Health Inequalities - Early Years

Pregnancy and Parents Centre

The Pregnancy and Parents Centre has prepared the following submission in response to the consultation being held by the Health Committee to determine whether early years interventions to tackle health inequalities are effective, from pre-birth services to interventions with young children.

Our submission is based on many years experience of working with pregnant women and their families throughout Lothian and beyond. Accessibility and social support through pregnancy to the early years are central to the PPC’s aims and objectives. That the PPC succeeds in providing an extensive and long term social supportive network is evidenced by parents still meeting following groups that started 25 years ago.

Pregnancy and Parents Centre

The Centre evolved from work with pregnant and postnatal women in 1985, and is now located in Lower Gilmore Place in a two storey building beside the Union canal. It was set up as a not for profit charity and currently provides a range of support groups, workshops and drop in sessions for over 350 pregnant women, dads to be, and parents with babies and/or young children each week. It is almost entirely self-funding and has a policy of welcoming all, regardless of income, background and beliefs. The Centre is run by six volunteer Directors, a full-time paid co-ordinator, two part-time paid administrative assistants, trained birth educators, postnatal yoga, music and massage teachers and midwifery facilitators, and relies heavily on volunteers.

Effective maternity care to support parenting

Listening to women

At the Centre we spend a great deal of time with women, listening to their experiences and understanding what makes a physically, emotionally and culturally safe birth for them, and why this is important for them as they make the transition to parenthood. We have a large proportion of women who are new to Lothian and whose first language is not English, as well as numbers of women who have suffered from or develop mental health problems during pregnancy or postnatally. All of these women are particularly vulnerable. Often they are unable to access midwives when they need to because they are not familiar with how services run, or because their midwives are too stretched, or because they see a different person at each antenatal or postnatal visit, or because they do not have long enough with a health practitioner to begin to explain how they are, or because it is difficult for them to communicate in a foreign language. These women sometimes have difficult experiences which are undermining, traumatic and do not set them up in a positive way for parenting. Many women, overtly vulnerable or not, tell us how they would benefit from seeing the same midwife throughout their pregnancies, labours, births and the postnatal period – a midwife who had time to get to know them and where communication and trust could develop.

Very many women also tell us that they would like to have a normal a birth as
possible without unnecessary interventions in order to be as fit and healthy as possible after birth, so that they can best take care of their babies. But many do not develop the confidence they need during their pregnancies, and feel overwhelmed by the conflicting ideologies of midwifery and medical approaches to birth and the medical environment in which they usually find themselves for birth. But because there are few, easily accessible, well supported alternatives, they feel obliged to accept what is on offer. They also want the very best medical services that are responsive and communicative when these are genuinely needed, but it is often unclear whether advice they are being given is because of routine hospital policies, or because they and their baby need a particular intervention. This can lead to feeling out of control and for some women leads to post traumatic stress, and/or postnatal depression. These are known to interfere with the early bonding between mother and baby and make it more difficult for a mother to care for her baby in the way she wants to. This in turn leads to a less healthy start for the infant, which can impact on the early years and beyond. The benefits of early years interventions are increasingly recognised:

'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking'.

**Benefits of midwifery-led care**

We now have first-rate evidence about what comprises best care for women in birth and the best start for new mothers, their babies, and their families.² This exactly mirrors what women have been telling us since 1985. Best outcomes for healthy women at low risk of complications come from caseloading midwifery led care, either in a midwifery unit, alongside or freestanding, or home birth, (though free standing midwifery birth centres had better outcomes than alongside units), when these are integrated into community and tertiary NHS services as required.³ Evidence from elsewhere suggests that all women benefit from caseloading midwifery care during childbearing, not only those women suffering the impacts of poverty and other disadvantages.⁴

**Continuity of midwifery care - caseloa**

In the UK the Cochrane review² on midwife-led continuity models of care concluded that women were:

- less likely to experience regional analgesia
- less likely to have an episiotomy
- less likely to have an instrumental birth
- more likely to give birth without analgesia/anaesthesia
- more likely to have a spontaneous vaginal birth
- more likely to be cared for during labour and birth by a midwife they
knew
- less likely to experience preterm birth
- less likely to have a fetal loss before 24 weeks' gestation
- higher maternal satisfaction
- lower financial costs

And a leading medical journal included the following in its editorial:

'The effect of continuity of midwifery carer on the health and well-being of women and their newborn infants has been underestimated and neglected for many years. The increased focus on mitigating risk, especially during labour, childbirth, and the first 24 h of life, has led to an increase in hospital births, where the highly individual and idiosyncratic processes of labour and delivery have to fit into hospital routines, timelines, and protocols. Such practices can lead to an increase in routine interventions and the presence of a multitude of carers working typical 8 h shifts. In such settings, women are less in control of their pregnancy, labour, and delivery, which can have adverse effects on the progress of childbirth through to early childhood'.

**Use of birth pools**

Over the last few years, more research has been carried out into the use of birth pools during labour and/or birth. Access to birth pools is still not uniform across Scotland and even in areas served well with birth pools, these are available on a first come, first served basis. Women have consistently reported to us over very many years that access to a pool (whether or not they had planned this) contributed to their experience of labour and birth and invariably provided them with pain relief and the ability to move around during labour and adopt favourable positions, enabling them to give birth without the use of analgesia, anaesthesia or other interventions. Their views are now supported by research, which shows that, especially for women having their first babies, they are more likely to have a straightforward birth when using a birth pool. The impact of straightforward positive experiences of birth cannot be underestimated in helping mothers feel satisfied and confident as they begin parenting their newborns.

