or something, which is very unfair to the hospital but it was not where I wanted to be. The birth itself went very well. I was very relaxed. The midwife who came to the labour I had never met before but it did not make any difference. She gave me tremendous confidence and I had tremendous confidence in her and I was so relaxed she did not realise I was in labour until I was nearly halfway dilated and because I had known the environment I was going to be in, I hoped, I thought if I want to be in this position I can be here and I had everything worked out so I was very comfortable and I get could into whatever position I wanted to be in. They were my midwives for the whole labour; they were not going to disappear off and go and see somebody else. And my husband was totally involved in it as well and he knew the role he had to play. He had a role, whereas in hospital you are subordinate to the professionals obviously; they are telling you what to do and if they had me in hospital and they said, "You need this," then I would have tried to prepare myself. I think I would have found it very difficult to argue with them, although I could imagine afterwards, I wish I had not done that; I wish I had not let them do that. As it was, I did not need anything at all. Afterwards the midwives cleaned me and him up and the lounge. They disappeared and there were the three of us and we were a family immediately and it was wonderful. It was really a wonderful experience and I totally enjoyed it. I would like that to be available to everyone and to feel that it was not something that they had to worry about asking for. I suppose most people I know have not wanted home births. They said I must be very brave, which is how I felt about them going into hospital! It is the difference in attitude, I suppose, but I really would like everybody to be able to have the birth that I did and to be as happy with it as I was.

1569. Birth is supposed to be a very happy time and a very fulfilling experience. We fellows, unfortunately, do not have that opportunity but I am delighted you involved your husband, as clearly most of your colleagues did as well. Thank you very much. Ms Robinson?

(*Ms Robinson*) My baby, who is howling out there, is my third and I had all three at home, under water, in fact, all three of them. My decision to have a home birth initially came from when I first got pregnant with the first child and I did quite a lot of reading, picked up every book I could read and wrote to quite a lot of organisations for information, one of which included—I remember it quite clearly—the Association for the Improvement in Maternity Services, and they sent me back this fascinating little leaflet full of statistics about safety, because that is one thing that is really important. Every mother who is ever pregnant firstly considers the safety of her child and I certainly got the feeling sometimes when I said I wanted a home birth and it was my first birth that people think you are taking a risk with your child. Clearly as a mother that is not what you are doing. The decision you make is clearly based on what you think is best for your child and I would never had thought, I am going to do this even though it puts my child at risk, and I think that is important because that is the feeling you often get. So this leaflet that I read gave me enormous confidence and made me believe that having my child at home was not going to put my child at risk, that there were some things that were slightly more risky at home but plenty of other things were more risky in hospital. So having then made my decision with my partner that we would like to have the child at home, I then was faced with the idea that I thought this might be almost impossible to achieve. My GP certainly was not interested in doing it within the GP practice but they were very supportive about the idea that I wanted to do that and they referred me to Dr Zander and I felt incredibly lucky. Within the whole area where I live in London apparently there are just two doctors who are prepared to do it and this is in London. I know it is worse in other parts of the country. There are only two doctors prepared to take women who are having their first babies at home. I think it is a bit easier if it is not your first; certainly with the first it is quite difficult. From then on it is pretty straightforward because Dr Zander says, "Yes, of course". My pregnancy went well, with no problems. The only think I had trouble with was arranging a water birth. That is a very long story but, in fact, I managed to hire a birthing pool and eventually got a midwife who was happy to do it.

1570. What benefits does a birthing pool give?

(*Ms Robinson*) I have never given birth any other way. It is unusual for people but for me I had three babies under water and they have all been over 8 pounds, not small babies, and I am not particularly big. All three births had no form of pain relief other than going in the water. I did not use gas and air or anything, I did not have any stitching, any tearing. Of all three babies not one cried at birth.

