Obstetric services in the UK: what we need now

Pregnancy and childbirth should be a safe and memorable experience for both women and their partners. This article discusses the current position of maternity services, their strengths and limitations, and suggests future directions required to improve these services further.

The objective of modern maternity services is to provide safe, accessible and high quality maternity care to both women and their partners (Department of Health, 2007). Pregnancy and childbirth should be satisfying for the woman and safe for both the woman and the baby (Department of Health, 2007). A high standard of maternity service should be available to all women taking into account their individual requirements such as language, religious, cultural and social needs. However, at present we are not able in the UK to achieve maternity care that meets this challenge. What do we need to do achieve that? This article will consider the current position and the short-term changes needed to aide a long-term solution.

In order to do this we need to consider the current and developing strengths of maternity services and then the weaknesses and challenges the service is faced with.

Strengths

There has been a longstanding culture of audit within maternity services starting with the Confidential Enquiry into maternal deaths. The Confidential Enquiry into Stillbirths and Deaths in Infancy developed this work and the two Enquiries are now under the umbrella of the Confidential Enquiry into Maternal and Child Health. The culture of learning lessons from these Enquiries continues today and although the budget has been reduced significantly, continuing effectiveness of the Enquiry will remain vital for maternity services. Maternity services in general have benefited from the guidance produced by national organizations including the National Institute for Health and Clinical Excellence and the Royal College of Obstetricians and Gynaecologists. These guidelines are used to promote the education and training of health-care professionals and help women make informed decisions regarding their care.

There has been a shift in the attitude of consultants to maternity care. Rather than being gynaecologists who do antenatal care there are an increasing number of obstetricians who do some gynaecology and even many pure obstetricians. There are now obstetricians with a special interest in a particular area, e.g. maternal medicine and fetal medicine as well as labour ward leadership.

Towards Safer Childbirth (Royal College of Obstetricians and Gynaecologists, 1999) encouraged greater consultant presence on the labour ward and the Clinical Negligence Scheme for Trusts incorporated this into standards giving some financial benefit. The active presence of obstetric consultants on the labour ward has increased and in 2002, 40% of labour wards in the UK had 40 hours a week of consultant presence as compared with 20% in 2000 (Royal College of Obstetricians and Gynaecologists, 2003).

The Royal College of Obstetricians and Gynaecologists has indicated the importance and benefits of a consultant-led service by suggesting that in the future 40-hour cover should become 60 hours and then 98 hours, with 168 hours a week in larger units with more than 6000 deliveries annually by the end of 2008 (Royal College of Obstetricians and Gynaecologists, 2005). The achievability and affordability of this is doubtful but the aspiration indicates a greater emphasis in obstetrics for consultants. Other evidence supporting the need for 168-hour consultant cover was highlighted by the Hospital at Night study (NHS Modernisation Agency, 2005) which has shown that in obstetrics, paediatrics, intensive care and acute medicine, the level of clinical activity remains the same throughout a 24-hour period; hence the cover provided should be the same 24 hours a day, 7 days a week.

There is great strength in the working relationships of obstetricians and midwives. Mutual respect can only enhance the provision of care. Midwives are skilled individuals who provide support for women, both high and low risk, and are integral to the service provided by obstetricians. When the professions work well together high quality care follows. When there is a lack of mutual trust the women and the service suffers.

Currently intrapartum care has very low rates of serious adverse outcome such as intrapartum perinatal mortality. Even though every death or disabled child resulting from labour is a disaster, these events are less common than previously.

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Weaknesses

Approximately 1 in 200 pregnancies end as stillbirth; of these, one third occur at term and the neonatal death rate is around 1 in 300 (Confidential Enquiries into Maternal and Child Health, 2004). Despite better monitoring and antenatal care, stillbirth rates continue to remain the same as in the 1990s. Women from ethnic minority, and women under the age of 20 years or over 40 years are more likely to have increased problems with their pregnancy (Confidential Enquiries into Maternal and Child Health, 2004). The levelling off of stillbirth rates is a concern. It is partly explained by changes in demography with an increased number of ethnic minority women. Unfortunately these women have higher loss rates and this creates a challenge for maternity services.

