

## **Maternity Services Strategy Public Consultation**

We welcome the opportunity to comment on this paper. However, the summary guide to the Maternity Services Strategy which is prominent on the website is just that – a summary. Despite the statement at the end of the guide that the full strategy was to be found on the NHS Lothian website, it is fairly well hidden in the Board papers and we suspect that many interested parties will have had some difficulty locating it, and consequently full public comment may have suffered. Having made this point we are grateful to John Thomas and a member of staff at the Deaconess who provided us with a couple of full paper copies.

In general we welcome the aspirations in the paper, although it seems that the main driver for change is the shortage in the workforce: not enough midwives, not enough obstetricians and anaesthetists. Our group is composed of people mainly over 50, and the opinion is that in general maternity services have not seen the same improvements as have happened in other specialties (with the exception of special baby units) – there were grandmothers felt they had been better looked after when they gave birth than their daughters are cared for now. However this was not a totally unanimous view and this probably depends on the experiences of the individual and possibly the fact that there are more births now to older mothers – which are potentially more difficult.

We noted that Appendix 2 to the full paper, which recorded the findings of engagement with stakeholders and in particular with mothers, appeared to be an honest account of what users of the services are experiencing. We would urge the Health Board to listen carefully to these voices, and to address and act on the issues that were raised, together with the recommendations in Appendix 4 ‘Saving Mothers’ Lives’ - The ‘Top Ten’ key recommendations. We were surprised and disappointed that these recommendations were needed, but from personal experience of one family in our own group, it is apparent that they are a priority. We would hope that there are guidelines now in place for dealing with pain and bleeding in early pregnancy, although as late as March 2009 there was no evidence of that in at least one case personally known to us.

Very recent experiences told to us by one family regarding the Simpson Maternity Unit agree with the findings in Appendix 2. The issue uppermost for this family was the fact that medical staff (doctors primarily, but also nurses) did not listen to the concerns they were raising, and the attitude experienced by them from the doctors was dismissive and one nurse was rude. Only when the new mother lost half her blood volume in a 3<sup>rd</sup> D&C post delivery, and the new father complained, did attitudes ameliorate and a consultant became involved. There had been no consultant involvement up to that point. This family is of the opinion that a birthing centre may help low-risk normal births, but that Simpson’s need to have more and better trained staff. They did praise the anaesthetist, who was helpful, and the midwife who helped with breastfeeding – however they felt this hardly made up for the lack of care at delivery and post delivery.

One other case involved a midwife, a “returner” to the profession, and therefore lacking in confidence and an understanding of current procedures. Labour was difficult and very long, partly because the baby was not presenting correctly. When it came to breastfeeding there were difficulties and the mother suggested that the nurse look to see if the baby was tongue-tied as this ran in her family. It turned out that the baby was indeed tongue-tied. Two suggestions arise from this experience. It would be helpful to have a workshop before birth on breast-feeding to build up confidence and understanding. And, it would be helpful to remind those helping new mothers to breast feed, that tongue-tie might need to be checked.

Many of the issues raised in the paper require education of pregnant mothers, and prospective fathers. This is something that we take for granted, and NHS Health Scotland produces much excellent information and literature to help pregnant women. But it should be remembered that last June a Literacy Commission was set up to report on the functional illiteracy in Scotland, reputed to be running at 25%. Handing out leaflets or written information can be regarded as an easy way of dealing with the information gap for young mothers, but we need to think about the method of delivery of information – especially for those who may be struggling simply to read.

One of the Key Issues in the full paper (para 5.1) refers to “neonatal nurses: many leave to work abroad”. Perhaps nurses, like teachers, should be prepared to give at least 2 years’ service to the country that has provided training. The other possibility is that the students originate from other countries and come here to be trained, so they are expected to return. If this is the case then more places at Napier will be required to fulfil our needs in Lothian.