1571. They do it subsequently!

(*Ms Robinson*) They certainly do that, but at birth we even got a video of the last one because the midwife wanted to video it for their own education purposes. So it was quite clear to me when the baby was born he came to the surface and breathed naturally but did not ever cry. The first time he cried was when they put tubes down him to suck him out, to get the mucus out, the time when he passed out of the water. As long as he was in the water he was really quiet and alert; that was really beautiful. I think the benefits of the water are twofold: for me for one, my getting into the water when I was in labour was just

[**Chairman** *Cont*]

for a wonderful experience; it gives you a rest, it takes the weight of your body, which can be quite heavy when labouring for a while, it is warm, it envelops you, it is really a lovely feeling. Then when the baby is actually born it feels like a very, very peaceful birth for the baby as well as for the mother. So, as I said, I cannot say it is better than any other way because I have not done it any other way. For me it was a wonderful way to give birth. I do not intend to have any more but, if I ever did, I would do the same again. Three times it has been wonderful.

Mr Rowe: Do you think we could achieve the same degree of peacefulness if we met under water?

Chairman: Are you referring to you and me or the witnesses?

Mr Rowe: The witnesses.

Chairman: Perhaps Mrs Nash will tell us.

(*Ms Nash*) I have never given birth under water but I did swim before giving birth and I suppose I have just heard so much that echoes my own feelings and experiences. I have not had a home birth yet but my second baby is due in the middle of February. With my first child, who is now two and a half, I felt instinctively that I wanted to give birth at home and I got a lot of support from my husband who, I think, was worried, like I was, about the risks of that but felt that if I thought them through enough and was prepared to go ahead with that he would be very much in support of that. So when our first port of call was to our GP, which is what all the antenatal books I had said, I was quite interested in the question that was raised about the proposal that the first port of call should be a midwife. In fact when I met my GP we had just moved from Oxfordshire to London in my fifth month of pregnancy, which was not really a good time to move but was unavoidable because of jobs. The first thing I had to do was to sign on with the new GP and I asked people around who might be sympathetic towards home births. I consulted the NCT. It was a very confusing time for us as a family. The only GP anyone could suggest in our area who might be sympathetic was extremely helpful. She talked to me for about three-quarters of an hour in the surgery but was very clear about the fact that she felt that I should compromise and go on the "domino" scheme, which is what I did do because, when you have not been through labour and pregnancy before, you are terrified of taking risks and when professionals tell you there are many risks about not being in hospital, you do actually instinctively take that advice.

1572. Are you implying by that that you do not think you were actually given real objective choice?

(*Ms Nash*) I am. That is something I wanted to come on to because although I cannot remember exactly what the point was, but Virginia Bottomley made a point about needing to know what women's choices are and then putting these into practice; but I hope that the Government will take a longer period than maybe they envisage before they take evidence from women and their partners because I actually feel that at the moment true choice is not available when you first go to your antenatal clinic because you get a very one-sided view about risk, that influences women a great deal. I think it influences every woman and it will be a long time before women can somehow re-educate themselves to trust their instincts. That will not happen overnight and that will not happen simply by suddenly being presented with informed choices on both sides. I think that is actually a cultural re-education and I think that will take a few decades possibly I do not know. So I hope that maybe a long timespan will be given or they will not be rushed decisions because, yes, I do not feel I was given enough on the pro side towards home birth, and we did not have much time. We felt we had to get on and make the decision. So I took a compromise. I had all my antenatal care at St George's—shared between St George's Hospital, Tooting, and the community midwives. My experience was that everything to do with the antenatal clinic run by the community midwives*. was extremely positive, everything to do with antenatal clinics at St George's was extremely negative—very long waits and on meeting the consultant for the first time after a 2½ hour wait to see this particular doctor he did not introduce himself to me. I feel that is actually quite an important thing when you are meeting someone, the naming. I was seen as a body, A, B or C—I do not know what. That is very difficult when you are also feeling very exposed, both in a physical sense—you are uncovered from *here* to *here* (*indicating*) with people examining your nipples, your everything; that is not easy—and it is also such an important time for you that you actually want to be able to talk about it and say "What will happen to me when I do come in to your hospital and I am under your care?". In fact, I suppose it was a ten-minute examination—I cannot remember—without knowing this consultant's name.

