

The People's Inquiry: One Year On

Evidence presented by Professor Cathy Warwick (CW) and Sean O'Sullivan (SO), Royal College of Midwives.

Tuesday 16 December
Central Hall, Storeys Gate, London SW1H 9NH

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:

Thank you for coming to see us again. It's very nice to see you. You will know that we wrote a report, *London's NHs at the Crossroads*, which of course changed the whole profile of healthcare in London. A pivotal report, a fulcrum point, the tipping point of care in London. It was good for shelf papers everywhere! But we are re-visiting it and we are delighted you have agreed to come and talk to us again, and tell us all the good things that have happened and how our healthcare has improved and women are producing happy, smiling babies at home on the kitchen table and how much better it all is...!

CW:

Thank you very much for having me back. We were really pleased to be asked to come. I am not going to go through all the stats I presented to you last year because when I told you about caesarean section rates and forceps rates and all these things. I think the truth is that nothing much has changed. You can assume on those kind of fronts that it's pretty much the same as before, and equally how women rate their experience of maternity care – which is probably the most important thing – has not changed dramatically either in the UK or in London.

Figure 1 shows you the birth rate.

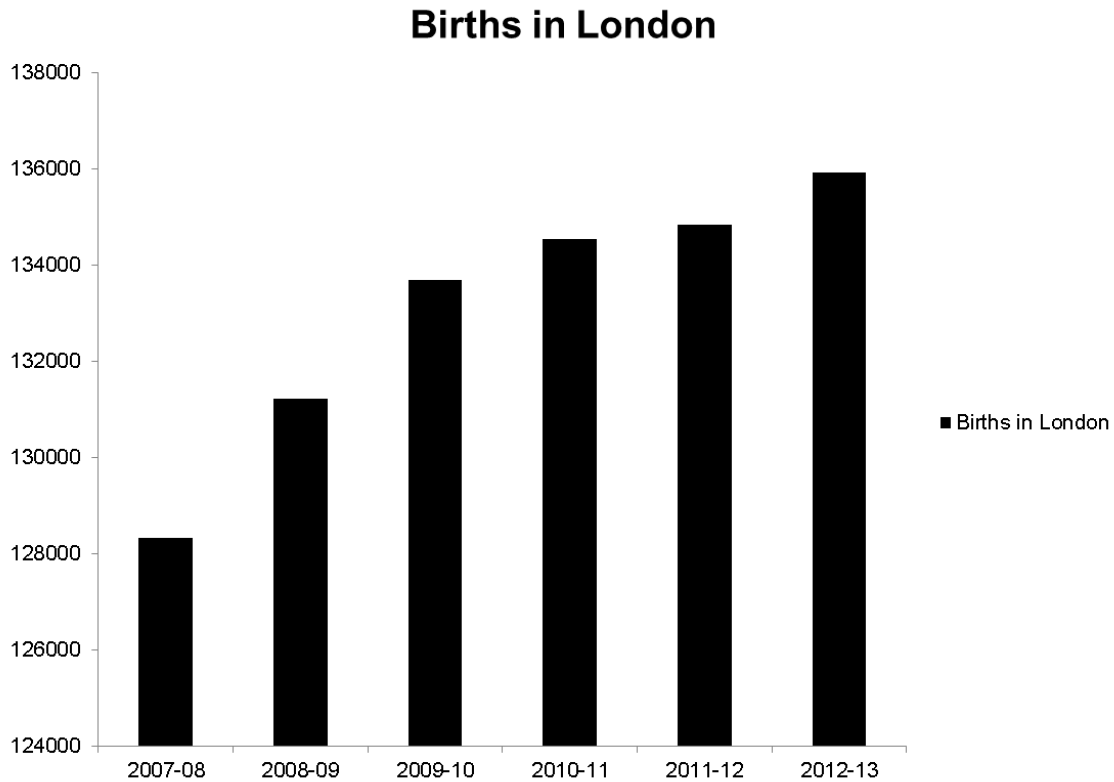


Figure 1 Births in London

I will update you on that. There were 135,926 births in London in 2013. That was an increase of 1,073 births on the previous year. The truth about the birth rate – which if you remember had been rising very dramatically – is that it is slowing down generally: but in London it is still increasing.

I think the important point about that is that in London particularly if it was just a case of delivering more babies whose mothers are completely straightforward it would be very easy for maternity services: but as you will be aware London suffers from really high complexity.