Pregnancy-related complications in the disadvantaged and vulnerable group of women remain high. These women are 20 times more likely to die from complications related to pregnancy. In addition, infant mortality rates are also higher in this group of women (Confidential Enquiries into Maternal and Child Health, 2004). The latest Confidential Enquiry into maternal death showed that:

- Women who lived in families where both the partners were unemployed, many of whom suffered from social exclusion, were up to 20 times more likely to die than women from the more advantaged groups
- Single mothers were three times more likely to die during pregnancy and childbirth than those in stable relationships
- Women from the most deprived areas of England had a 45% higher death rate than women living in more affluent areas
- Women from ethnic minorities (non-white) were three times more likely to die.

Many national documents are aiming to address these issues with aims 'to develop a patient-led National Health Service (NHS) that uses available resources as effectively and fairly as possible to promote health, reduce inequalities and deliver the best and safest health care' (Department of Health, 2006). The Department of Health has produced the National Service Framework and *Maternity Matters*; all of these documents promise high quality care, individualized and with continuity. One of the aims of these documents is to encourage women's choice with a view to reducing intervention rates, particularly since increased intervention rates do not necessarily produce benefits in terms of better outcomes. On the other hand, the maternity service has huge difficulties meeting the expectations placed upon the service by these documents broadly because of workforce issues, interprofessional issues, litigation and funding.

While consultant obstetrician numbers have increased, further increases to meet the hours targets above are unlikely because of funding issues and lack of appropriate candidates. Recruitment to obstetrics and gynaecology is low at present. Fewer UK graduates than ever show intentions of continuing to train in obstetrics and gynaecology (British Medical Association, 2004). Turner et al (2006) found that, in 2002, only 2.8% of graduates selected obstetrics and gynaecology as their first choice of specialty. These numbers will not be sufficient to replace the increasing number of retirements and will not allow for consultant expansion (Royal College of Obstetricians and Gynaecologists, 2005), as a result of which competition for jobs and choice for employers will be reduced. The reasons for the problems in recruitment are complex and multifactorial. The main deterrents to recruitment and retention have been identified as current prolonged working hours, unsatisfactory working conditions and the shift pattern of work (25%), fear of litigation (13%) and bad undergraduate experience (11%) (Whitten and Higham, 2007). Other perceived factors were difficulty in obtaining a national training number and a general level of dissatisfaction and disillusionment within the specialty.

The European Working Time Directive has led to a reduction in the working hours of doctors. From August 2004 the average working hours were reduced to 56 per week with a further reduction to 48 hours required by August 2009. Before changes in training and the European Working Time Directive, a surgical trainee could expect to work over 30 000 hours between becoming a senior house officer and getting a consultant post (Phillips et al, 2003). The Chief Medical Officer proposed further reforms that would reduce this to 6000 hours (Donaldson, 2002).

A survey in one of the training regions indicated that even if trainees had the opportunity to perform every single operation on the theatre list, the total number of procedures available was a third less than the minimum numbers recommended by their trainers (Crofts et al, 1997). The same survey also showed that an increase in theatre time required for increased trainee operating in one specialty was estimated at approximately 270 extra theatre days per year with a resulting cost of around £1.3 million (Crofts et al, 1997). This trend is similar in gynaecological surgery with the number of surgical procedures decreasing and the procedures that are still being carried out often being too complex for trainees to perform. Therefore to ensure safety of women and achieve good outcomes, major pelvic surgery will be considered as an advanced skill that only a few will be trained to perform.

Midwives reasonably consider themselves as independent professionals. While this is correct, it flows against the general tide of multiprofessional working. This creates a tension in services about who the woman 'belongs' to rather than concentrating on ensuring that appropriately skilled professionals are available in a timely way for all women. Women's expectations of a good outcome are higher now than at any stage and strong team working will be needed to meet these expectations. Obstetricians and midwives cannot engage in a turf war fighting over existing resources – instead we should be arguing the need for more turf.

This is reflected in the reduced numbers of midwives. This is either because there is a shortage of midwives or staffing establishments do not meet those expected when an analysis of workload is undertaken. Unfortunately now in some areas student midwives completing training have no jobs to go to even though services need more midwives to provide the level of services expected from Department of Health guidance.

Obstetric litigation accounts for about 50% of all clinical negligence cases reported to the Clinical Negligence Scheme for Trusts (Department of Health, 2000). Cerebral palsy remains the most common type of neurological abnormality to feature in litigation and despite improvements in antenatal and intrapartum care the rates remain the same, around 2–3 per 1000 births (Capstick, 2004). Payments in obstetric claims are of the order of £250 million per year. The current contribution to the Clinical Negligence Scheme for Trusts is of the order of £450 per birth. This creates a fear within the service of criticism with an adverse outcome and is part of the reason for an increasing rate of intervention. Wrongful caesarean section is not a common claim.