1573. Did you ever get to know him?

(*Ms Nash*) I could have asked him. I never saw him again. I could have asked him and I spent the ten minutes thinking, shall I ask him to introduce himself to me, and I think you are very frightened of sticking your neck out in hospital. I worked for the Lothian Health Board for four years when I was living in Edinburgh and so from the other side I am aware of some of the difficulties about being under professional care or having power over the patient and actually I think that experience made me very worried about making myself unpopular in the hospital where I was to give birth. So I decided not to take the risk and be thought cheeky which might go down on my notes, so I held my tongue and lost my temper afterwards. So they were small things but they seemed very big at the time. In fact, I did not have the baby at St George's at all because my waters broke suddenly in a motorway service area, luckily in Wales, where we were whisked into the Bridgend Hospital. We drove into Bridgend Hospital in South Wales and had, I think, probably as good an experience as most people ever have in hospital. I was delivered by the senior midwife there, who examined me when I first went in and said, "Oh, I'm itching to do a good natural birth." Those were not her actual words, but she certainly conveyed the sense of looking forward to assisting at a normal delivery. So she came and she altered her timetable and gave us

**Note by witness:* Apart from my first visit to the hospital, I saw community midwives at St Christopher's Clinic in Battersea, which was run more efficiently than the hospital antenatal clinic.

[**Chairman** *Cont*]

a lot of privacy. She left me and my husband alone without us having even asked for that. She just left. She obviously could sense that we were coping fine and so I ended up having in some ways the sort of labour I would have hoped to have at home, which was completely drug-free and gas and air- free. The only problem there was was that I tore very badly and I believe that was because I was encouraged too early to get up on to the bed, because I was told at a particular stage, "You are getting tired, dear, you must rest. Get up on to the bed and lie back between contractions." So I immediately did what I was told, though in my fact all my instincts told me to keep on doing what I was doing, which was remaining upright as much as I could and moving with the contractions. But again somebody said how difficult it is to follow your own instincts and feel you are in control when you are under somebody else's care when they are professionals in their own territory. So when I delivered Benedict I was lying back with my legs strapped up in the stirrups and they said it was one of the worst tears they had ever seen and the midwife wanted to do an episiotomy and I made it quite clear I did not want an episiotomy because I felt if I tore I just had this feeling that at least I would tear where my body wanted me to tear; it was not going to hurt the baby, it was just me. I thought, to hell with it, I will tear if I am going to tear, and I did and in fact, having thought afterwards, why was I so stupid. In fact, it healed a lot quicker than the episiotomies that had been done for friends of mine who had only had, say, four stitches where I had, I believe, 40 stitches, and my huge tear healed much more quickly than their small cuts. So that is just an indication that even when you are getting excellent care and very sensitive midwifery it is still, when you are on somebody else's patch, very difficult really to stick out for what you feel your whole body is telling you. I think it is a time in your life, one of the few times, I think, in our society, where we still can get in touch with—it is something about primitive instincts that I think we have lost to a large extent and need to hang on to in order to go through this really very extraordinary process of giving birth. So that really is why the second time round my husband also was quite encouraging. He did not even question the risk factor next time, but, of course, we read very widely on both sides and again I had a very similar interview with my GP the second time round, who again gave me a long interview about why did I really want a home birth and gave me all the same arguments about the risk and I worried to the same extent but I had done a lot more reading and had also been through one birth and felt that if I tried to take a sensible view and, if necessary, was prepared to go into hospital, then I was giving my baby as good a chance of a good birth as possible. So I said, "Yes, we have thought through the arguments but still want a home birth. Who can you refer me to in this area so that my care can be taken on by a GP in the area?" and my doctor said, "I'm afraid I can't. There is not any GP that I can recommend in this area but I will give you Dr Zander's telephone number and perhaps you can contact him and he will take you on, even though he is in Lambeth, which is a different area in London," which is what happened. I was very delighted to be under Dr Zander but the problem in not being under a GP who is in your own area and in the area of the hospital where you will go if any complications arise and, of course, as the hospital where the community midwives operate from, is one of communication between the hospital and the midwives and the GP. That has been frustrating, I think, for everyone concerned, I think mainly frustrating for me, for my GP, Dr Zander, and the main problem seems to have been that St George's do not hand over full medical notes to women at all during antenatal care unless you are having a home birth when you get them three weeks before the birth, and that does not make communication very easy. We do have something called a co-op card but that is not your full medical records and it is obviously not very easy for the GP concerned not to be working from your full medical records, and I think it would be helpful for women. I believe we are entitled by law to have our notes.

