Obstetrics: what we need in the future

Health-care professionals who work in obstetrics have seen many changes over the last decades, with both good and bad results. But what changes could be made to improve the future care of pregnant women?

There have been many changes over the past two decades in obstetrics services. Some of these have been the result of technological advances and the application of findings of sound scientific studies. The introduction of screening for aneuploidy, better ultrasound imaging and the creation of the sub-specialty of fetal medicine are all examples of this.

Another change has been senior clinicians specializing in obstetrics alone, recognizing that their energies are better spent concentrating on the care of pregnant women, without the distractions of general gynaecology, as recognized by the Royal College of Obstetricians and Gynaecologists in their report *The Future Role of the Consultant* (Royal College of Obstetricians and Gynaecologists, 2005). This mirrors the change in the other specialties; there are few true general surgeons and physicians left practicing in the NHS.

There have been political and social changes that have altered the way that doctors of the future will be trained and work in the NHS. First there was the Calmanization of training and the loss of the senior registrars, with subsequent shortening of training. The pursuance of better rotas by the British Medical Association in the New Deal, and the implementation of the European Working Time Directive, has meant that trainees now work shorter hours, and inevitably have fewer training opportunities to experience the rarer clinical problems on the delivery suite and to learn how to perform procedures.

Perhaps what is needed in the future is less change and more consolidation of what there already is. In the Department of Health's publication *Maternity Matters* it was declared that what was wanted was choice, access and continuity of care in a safe service (Department of Health, 2007).

Choice, access and continuity

The choices in *Maternity Matters* are about how women access maternity care and where this is provided. It is recognized that it is now the community midwife who is often approached first, but that a woman should be able to refer herself direct to hospital care if she wishes. A more flexible approach is needed to booking women so that this can be achieved. There needs to be a range of areas in which women can access further antenatal care, recognizing that not all women will be seen at home by the community midwife (in any case this is inefficient), and not all women need to go to hospital for appointments that do not require specialist services. There is a need for more satellite sites for comprehensive low-risk antenatal care in the community. There needs to be the development of self-managed midwifery partnerships, like the Albany midwifery practice in London (Atkins, 2007), which has reduced the caesarean section rate and increased the home birth rate, just by educating and supporting women. This increased choice of care in the community will lead to better access and continuity.

Concentrating low-risk care in the community will mean more time in the hospital clinics for high-risk women to be seen by obstetricians with special interest in the relevant problems, such as previous preterm labour, and significant medical problems including perinatal mental health problems, which has been shown to be a much neglected area of care. It would also give more time to the development of better postnatal care and debriefing sessions for women who have had complex pregnancies and labours.

Place of birth

Women should be offered more choice about where they will have their babies: at home; in stand-alone birthing units; in midwifery-led units co-located with obstetric units; or in consultant-led obstetric units. All the choices need to be safe. There is no conclusive evidence that home birth or birth in other non-consultant settings is as safe as within a consultant-led unit (National Institute for Health and Clinical Excellence, 2007). It will be vital that there are clear and agreed standards for transfer of women from home or midwifery units in case of complications to maximize safety. The different reasons for transfer to an obstetric unit need to be agreed, and ambulance services need to be comfortable with the likely increased levels of activity. The stringent clinical governance of obstetric units must be mirrored in the community non-obstetric setting.

With increasing community care, including deliveries away from obstetric units, some obstetric units may become increasingly unviable because of fewer deliveries. This is already occurring around the country because of changes in neonatal services. In time it may mean that in some areas there needs to be consolidation of smaller obstetric services, and the creation of big units with 6000

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or more deliveries per year. This is likely to cause significant local anxiety and concern and the changes need to be well managed.

Funding

In obstetrics, safe services can only be ensured by their smooth running. The problems at Northwick Park Hospital (Healthcare Commission, 2006), which was clearly not a safe service, stemmed from problems in the running of the service. In turn there were deficiencies in staffing and funding. To resolve the issues highlighted in the Healthcare Commission's report, new staff were recruited and funds were made available for both staff and refurbishment. Do more women in other units have to die and are further time-sapping investigations and reports needed to direct more funds to obstetric units?

It is widely acknowledged that in the last 10 years government funding of the NHS has reached new heights. The cost of salaries has increased but largely as a result of funding new contracts for doctors and other health professionals, rather than increasing staff numbers. It is unlikely that there will be further central funding. And, despite increasing numbers of medical graduates year on year, there are fewer joining the specialty of obstetrics and gynaecology.