Figure 2 shows how the age of women having their babies is increasing really very dramatically.

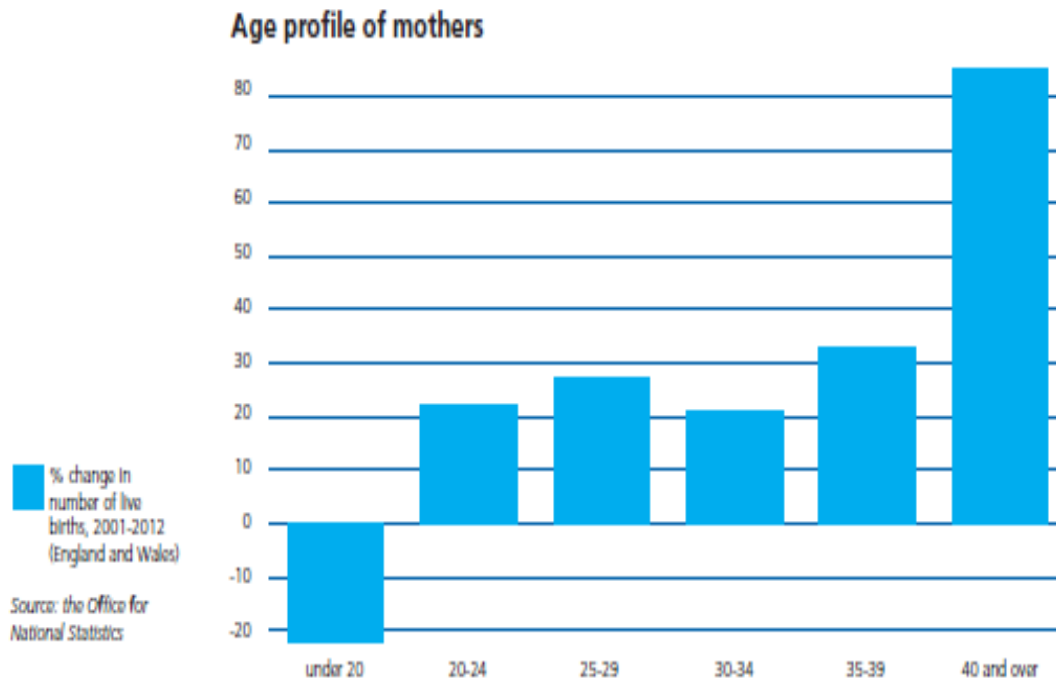


Figure 2 Age profile of mothers

In 2012 for example, there were 85% more babies born to women in England aged 40 or over than there had been in 2001. This trend is particularly acute in London which has the highest birth rate for women aged over 45. Two women in every 1000 births. The birth rate isn't increasing in any other age group very dramatically but it is in the over-40s. The fact is they experience more complications.

Obesity is another major problem. In England between 1989 and 2007 the incidence of maternal obesity in the first few months of pregnancy more than doubled, from 7.6% to 15.6%. The complexity is rising.

There are fewer maternal mortalities, but:

- Two out of three women who died had medical or mental health problems.
- Three out of four women had pre-existing medical or mental health problems.
- More than two-thirds of women had not received the recommended amount of antenatal care.

This is also higher in London than across the country. We've just had a new report talking about the last 3 years' figures in terms of maternal mortality. Two-thirds of the women who die, die from medical and mental health problems with pregnancy. Mental health in pregnancy is an increasing issue. Three-quarters had medical- or mental-health problems before they became pregnant. In other words, we should be able to find out who these women are and to give them the highest quality care so that we prevent them suffering at all, and certainly prevent them from dying. But more than two-thirds of all the women who died in this latest report have not had the recommended amount of ante-natal care. We know that the women who don't turn up for ante-natal care are over-represented in the London population. They are often ethnic minority groups, they are often asylum seekers, women who are incredibly needy.

Given that birth in the UK is safer than ever and maternal deaths are rare, we really should be looking at these small numbers of very significant tragedies and doing more.

One example of how women die is they don't have the flu vaccine. One in 11 of the pregnant women who died actually died from the consequences of having flu. Prompt diagnosis and rapid administration of antibiotics could have prevented them from becoming septic and then dying.

One of the important messages I would really like to stress to the panel – which I don't think I said very much about last year – is the critical importance of good multi-disciplinary care. Particularly the importance of the GP being involved in maternity care.