1574. You are, yes, that is correct.

(*Ms Nash*) Again it is something maybe if I was not somebody who was worried underneath about authority and what it does to you when you stick your neck out too far, perhaps I should have just gone ahead and said, "Look, I'm sorry, I want them anyway." I do not know. So that has been a bit of a problem, but otherwise so far antenatally it has certainly been a much better solution to the previous experience.

Chairman: Thank you very much indeed, Ms Nash. My colleagues have been very patient and have been listening with equal fascination to me. Do my colleagues wish to put any points? I know Ruth Unwin wants to come back with one or two observations on what Mrs Bottomley said and obviously if any of our other witnesses would like to do that, please do so.

Mr Hinchliffe

1575. Can I ask a general point which is related to the letter that I received in respect of Ruth Unwin's case when I raised it with the Minister, to have a response both from Ruth and from our other witnesses. The Minister stated quite clearly that women are encouraged to discuss the options of place of delivery with their GP and midwives. Was that your experience?

(*Ms Gartland*) No.

(*Ms Unwin*) No. I think everyone felt as I did really. You go and they say "Where do you want to have a baby?" and they mean in which hospital; they do not mean, do you want to have it at home or in a birthing pool or wherever—it is not a choice really.

(*Ms Hedderwick*) I think probably I am the only different one. I was lucky because I belonged the clinic where Dr Zander practised, although my GP is a different GP. So when I said "I want a home birth" they said "Right, fine". That was that. That was just by luck because of where my GP was practising.

Audrey Wise

1576. Do you think that fear of childbirth is increased by the way that women are first told about the issues?

(*Ms Robinson*) Yes. Everybody talks about risk and everything. There is nothing about how natural

[**Audrey Wise** *Cont*]
and normal the vast majority of births are. It is all risk, risk, risk.

(*Ms Hedderwick*) Also particularly in London—I do not know how different it is in the country (obviously if you are in the countryside and not in a town you are not going to be so near a hospital)—you can be very, very near a hospital and if a risk situation seems to be developing the midwives are very quick to alert you and the hospital to the problems and take you into hospital if you need intervention or special care.

1577. That is a very interesting point because that matter of transfer is often used as if it means that therefore you should be in hospital all the time because you might be transferred there. Do you feel that that is a proper conclusion?

(*Ms Hedderwick*) I think in the situation of my first baby's birth, if I had been in hospital from the start, I would have had a great deal more intervention than I ended up with. I had a labour of 48 hours start to finish and I was at home for about 40 hours of that and it was not progressing fast enough in the midwives' opinion. They thought I needed more sensitive monitoring, which I had in hospital, and possibly a drip to speed contractions up, and that is all I ended up having. I had a perfectly natural delivery.

1578. You did not wish you had been in hospital to start with?

(*Ms Hedderwick*) What I was coming round to say is, even if I had been in hospital from the start of my labour (and I believe St Thomas's does have time management of birth policy), had I been in earlier, I would have been on a drip earlier and still might not have progressed at the required speed and got full dilation at the required time and possibly could have gone to forceps or even caesarian birth. I know people who have had very slow first labour who have been on drip and had a caesarian birth. It is an imagined scenario but that could have happened to me. So I was better off starting at home.

Mr Sims

1579. You ladies are almost by definition the odd ones out, you are the minority because you felt you not only wanted to have babies at home but you would stick your neck out and insist on it. You obviously have friends who have taken a different course. I think, Mrs Gartland, you said your friends thought you were very brave, and you thought they were brave going into hospital. Amongst your friends do you feel that they go into hospital because they really want to, because they are reluctant to stick to their ground in the way you have, or simply because, as I think Mrs Nash was implying, this is the culture, the accepted thing and that, even if home birth were offered to them on a plate, they would still prefer to go into hospital?

(*Ms Gartland*) I think they go into hospital because they are scared of being at home because they think they need everything that is available in the hospital.

1580. Somebody puts this idea into their head?

(*Ms Gartland*) I think that is a cultural thing, yes.

1581. You said you do not want to do anything to endanger the life of your baby and, if what everybody is telling you is that you should be in hospital because that is the safest place, then that is where most people are going to go?

(*Ms Gartland*) Yes. We are the minority. For some reason we did not feel happy with that and we all researched it and we were all confident that it was not safer, not for a normal birth, and that there is no reason why we should not have a normal birth unless somebody comes up with a reason—that sort of thing.