**Barriers to promoting woman-focused support to improve overall health**

We also have a good understanding as to why many women are not receiving optimum care and the lost chances to build individual maternal health for women and better broad health outcomes for our communities. Amongst other indicators, a rising maternal mortality rate since 2007 across the UK is our most sensitive measure that all is far from well.

Of the approximately 58,000 births per year in Scotland, there is a normal birth rate of only 38% while the caesarean rate stands at 27%.

**Cost effectiveness of midwifery/community care**

It has proved very difficult to mainstream evidence-based, cost effective care within the NHS in Scotland which would reduce the rates of interventions, increase safety and well-being for women and reduce overall costs. These are the figures below on cost effective care.
For women with low risks, the majority of women, the costs per birth are as follows:
£1066 home
£1435 free standing midwifery unit, like Montrose
£1461 alongside midwifery unit, like Edinburgh Royal
£1631 for consultant obstetric units

**Midwifery shortages and lack of resources**
The Health and Social Care Act, England has already led to the competitive tendering of some £65 million of community midwifery service provision, much to the dismay of the London-based Royal College of Midwives. The RCM has raised serious concerns about the continued increase in the birth rate at the same time that maternity services are under severe pressure to cut costs, while an ageing midwifery workforce is subject to midwives burning out and dropping out. Outcomes for women are not as good as they should be when measured against international research.

In Scotland, training places have been radically reduced, cutting midwifery schools from six to three and cutting midwifery tutors and other staff in those remaining three centres.

**Possible solutions and models of care**

**Midwifery Caseloading**
Community based midwives are concerned about their reducing numbers and about top-down initiatives like the Early Years Framework which take insufficient account of local capacities and how best to achieve the genuinely good outcomes for women from early pregnancy onward.

There is an excellent and proven model for improving outcomes which is workable for midwives, the internationally recognised Albany Practice which produced best outcomes for all women, especially those women experiencing multiple disadvantages. In a setting like East Glasgow for instance, where one in two children lives in poverty, an Albany model practice would immediately begin to raise the profile of health and well-being for young families in that community.

**Birth centres**
Another social model that has been shown to be safe and cost effective is a free standing birth centre (FMU) model. In a large prospective trial, Birthplace study free standing birth centres had particularly good outcomes, especially for women having their first babies. They were shown to be very safe for babies and women received fewer interventions. A secondary study showed that: ‘For births planned in FMUs, immersion in water was associated with a lower risk of intrapartum caesarean section and a higher chance of a straightforward vaginal birth’. The transfer rate to an obstetric unit was also lower than for home births and alongside midwifery units. In Scotland, free standing birth units were relatively common; however they have been gradually closed, often amid public protests. An outstanding example of a more recent Birth Centre, led by midwives, is that of Montrose, which serves a mixed population and has excellent outcomes.
consistently excellent outcomes and are well liked by their communities. Midwives enjoy working in them and recruitment is never an issue. In the Birmingham area, two Birth Centres have been introduced in areas of high deprivation and poor outcomes in order to improve services and outcomes and attract midwifery staff. They have been positively evaluated. For the most recent three year evaluation contact Consultant Midwife, Kathryn Gutteridge (Sandwell and west Birmingham Hospitals NHS Trust), kathryn.gutteridge1@nhs.net.

Building on community resources
We have long been attempting to introduce caseloading midwifery at the Centre, in order to respond to what women want, reduce stress (known to be detrimental to babies in the womb), improve outcomes, strengthen families and increase capacity in our local community. With well over 100 pregnant women already coming to the Centre each week, we are ideally placed to run a research project with a group of midwives offering a caseloading service. We are located in an inner city area, close to Haymarket and Gorgie/Dalry – areas with known populations suffering disadvantages (our Centre was used as a venue for the Peachie Project for young pregnant women) and we worked with the Scottish wide Muslim Women's Resource Centre, Amina, to run pregnancy groups for Muslim women. We also have a New Arrivals weekly group for women new to Lothian. In addition we are integrated into existing services through our local community midwives, who recommend women to our services. We are currently seeking opportunities to introduce caseloading at the Centre, in order to evaluate potential benefits for women, families and midwives.

Supporting a responsive NHS
There is clear political expression in Scotland for not turning NHS Scotland into a commodity for private health care providers to be sold off piecemeal. This makes it easier to begin to ask what directions can NHS Scotland take to come closer to the expressed need and vision people now have to retaining health services as a core social good for all and to reducing health inequalities overall. Many of the administrative problems and aspects of the institutional culture of the NHS in Scotland and the historical issues of the costs of the three PFI hospitals14 in Scotland are amenable to change in order to gain the NHS people need and want. Dr David Gillies, the Chair of the Royal College of General Practitioners Scotland makes the case for two broad changes in shifting resources in the most beneficial direction:

1. An extended network of primary and community–based care services  
2. A ‘communitarian approach’ which entails a genuine inclusion of the community voice in the NHS and responsiveness to community need.

How to make these approaches and models like the Albany a reality in Scottish communities:
- community forums to give women and midwives the space to speak out about what they need  
- bringing the research evidence to women and midwives to say this is what could happen
rejecting the Fordist production line of care enforced on an overstretched and fractious NHS, dominated by concerns of about clinical indemnity and risk which actually create real risks for women, while midwives lose their confidence and skills

- helping communities to hear the stories of those women fortunate enough to have had the care from midwives like those in Montrose and to hear how the Montrose community retained its midwifery unit and transformed it into a UK-wide award winning practice

Pregnancy and Parents Centre
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References
13 http://birthinangus.org.uk/angus-midwifery-services/montrose/
14. Allyson Pollock estimates a PFI as costing between 12% and 14% of any given NHS budget for 30 years, See her *NHS PLC*, 2004:2.