How GPs can contribute:

- Information giving.
- Information sharing.
- Identifying and referring women with pre-existing/acute conditions.

It's now about 3 years since the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, and the Royal College of General Practitioners, actually put together a report about GPs' involvement in maternity care. I think that really went below the radar.

We need to pull it out again and emphasise to GPs how critical their engagement with maternity services is. It's not about them giving basic care. They don't need to be midwives and they haven't got the time to be midwives. But the information exchange is really important. The chair of the London Clinical Network told me the other day that at UCLH where he works they got a GP referral on a scrap of paper that just said 'pregnant'; that was the sum total of the information. That is an area where significant work needs to be done.

It's not just the GPs. The midwives need to be encouraged to communicate with the GPs. It's about giving information about women, it's about sharing information, and it's particularly about coordinating care for women who have pre-existing medical problems. These are women who have mental health problems but also women who are, say, diabetic, or who have previous cardiac problems.

Moving on to workforce trends, you will remember my talking about the numbers of midwives that we have in our services. It's good news here.

Figure 3 shows there is still a gap between the birth rate (red line) and the numbers of midwives that are needed to look after those women, but the gap is closing a little bit. London has been responsible for almost half of the net rise in midwives' numbers in England since 2002. In the last year, an extra 120 midwives were employed to care for women in London.

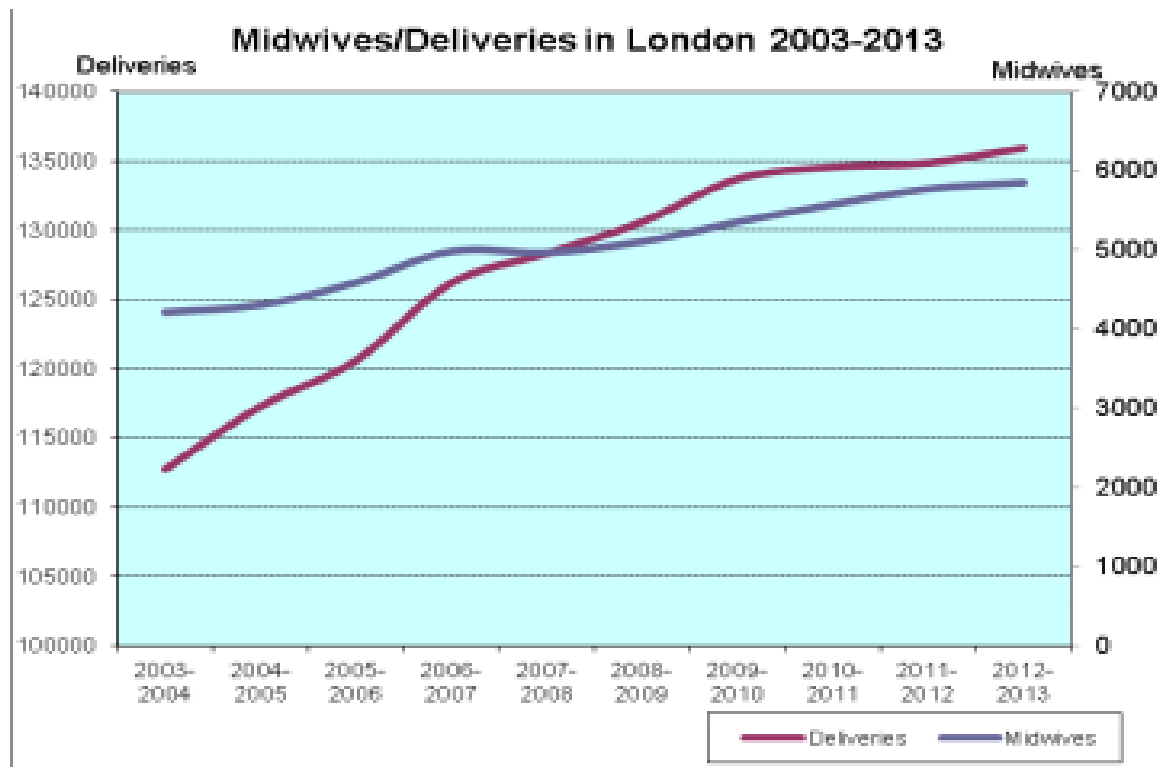


Figure 3 Numbers of midwives and deliveries in London 2003-13

The RCM recommends a national ratio of midwives of 1:29.5 and in London the ratio of births is 1:30. It's really not bad. The vacancy factor in London trusts has decreased from 9% to 8%. The other bit of good news is that there were fewer occasions on which a maternity service had to suspend its services. There were 75 in 2011-12 and 71 in 2012-13. Which suggests that the services are under slightly less pressure in terms of their resources that are available to support women.