(*Ms Robinson*) I have friends who feel envious really of my birth experiences. I remember meeting one woman who was wanting to do an article on women's experiences of birth and was trying to find women with positive birth experiences and she could not find any. This is in Brixton. Every woman she spoke to did not have a positive experience; I was the first woman she had spoken to to have a positive birth history. My experience of talking to other women is that when they hear about mine they feel jealous, nevertheless I still think there are quite a lot of women who, like you said, would still go into hospital because the professional image, everything you get from the professionals, is that being at home is risky and not what you should be doing.

Sir David Price

1582. We were asking you earlier on quite a bit about the professional advice you were getting and these sorts of consequences, but I wonder how far discussion with other women, with your chums, is not quite an important thing in people's decisions. I have one parish in the Southampton area where they are very strong on home delivery, and if not home delivery a GP unit. There the people are mums who have done it and they have an influence. Move two miles away and you get what is now the traditional, play-safe step of going into an obstetric unit. But in that particular parish, Fair Oak, it has been mum and midwife led and I think the GPs have just had to follow because that has been a very strong view for first-time mums, first pregnancies, to follow that because they talk to other mums who have said "This is a much more beautiful experience"—all the things you are saying. I think this whole question of what your own friends, your own circle, are doing is a terribly important factor. I do not know if you agree with that.

(*Ms Gartland*) The day after he was born a lot of friends came round, women. A lot of my friends already have one or two children and they were fascinated and the ones that want more children are saying, "Well, I think maybe I will go for a home birth next time", because it was so good, they could see all the advantages.

(*Ms Hedderwick*) I think it does have an influence, but I found that not many people I knew had babies at the time and nobody I knew had a home birth, but people have talked about it since I had the home birth. Mine was from the influence of my mother who had all her children at home; that was long ago and it was also what was done more than going into hospital, but that is the influence of another woman's experience which is the important thing. But also I found people who were around St Thomas's had not even considered it, which points to the lack of choice;

[**Sir David Price** *Cont*]
they did not even consider it as an option that it was possible for them to take.

Chairman

1583. Before I come back to David, Mrs Nash, could I put a question to you? Was there any suggestion during your antenatal care, particularly at the beginning, that you could have a midwife for your delivery even if you did not have a GP?

(*Ms Nash*) No, I have only discovered that in retrospect.

1584. So there was no suggestion, it was not mentioned to you at the time?

(*Ms Nash*) No, I discovered that through reading.

Mr Hinchliffe

1585. I was interested in the comments one or two of you made about following your instincts in the process and struck by this because this reminded me of a conversation that I had with a midwife in Holland, where the system, as you may be aware, is very different. We paid a visit to Holland, including visiting some mothers who had given birth only a few hours previously in their own homes, and the midwife—and you remember the midwife particularly, Mr Chairman,—was making reference to the way in which we were unnecessarily complicating the birth process and that the concept of pain is in a sense forced on people. She was explaining to me and I was describing the process my wife went through, and I was with her on both occasions she gave birth to our children. She was saying the pain experience is a different form of pain and that we in a sense overstate the of which occurs within a natural process and add to the complications by intervening in that. Would you share that view?

(*Ms Gartland*) Yes.

(*Ms Hedderwick*) Yes.

(*Ms Robinson*) I would, certainly. I have been reading very recently about a physiological study of the hormonal level inside women when actually in labour and giving birth. I cannot remember the names of the hormones that are given out. I think there are some endorphins or something like that that are produced when a woman is relaxed, even though she is in pain. If a woman is relaxed she produces natural painkillers which actually help to reduce the level of pain experienced, when medical interference, even in forms of just going into hospital, for instance, and environmental changes, actually suppresses the natural production of her hormones that help in the care. So I think, coming back to instincts and doing it the way nature intended you to do it is very important in terms of the experience of pain on a very physiological level, not just an emotional level.