## Questions

### **How can we increase women’s confidence in their own ability to safely give birth either at home or in a birthing centre or in a hospital with less medical interventions?**

Education and reassurance that this is a serious option is key to its success. At booking appointments, it would be helpful if midwives, who also need to be well trained, discuss the possibility of home birth and offer written material to be further discussed. Obviously, midwives will need to be sensitive to the method of giving information (see previous comments about reading and literacy) – maybe a DVD would be helpful. One very powerful way of reassuring women that safety will not be compromised might be to invite a mother who has had home birth along to ante-natal classes to describe her experiences. Also continuity of care has to be assured. At most, women should have only a maximum of two midwives involved.

We think the target percentage for home births is very low. The aim of increasing home births to 5 per cent is very unambitious. In parts of Wales 10% - 12% is being achieved. A recent report from the Netherlands indicated that home births there are a third of the total, and this has proved no more hazardous than births in hospital or birthing centre, and

that home births are probably cheaper for the health service. This obviously means increasing the number of community midwives, and making sure that they are suitably trained to support breast-feeding.

### **What do you think about the idea of having a Birthing Centre?**

We think this is a good option for those forecast to have a normal birth. The benefits should be continuity of care (hopefully) with a named midwife and more homely surroundings. Nevertheless, it may be reassuring to have a birthing centre close to high tech facilities should they be required for those who choose the birthing centre option. Pregnant mothers may choose the birthing centre rather than a home birth as less risky because it is close to high-tech facilities. We understand that the experience of midwife-led units has been very good, particularly where they are attached or near to a high-tech facility.

### **Would you like to be involved in the design of a Birthing Centre?**

We think it most appropriate to target this discussion at recent mothers (and fathers). However, despite Lothian Health Board's present attitude to car parking, we think it is important to have car parking facilities available for patients (and partners), visitors and staff. Babies (like all health matters) are not 9-5.

### **What improvements would you like to see at:**

#### **• The Simpson maternity unit at Little France in Edinburgh?**

Recent experience within our group suggests that what is needed is

- Better consultant cover – especially between 8 at night and 8 in the morning
- Higher staffing levels generally – more midwives – again at night
- Better expertise – having an SHO or registrar tackle complex Caesarians without supervision can prove to be extremely risky.

#### **• The maternity unit in St John's hospital in Livingston?**

There were no comments from our group on this.

### **Do you think women should be able to book their first appointment with the Community Midwifery Service directly? They will be able to do this using the Central Booking System telephone number.**

We were not sure if this is a genuine question on which you are seeking views, because a report in the Scotsman on 6 April stated:

Women will no longer go to their GPs for routine checks during pregnancy, it emerged yesterday.

Under a shake-up of maternity services, the usual GP checks are due to be handed over to midwives.

The new rules are expected to be launched throughout Scotland later this year and are designed for healthy women who do not develop complications during their pregnancies.

The plans are part of the Scottish Government's strategy Keeping Childbirth Natural and dynamic

We think there may be a danger of less satisfactory “joined up” working if the GP and Community Midwife service begin to work independently and the patient will not receive the care she needs – especially if there are any underlying long-term conditions or other medical factors that need the expertise of the GP and the midwife together.

### **How do you think maternity services can reach out more effectively to:**

#### **• Women from black and ethnic minority groups?**

Focus groups – with interpreter services built in and preferably new mothers from the ethnic groups to be reached.

#### **• Women who are vulnerable, isolated and from areas of multiple deprivations?**

This is a multiple question, which perhaps needs different approaches and awareness for each category. It is important to recognize that it is not only poverty that puts women in certain groups.

Vulnerable women – can occur in any social class and be for example victims of domestic violence.

Isolated women – this group can be anything from the recognized ethnic minorities to those who may have moved to this country to work and those from the indigenous population who may simply not have any friends or family support for a variety of reasons.

Areas of multiple deprivations - it is a fallacy to base extra resources **only** on women who come from recognized areas of deprivation. It is the experience of women in **all** groups, including those conventionally described as vulnerable, that there is a need for maternity services to be more effective across the board. It is also the experience of some new mothers that those from “deprived” groups shout so loud that others are ignored and left to their own devices, when help and support is required. This point was referred to by the focus groups in Appendix 2.

All of the above factors require all medical professionals who work in maternity services to be trained to recognize and deal sensitively with the problems that may arise from any of the groups.