It's very encouraging that London's continuing to recruit more midwives but I think it's really important that there is no complacency around this. There is still a gap. As I've said, the workload is getting more complex and it may well be that the ratio of 1:29.5 isn't enough for London because that ratio will vary in terms of local circumstances. Also, we've got a huge retirement bulge coming up in our midwifery workforce. Seventeen per cent of midwives in London are aged over 55. A high proportion of young midwives are actually finding it increasingly difficult to afford to stay in London. The sheer costs of living is a problem.

In terms of safe staffing, the following is a quote from the Francis Report (Recommendation 23):

'The measures formulated by NICE should include measures not only of outcomes, but of the suitability and competence of staff, and the cultures of organisations. The standard procedures and practice should include evidence based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff of wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.'

I think we are now at least seeing an acknowledgement amongst the policy makers that safe staffing is critical if we are going to give high-quality care. Interestingly of course the evidence is increasingly

pointing to the fact that trusts that do employ reasonable numbers of staff actually do deliver better outcomes. There's stronger evidence.

We are looking forward in the new year to NICE publishing guidelines for safe staffing levels in maternity. Implementation of these guidelines ought to help, and it ought to encourage rigorous and regular assessments of their staffing requirements in maternity units based on what women and babies need. Having said that, the RCM has seen the first draft of the NICE guidelines and we have some considerable concerns: that at best it will be harmless and at the worst it could be unhelpful to totally harmful. Because at the moment we feel the guidance really is confusing. We've done a lot of work with NICE trying to rectify that situation and we are hoping that what comes out in February will be a lot better.

The big danger in maternity services is that services staff their labour wards and they pull midwives from the ante-natal period and the post-natal period, deplete them in order to cover this period that's meant to be 'the most risky'. The fact of the matter is that the women I've talked to you about already – the ones with medical problems, mental-health problems – they need care ante-natally AND post-natally. That's where they need the input most, and those are the services that are under most pressure. We very much hope that the guidelines will improve and we've certainly submitted comprehensive feedback to NICE, suggesting some changes that they might make.

The other thing that I wanted to mention to you was the pay dispute, and I think it's impossible to talk about health services across the country without referring to that. You will know without me saying that we are very upset about the government's refusal to implement the Pay Review Body's 1% recommendation. We think there is an absolute out-and-out assault on the NHS pay system and on the independence and integrity of the Pay Review Body. I think that's our biggest upset: that the Pay Review Body has been a clear deal between the staff and the employers. We've all abided by its recommendations over many years. It seems positively cavalier just to suddenly ignore it.

Figure 4 shows some aspects of the pay dispute.