(*Ms Hedderwick*) Could I just add about pain on a psychological level, I think in hospital with medical staff that are keen to give intervention where it is wanted or needed, if pain relief is offered at a time when you are feeling an extreme pain, however you are dealing with it, and offered in a way that it is the normal thing to happen, then it is much more difficult for the woman to think positively that she can get through it without that pain relief, whereas there is a sort of movement about active birth as a team that are involved in looking at natural forms of birth such as the positive psychological process of thinking, this is a pain that is a positive pain that is going to get somewhere; every contraction leads you to the birth, and those forms of psychological pain relief are as powerful as the other and if a woman expects she can get through the pain herself she will and if she is offered a pain relief then she might well take it whereas she could have got through without it.

Chairman

1586. Thank you very much indeed. I am about to suggest that a partner and dad might care to make a comment. I do not know how many are still in the room. I can see one there obviously, but Ruth Unwin does have one or two comments, if you can make them very briefly, about the comments or the answers that Mrs Bottomley gave to some of our questions.

(*Ms Unwin*) One of them is particularly the response which she made to my case, which is, unfortunately, not very relevant to the other people here but one of which has already been raised. She said in this letter; "The local Family Health Services Authority will be able to provide a list." Nobody tells you that, nobody gives you information. I knew that myself and having taken up that offer of information from the Family Health Services Authority I actually found that the service was not there. Virginia Bottomley was seeming to imply that I did not know where to look for advice. That really was not the situation. I think everyone here knew where to look for advice and you sort of ask friends where you could find a GP who was sympathetic, but the service just was not there. And something that I thought might be worth considering is that doctors have to fulfil certain requirements to be taken on to provide maternity services as they do to provide paediatric services. Surely to provide a maternity service they ought to be able to provide the whole package, not just antenatal and postnatal care. It is insufficient for them to say, "We can see you up to the point of birth and after the point of birth we cannot actually see you through the birth." That was really the only other point I wished to make.

1587. We are very grateful. I think they are two very positive points. Can I suggest if two of the fathers who are here now, Mr Turner and Mr Johnstone, could come forward, then you can identify yourselves to us for the benefit of our shorthand writers who take down, and you may like to add to the excellent evidence that has been given?

(*Mr Turner*) I am the husband of Deborah Hedderwick. Obviously fabulous things have been said. The man's role, in my view, obviously is nowhere near as important as the woman's and the child's but I think the importance comes in, in my experience and the experience of virtually everyone else I have talked to, that the husband is very important to the woman and at home, for all the reasons that have been said before, you get much more control and the husband is much more part of it. I have just one little point about going into hospital. It is fairly well accepted that any disturbance in pregnancy, in labour, can actually bring about a reduction in the progress of that labour and it is frequently said how many women think they are going into labour, rush to hospital, then it all starts to go away again. I think that is not surprising

[**Chairman** *Cont*]
because it is quite a disturbance to get everything together, you get all excited and worried, get in the car and go to hospital. I think that is something worth noting as well.

(*Mr Johnstone*) I am partner to Helen Robinson. My vivid memories of especially the first birth are fighting administration when it should have been just getting into family life and being prepared to have a new member of the family. A lot of our time went into debates with midwives and again doctors passing us on basically. That is what I remember most from the first birth.

Chairman: Can I say the last two comments have been extremely helpful. Can I thank you all very much for braving the House of Commons and the wrath of a Select Committee to come and give such valuable evidence as part of our inquiry. Thank you and your babies very much indeed.

ISBN 0-10-283892-5

9 780102 838923

Printed in the United Kingdom by HMSO
Dd 0507540 C7 3/92 1902547 PP

HMSO publications are available from:

HMSO Publications Centre
(Mail, fax and telephone orders only)
PO Box 276, London SW8 5DT
Telephone orders 071-873 9090
General enquiries 071-873 0011
(queuing system in operation for both numbers)
Fax orders 071-873 8200

HMSO Bookshops
49 High Holborn, London WC1V 6HB 071-873 0011 (Counter service only)
258 Broad Street, Birmingham B1 2HE 021-643 3740
Southey House, 33 Wine Street, Bristol BS1 2BQ (0272) 264306
9-21 Princess Street, Manchester M60 8AS 061-834 7201
80 Chichester Street, Belfast BT1 4JY (0232) 238451
71 Lothian Road, Edinburgh EH3 9AZ 031-228 4181

HMSO's Accredited Agents
(see Yellow Pages)

and through good booksellers

ISBN 0 10 283892 5