### **How can we encourage women not to smoke or drink alcohol during pregnancy?**

The smoking cessation model referred to in para 7.7 of the full paper would seem to cover a good approach for those already pregnant. We would also suggest that school might be the place to make young girls aware of the drawbacks of smoking and drinking during pregnancy.

### **Do you have any suggestions as to how we can increase the number of mothers breastfeeding?**

The benefits of breast feeding are often pointed out to mothers-to-be, but can come over as worthy do-gooding. Perhaps an alternative more positive approach would be to

emphasise the pleasure it can bring, the instant food on tap for baby without the guddle (and expense) of making and sterilizing bottles, and the figure-restoring qualities that breast feeding brings to the mother. There are also the benefits that breast-feeding brings: including for the infant, the mother's immunities and a wonderful bonding experience, and for the mother, protection against ovarian cancer, breast cancer, and weak bones in later life.

Although it is the mother who must be persuaded to undertake breast-feeding, we think it would be helpful to target partners and grandparents to support and help the new mother.

Breasts have been designed (evolved) for feeding babies. If we do not use them for this purpose, we abuse our bodies. Many women ~~people~~ need help in starting and continuing breast-feeding, and they should be given appropriate support. A recent contribution to Woman's Hour on Radio 4 made the point that often midwives do not have the appropriate training to give this support, so women give up too easily. If feeding is not established quickly this can result in dehydrated babies: help and support is essential. Given that the objective of maternity services is to keep new mothers in hospital for as little time as possible, there needs to be a resource within the community to help new mothers establish good breast feeding.

An account by one of our members told of a recent case where a mother had given birth to twins, one of whom needed intensive care. The mother and baby no. 1 were discharged home, but the mother still had to make daily visits to baby no. 2, resulting in severe fatigue. This is surely an example of a situation where the mother should have been offered 'step-down' accommodation, where she could have been immediately available to care for both her babies, without undue tiredness. It is hoped that the 'birthing centre' could in future offer this kind of accommodation. This would also help to establish breast feeding.

It is also important to emphasize that bottle feeding, if this is resorted to, must be done carefully, and that putting feeding bottles in the microwave oven is not advisable, since harmful chemicals (endocrine disrupters, specifically BPA [bisphenol]) may leach from plastic bottles.

### **What are your suggestions for improvements in Parent Education, both antenatal and postnatal?**

Para 5.1 of the full paper states "‘At risk’ patients include those who are overweight, have diabetes, are over 35: therefore more high-risk procedures, especially Caesarian sections, are undertaken." It is important to stress in school education programmes on sexual health that girls must be aware of these matters if they wish to give birth eventually. After they have left school it will be too late. Cutting the numbers of Caesarians would cut the cost overall. The possible downside of a Caesarian should also be pointed out.

It is sobering to discover that ‘half of the pregnancies in the UK are unplanned’. The education programme outlined in Section 7 of the full paper sounds acceptable on the face of it, but a rise in abortions is not necessarily a good thing (some would say it is highly undesirable): abortion itself carries both physical and mental health risks. The advice given to young women still at school must be consistent with the general health advice offered in schools, where relatively trivial complaints such as a cut finger require parental consent for treatment, but powerful drugs in the form of oral contraceptives are handed out in schools without parental consent. Also, oral contraceptives are available to girls as young as 13 from pharmacists, without any obligation to inform the patients’ GP. We have a problem here, which must be addressed.

On teenage pregnancy, we cannot approve schemes whereby schools can hand out oral contraceptives without parental consent. We recognize that there are situations in which there is chaotic home life and dubious parenting but that does not mean that for most children the school should assume the role of parent. There needs to be much greater openness and co-operation between teachers and parents on the whole matter of sex education. Both parents and teachers need help to address these sensitive issues, but it has been, and can be done successfully. Termination of pregnancy is not a good strategy: it may do long-term damage.

It is obvious that schools have an important role in giving basic advice on a range of health issues, pre-pregnancy, contraception, pregnancy, and parenting. Senior pupils should all have the opportunity to learn basic information about these topics – medical professionals and teenagers with experience to offer may be best placed to give that information and advice.

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