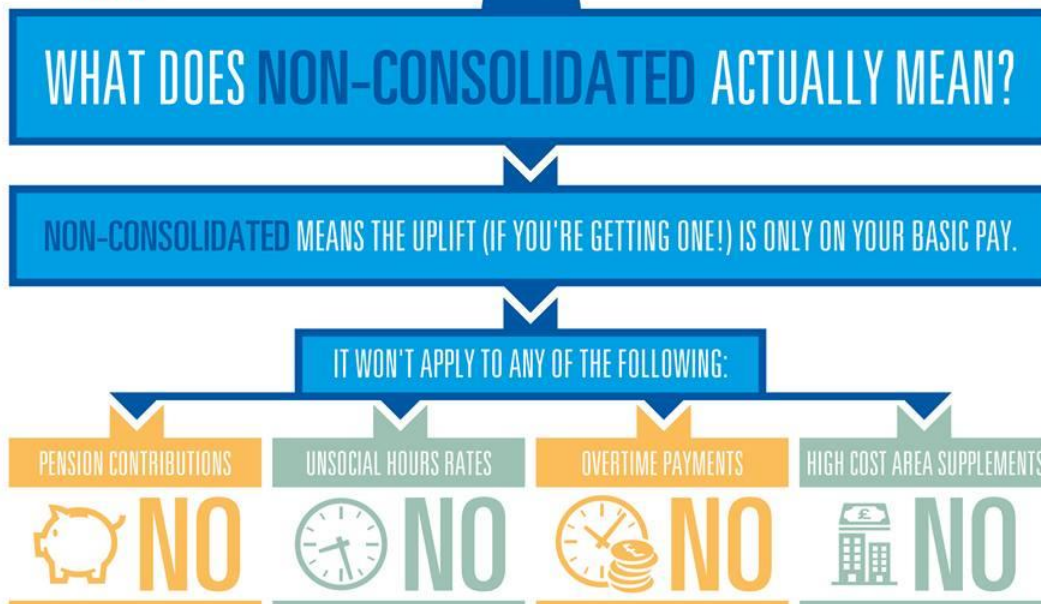


Figure 4

We are particularly upset that the impression has been given that midwives as well as other healthworkers have had a pay rise. It's absolutely not true. Only a small proportion of midwives at the top of their pay band received a 1% pay rise and it's what's called 'non-consolidated': given and then taken away. How anyone could call that a pay rise I don't really know. That will apply for the next 2 years.

We are now in the position where some staff have had a rise and other staff haven't. Midwives and maternity support workers in different parts of the UK have experienced different rewards. That's very divisive in terms of where people will go and work. Also, the failure to pay a rise to people who are moving up incremental pay progression means that newly qualified and younger staff are hit hardest because they are not at the top of their pay band. If there is an argument to be had about whether or not incremental pay increases are indeed a pay award, then that needs to be had in proper circumstances and not just a decision overnight by the government.

We're very upset about that, and I think it will affect our ability to recruit and retain midwives in London particularly, where the cost of living is so high.

Comparatively, Figure 5 shows what the pay award would cost.

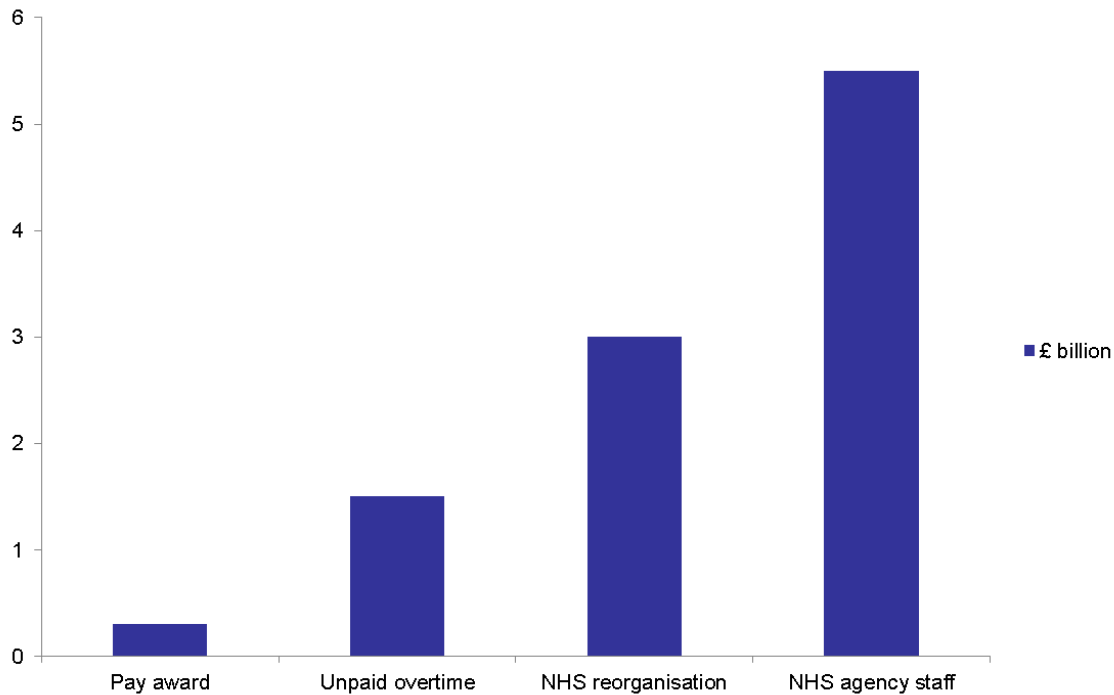


Figure 5 How much will the pay award cost the NHS?