A safe service

The concept of clinical governance was introduced in *The NHS Plan* (Department of Health, 2000). The creation of the NHS Litigation Authority, and its Clinical Negligence Scheme for Trusts (NHS Litigation Authority, 2007) has contributed to a focus on risk and it is trust chief executives and medical directors who are held ultimately responsible for risk management and clinical governance issues. Gaining higher levels in the Clinical Negligence Scheme for Trusts standards, with their significant reduction in annual premiums to the NHS Litigation Authority, focuses managers' minds towards clinical governance and risk management. Trusts that have achieved Clinical Negligence Scheme for Trusts level 3 have not only had the benefit of lower premiums, but a number have also reported significantly fewer babies with low Apgar scores, low cord pH, and hypoxaemic ischemic encephalopathy, all risk factors for cerebral palsy, which could potentially reduce the risk of cerebral palsy to families and, in financial terms, to the NHS (Collins et al, 2007).

Clinical Negligence Scheme for Trusts level 3 may be the 'carrot' that drives some change within some obstetric services, but it should be remembered that it was the 'stick' of litigation that started it all off in the first place. A possible consequence of no fault compensation would be the loss of this stick. Much has been achieved with the development of the Clinical Negligence Scheme for Trusts, subsequent risk management and clinical governance. It is vital that if no fault compensation is introduced that it is not at the expense of the increasing safety culture within obstetrics. There is a need to keep the drive for better safety going for the benefit of mothers and babies in the future.

Recompense for clinical negligence

A huge drain on the current and future resources of the NHS is payment for litigation and compensation following obstetric misadventure, especially for cerebral palsy. Litigation is costly for both claimants (and through legal aid, the state) and trusts. It is often unsuccessful and the only apparent winners are the lawyers and their advisors. Perhaps if there was better provision of care for the sufferers of obstetric misadventure, such as no fault compensation (Department of Health, 2003), this significant drain on health-care resources could be reduced. Furthermore with the reduction of the fear of litigation there would be more favourable conditions to recruit to the specialty.

Standards and benchmarking

Quality and safety of maternity services need to be assured. This requires robust national standards for services and standard datasets to allow meaningful benchmarking, which has to compare like with like, as well as allow comparisons in outcomes between different types of settings. The publication of organization-specific performance data is already with us through Dr Foster (www.drfoster.co.uk/Guides) and practitioner-specific performance will inevitably follow. This gives rise to threats and challenges. The accuracy of hospital episode statistics data that Dr Foster uses has been questioned (Westaby et al, 2007). The challenge is for organizations and individuals to improve the accuracy of the data and to embrace the concept of performance monitoring (Lane et al, 2007). If they don't, others will do it for them, badly.

Workforce

If the specialty is less litigiously minded might it be able to recruit more doctors to its ranks? But what will they do? Changes in postgraduate medical education will mean that the traditional model of consultant-led care in obstetrics will change. The new consultant-delivered service will mean better supervision of juniors and not just during the now well-established 40-hour cover of the delivery suite. *The Future Role of the Consultant* states that there is a need for a continuous presence on the delivery suite (Royal College of Obstetricians and Gynaecologists, 2005) and the gradual implementation of a consultant-based service. The optimum consultant cover on the delivery suite needs to be established. Should it be 168 hours (i.e. constant consultant cover), or the more workable 98-hour cover (8 am until 10 pm cover, 7 days a week), as suggested by Darzi (2007)? And what will the consultants of the future do when they are not working on the delivery suite? Careful consideration

must be given to job planning in the future, so that jobs are fulfilling both personally and professionally.

A balance must be achieved within the specialty of obstetrics and gynaecology, as there is a need for increasing obstetric provision, but with less gynaecological work. Trainees will enter a revised training scheme with a well thought-out curriculum, and a new core-training logbook that is grounded in what is achievable within the bounds of the new NHS.

It is important for training in the specialty of obstetrics and gynaecology that attention is given to planning the provision of sub-specialty training (i.e. fetomaternal medicine in obstetrics) and the new advanced skills training modules. The provision of these should anticipate the requirements of the near future service (such as allowing for retirements and technological advances), rather than the desires of the trainees. There is a need for openness with those entering the training programme of some of the limitations of the training, as well as potential job prospects. Nationwide appropriate, accurate workforce planning is needed. **BJHM**

Conflict of interest: none.

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KEY POINTS

- There have been many recent changes in the specialty of obstetrics.
- There is a need to consolidate and use the ideas that have been proposed in *Maternity Matters*.
- Quality and safety of maternity services need to be assured. This requires robust national standards for services and standard datasets to allow meaningful benchmarking.
- Performance monitoring of services and individuals is needed.
- There is a need to maintain the specialty as an attractive career, which will require careful attention to the training and retention of the obstetricians of the future.