However, this also impacts upon funding for services. With an average payment for a normal birth under the current tariff of around £950–1000 nearly half goes in indemnity cost. As indemnity costs rise much faster than the tariff is being increased, within 10 years the cost of indemnity may be greater than the payment to provide care. Each new Department of Health document suggests a requirement for improved services and identifies aspirations which women expect to be achieved, e.g. one-to-one care in labour, interpreters for non-English-speaking women, specialist midwives for screening. There is a seemingly endless list of demands on maternity care, yet for a trust it is a high volume service that loses money on every case. In the financially driven service we have to live within these are competing difficulties which have no obvious solution.

What do we need now?

So, having described the difficulties what are the solutions? The aims of the national documents are generally laudable and no one could disagree with the aim of increasing support to improve outcomes in vulnerable women. Much of this can be achieved by smarter working relationships between professionals. Low risk women will have to have less care although most of them still want more. However, the single most important requirement is an acknowledgment that the way in which the tariff is structured will not allow care to meet the standards described. If indemnity costs were met from outside of tariff this would be a more realistic funding approach and would separate the different rates of inflation. The tariff also needs to acknowledge that birth outside hospital within the current structures is more expensive. If there is a genuine aim to increase outside consultant unit birth then extra funding for midwives will be required.

However the current patterns of place of birth evolve, improving communication between midwives and obstetricians is obligatory to prevent increasing problems. With the greater involvement of consultants in care around birth hopefully increasing mutual respect will avoid the disagreements about the roles of the different professionals. This would hopefully improve trainees' views and perspectives on a career in obstetrics. **BJHM**

KEY POINTS

- The framework for obstetric services is provided by national guidelines and national audits including the Confidential Enquiry into Maternal and Child Health.
- There is now a greater presence of consultants on the labour ward in order to provide obstetric cover in line with recommendations by the Royal College of Obstetricians and Gynaecologists.
- Despite improvements in maternity services, stillbirth rates and maternal mortality among vulnerable women remain high.
- Poor rates of recruitment and retention of trainees in obstetrics and high costs of litigation remain a problem.
- What is needed now is recognition within the maternity tariff of the high indemnity contribution which is increasing faster than inflation.

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British Medical Association (2004) *The BMA Cohort Study of 1995 Medical Graduates.* Ninth Report. BMA Health Policy & Economic Research Unit, London

Capstick B (2004) The future of clinical negligence litigation? *BMJ* **328**(7437): 457–9

Confidential Enquiries into Maternal and Child Health (2004) *Why mothers die.* The sixth report of the United Kingdom Enquiries into maternal deaths 2000-2002. Royal College of Obstetricians and Gynaecologists Press, London

Crofts TJ, Griffiths JM, Sharma S, Wygrala J, Aitken RJ (1997) Surgical training: an objective assessment of recent changes for a single health board. *BMJ* **314:** 891–5

Department of Health (2000) *An organisation with a memory.* Department of Health, London

Department of Health (2006) *Health Reform in England: update and commissioning framework.* Department of Health, UK

Department of Health (2007) *Maternity Matters Choice, access and continuity of care in a safe service.* Department of Health, UK

Donaldson L (2002) *Unfinished business: proposals for reform of the senior house officer grade. NHS consultation paper.* Department of Health, London

NHS Modernisation Agency (2005) *Fundings & Recommendations from Hospital at Night Project.* NHS Modernisation Agency, London

Phillips H, Fleet Z, Bowman K (2003) *The European Working Time Directive—interim report and guidance from The Royal College of Surgeons of England Working Party.* Royal College of Surgeons, London

Royal College of Obstetricians and Gynaecologists (1999) *'Towards safer childbirth-minimum standards for the organisation of labour wards'. Report of a joint working party,* Royal College of Obstetricians and Gynaecologists, London

Royal College of Obstetricians and Gynaecologists (2003) *Response to the report by CMO: making amends a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS.* Royal College of Obstetricians and Gynaecologists, London

Royal College of Obstetricians and Gynaecologists (2005) *The future role of the Consultant: A Working Party Report.* Royal College of Obstetricians and Gynaecologists, London

Whitten SM, Higham J (2007) Recruitment and retention into obstetrics & gynaecology; the influencing factors. *Br J Hosp Med* **68**(1): 42–6