A mere £300 million, which is far less than the £3 billion that the government wasted on the reorganisation of the NHS – which the RCM believes was an unnecessary activity and I couldn't even say it is settling down now. It's actually very, very difficult working with the current structures in the NHS. Very confusing and harder for everyone.

I also point out that if we paid staff 1% it would amount to £300 million, which is a fraction of the £5.5 billion that the NHS is currently spending on agency staff in London, or that they have spent over the last 4 years.

The other policy document that I would like to mention is the NHS *5-year Forward View*, which was published by NHS England recently. Simon Stevens has set out a strong case for transforming NHS services, which is allied to increased and sustained investment. In that he actually acknowledges that continuing pay restraint is probably not acceptable and not sustainable in terms of the productivity gains and improvements that we need to make. There is a strong argument that investing in staff will allow us to make some of the savings that are necessary.

Certainly in maternity services, we do need to transform the way we deliver maternity services and we do to make sure that staff are motivated and committed to doing that.

Moving on to service delivery, births in maternity-led units and at home have been very topical recently following the publication of the NICE intra-partum guidelines, and you would have certainly thought from the media that they only thing they made recommendations on were out-of-hospital births. They actually talked about a whole load more than that, but it was ignored.

If we do talk about midwife-led care and home births in midwifery-led units, the fact is that 45% of women in London could, according to estimates made principally by the Royal College of Obstetricians and Gynaecologists, actually deliver outside of our obstetric units. In London the average midwifery-led birth rate is 15%. We are way off the possible change that we could introduce.

The range of maternity services in London is from 1.4% of women delivering outside of the obstetric unit to 23.9%. There is a long way to go and the point is that we are very clear on the evidence now. That actually, certainly for women who are having their second or third baby, home births, a free-standing midwifery unit or alongside midwifery-led unit is a very positive place to plan to have your baby. For a first-time mother, home birth has got increased risks for the baby, but the midwifery-led units offer a very safe and positive experience as well – and it’s cheaper. But of course it’s not cheaper if you add it on to what you are already doing. What you have to do is transform the services and really turn them on their head and then overall you would save costs and of course you would save costs further up the line if outcomes for women are better.

Table 1 shows the home birth rates across London.

| Trust Maternity Units | Home Births 2010 -2011 | Home Births 2011-12 | Home Births 2012-13 |
|-------------------------------|------------------------|---------------------|---------------------|
| Barking Havering & Redbridge | 1.1% | 1.1% | 1.1% |
| Barnet & Chase Farm | 1.2% | 1.2% | 1.1% |
| North West London | 0.6% | 0.5% | 0.2% |
| Chelsea & Westminster | 0.8% | 0.6% | 0.7% |
| Ealing Hospital | 0.8% | 0.5% | 0.3% |
| Guy's & St Thomas's | 2.4% | 2.5% | 2.5% |
| Hillingdon Hospital | 1.1% | 1.4% | 0.7% |
| Homerton Hospital | 2.5% | 2.0% | 2.2% |
| Kings College Hospital | 5.2% | 5.4% | 5.4% |
| Kingston Hospital | 0.8% | 1.0% | 1.1% |
| Lewisham Healthcare | 1.0% | 0.7% | 0.7% |
| Croydon Health Services | 1.8% | 2.1% | 1.4% |
| Newham Hospital | 1.3% | 0.7% | 0.3% |
| North Middlesex Hospital | 0.4% | 0.9% | 1.0% |
| Royal Free Hospital | 9.4% | 1.3% | 0.6% |
| St Georges Hospital | 0.6% | 1.3% | 1.4% |
| St Helier and Epsom Hospitals | 0.3% | 2.3% | 2.0% |
| South London Healthcare | | 0.4% | 1.8% |
| Imperial | 0.4% | 1.4% | 1.2% |
| The Royal London Hospital | 2.6% | 0.8% | 0.7% |
| University College Hospital | 1.4% | 1.1% | 1.1% |
| West Middlesex Hospital | 0.2% | 2.0% | 2.2% |
| Whipps Cross Hospital | 1.2% | 0.5% | 1.1% |
| Whittington Hospital | 2.3% | 1.9% | 2.0% |
| TOTAL NHS | 1.5% | 1.4% | 1.4% |

Table1 Home birth rate across London

That is declining and now stands at just 1.4% of births in the capital. There is a significant variation across London with one in three trusts having home-birth rates below 1% while four trusts have home-birth rates at or above the national average, with King’s College Hospital achieving a rate of 5.4%.

It is interesting at King’s College because they have actually had a very high home-birth rate now for what will be 15-20 years. That is because there has been a strategic approach to delivering a home-births service in that maternity unit, which is not person dependent. So often home births depend on

charismatic midwife advocating them, but when you strategically plan a service you can maintain it and sustain it regardless of people in post. I think King's is a very interesting case study.

It could be that if we develop midwifery-led units fewer women will want to give birth at home. Some of the midwifery-led facilities are nicer than some people in London's homes – a lot nicer. So we don't quite know how that will pan out. On the other hand, as I say, where there is a commitment to increasing the home birth rate you tend to be able to do it. Kingston Hospital has just introduced a dedicated team of midwives to deliver home births and they have already increased the rate from 1% to 3%.

Other things in terms of maternity policy (Appendix 1). I've mentioned the NICE guidelines and I think it's going to be very interesting to see how commissioners respond to the particular aspect of the guidance which I've already touched on, which is about the safety of out-of-hospital birth. I've already mentioned the *5-year Forward View* and we are very pleased that the general principles in that which effectively say what we've been saying for a long time. Which is that you can't transform services if you start from where we are. There are just not enough resources, or energy, to make the changes that are desperately needed. It will need investment. But in the long run that should ensure we can deliver more effective and high-quality services.

The *Forward View* has recognised that maternity services specifically need to be delivered differently. They are going to do a review of maternity services; we don't know a lot about what that will look like, but we are obviously following that with interest. They are also interested in looking further at the tariff for maternity services and how maternity services are funded – an issue that is causing increasing problems.

NHS England has also reviewed the policy of women accessing a named midwife to assess how this is being defined by maternity services, and to try and measure the extent to which vulnerable women are getting a named midwife and the extent to which that named midwife actually improves their care. For many women, it's just a name on a set of notes. But we now know that if women – particularly vulnerable women – get more continuity of care, have a relationship with their midwife, things can improve for them.

It doesn't feel like rocket science: that if you build a relationship with someone your care over a 9-month period is likely to be better and you are less likely to fall through the cracks in the system. But it doesn't really happen in many of our maternity services.

In London the Maternity and Children's Strategic Network I think is doing a good job. They are certainly working on things that certainly the RCM and RCOG would very much consider to be the priorities. They are working on increasing the number of women accessing continuity of midwifery care in London, which I've just mentioned. They are looking at improving the detection of foetal growth abnormalities as a way of reducing the number of still-births which is still shockingly high. They are very much looking at reducing the number of maternal mortalities in London. So we are on the same page as they are.

Three final challenges:

1. Growing and sustaining freestanding midwifery-led units (FMUs).
2. Role of maternity networks in the context of greater competition.
3. Do maternity PbR tariffs reflect costs of specialist care and care for high-risk women?

I've touched on the first one, which is how are we going to increase the number of out-of-hospital births in line with the evidence. Secondly, how can maternity networks really be effective in the competitive environment that also being promoted? We find the whole issue of collaboration and competition sometimes works against itself, they work against each other. In maternity there is absolutely no doubt that collaboration is the way to deliver high-quality services.

Finally, what I have not said very much about: there is a major problem with the fundamental funding methodology of maternity services. The tariff is just not right, and it's particularly a concern in London amongst some of our more specialist obstetricians that the needs of women who are severely medically ill and severely mentally ill are simply not covered by the tariff. There is a real worry that the specialist units will not see women being referred for the multi-disciplinary care they need because there is no incentive to do so within the tariff. There is also a current problem in that foetal medicine services, which are delivered by a lot of the maternity units in London, are now coming out of specialist commissioning into the ordinary tariff with no additional funding following them. There are some major problems to be picked up.

That's a quick romp but I hope that gives you a flavour.

RL: I'm exhausted!

LI:

Most of my middle-class friends had babies at home, and I work in a deprived area as a GP in Deptford and most of my patients wouldn't have space, it wouldn't be easy for them to have home births. You talked about the different rates across London. Does that correlate with incomes and house sizes?

CW:

No. Interestingly, it actually is the other way up. King's, with the highest home birth rate, also sitting in Southwark, Lambeth and South-East London, with one of the highest deprivation indexes, delivers care wherever the women live. Many of their women choosing home birth are very very disadvantaged, deprived, young single women living in very small bedsits; whereas somewhere like Chelsea & Westminster actually has one of the lowest home-birth rates in London. So it's actually all about what the services really support and really offer to women. You can deliver a woman in any sort of home.

LI:

That's fascinating. You talked about the safety of home births and stand-alone midwife units and ones that are attached to an obstetric unit but not part of it. Is there any difference between the stand-alone and the attached ones, as far as you know?

CW:

No. The big study on which this all based is *Birthplace in England*, which is the only study that has had adequate numbers to show any potential statistical differences. For multips [multiparous women] there was absolutely no difference for their babies whether they chose to birth at home, in MLUs, free-standing or alongside. Their own experiences and experiences of intervention were better than in the obstetric units. For primips [primiparous women] the only difference is the babies have a slightly increased risk of a poor outcome at home. There is no difference between the FMUs and the AMUs¹.

¹ Alongside Midwifery Units and Freestanding Midwifery Units

SR:

Can I just take you back to the figures about the pay rise and bank and agency midwives. Perhaps it's better being national rather than London, but I was just struck that they weren't necessarily easily comparable. It would be really good to have your estimate of how much is being wasted on bank and agency midwives as a result of poor pay. So that we could actually see: they might even balance, therefore that just looks like the supreme incompetence.

CW:

It's difficult I think to know what the direct correlation is. So you would have to start from a premise that if you pay staff properly and you treat them with respect, you are more likely to retain them, you are more likely to keep them in service. Ultimately, you will not end up having constant gaps with people leaving. You will have less sickness and absence and by actually hitting retention rates and sickness and absence rates, you will reduce your need for agency spend. It's not really as direct as 'because midwives aren't getting paid enough we're therefore having to go to bank and agency'. I think it is more to do with the morale, motivation, people being able to stay in London.

SR: It would be really good to have something worked out by your organisation.

CW: It definitely would be like for like.

RL: What's the upshot of these pay talks going to be? I think there were talks on Monday weren't there [15 December 2014]? Were you there? What happened?

CW: No I wasn't there on Monday and I haven't had any feedback yet from Monday, which effectively means probably no change.

RL:

The end of this is going to have to be sorted by the election isn't it? They won't want to go into the election with a pay dispute, but it's difficult to see where the uptake would come from in the current financial cycle.

CW:

Yes, and yet it feels like a relatively small sum of money to be found. It may be that there is some position which isn't about this year and is about next year.

RL:

I'm not asking you to give away your bargaining position, but the solution might be found in the pay spine, whether or not we'll have this dual uplift arrangement, or you can see where this will head. Because there is no law that would need to be changed for trusts to be able to settle themselves.

SO:

Agreement has been reached in the last couple of years around changes to Agenda for Change and around pensions, but the key is there's been proper talks and negotiations and it's not been an imposition, which this was.

JL:

I do know that there is anecdotal evidence that some of the nurses who are coming back on agency are doing so because they can actually relieve pressure at work, they can choose their hours a bit more, and they don't have to carry the day-to-day stress of very busy units. Do you find that is also an issue with midwives? Are there any particular trusts where it is a big issue?

CW:

I think there is. I think there are places where midwives just want to have more control over what they do and when they do it and they come back on agency. I also am hearing anecdotally that you do earn significantly more. That wasn't the case when we were mainly using bank, because we held those rates. But it seems to be slipping again. So there is an incentive, if you don't really mind about not being part of the team and all you are interested in and have to be interested in is making ends meet: agency becomes quite an attractive process.

RL: Flexibility as well, that makes a difference. You can do 2-3 days, work it in with your partner.

CW:

There's no doubt at all that when you go and visit maternity units the places that have got good, flexible high-quality leadership and really help staff as they want to as opposed to this one rule and everybody follows it recruit the staff.

RL: Thank you very much.

Appendix 1 Key maternity policy developments

NICE intrapartum care guideline: <https://www.nice.org.uk/guidance/cg190>

NHS England Five Year Forward View: <http://www.england.nhs.uk/ourwork/futurenhs/>

NHS England review of access to a named midwife policy

London Maternity & Children Strategic Clinical Network, work programme:

- Increase number of women receiving continuity of midwifery care.
- Reduction in stillbirth rate.
- Reduction in maternal mortality rate.

Source: *RCM Heads of Midwifery Survey 2013*.