Midwifery 2020: Where has all the normality gone?

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Beginning
• Review the current focus on normality within midwifery practice.

Middle
• Consider the changing context and the challenges facing midwives and “the ever narrowing window of normality”.

End
• Consider ‘normality in childbirth’ in 2020 and beyond and identify the opportunities for midwives in relation to education, research and practice.
“The midwife ....... works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and carrying out of emergency measures.

International Confederation of Midwives (2005 & 2011)
“being autonomous practitioners and lead carers to women experiencing normal childbirth and being able to support women throughout their pregnancy, labour, birth and postnatal period in all settings including, midwife-led units, birth centres and home.”

(Nursing and Midwifery Council, 2009 & 2012)
Mode of Birth (%)
Spontaneous Vaginal Birth Rates (%)

*Data - Information and Statistics Division Scotland (SMR 02)
Perinatal Mortality Rates per 1000

Figure 2.2  Stillbirth$^1$, neonatal$^2$ and post-neonatal$^2$ mortality rates: 1977 - 2011

*Data - Information and Statistics Division Scotland (SMR 11)
Maternal Mortality (UK)

Rate per 100,000

*Data: Confidential Enquiries into Maternal Deaths*
Rising intervention rates

- Rates of obstetric interventions continue to rise
- Further decline in spontaneous vaginal births (normal birth)
- No significant improvement in maternal or neonatal mortality and morbidity
- Some evidence that unnecessary interventions are associated with short and long-term morbidity
- High intervention rates have economic consequences for the NHS
Normality agenda

- Consumer movement began with rising rates of obstetric interventions (1990s)
- UK government working parties were formed to review maternity services in Scotland and England
- Government reports recommend radical changes in service provision, including agency and choice (Changing Childbirth 1993, Winterton Report 1992)
- Randomised controlled trials of midwife led pathways of care were published and implemented into practice (defined group of women)
- Changes to GP funding, Consultant Contracts & European Working Time Directives
- ?? Affordability & sustainability of maternity care
Midwife-led vs doctor-led maternity care (2012)

Systematic review of reviews
28 trials in high income countries
>21,000 women

Findings:
↓ instrumental births
↓ episiotomies
↓ anesthesia/analgesia
↓ antenatal hospitalisation
↑ maternal satisfaction
↔ caesarean section, neonatal mortality or morbidity
Maternity Services Policy (UK)

February 2001

A Framework for maternity services

National Service Framework for Children, Young People and Maternity Services
Core Standards

Change for Children - Every Child Matters
• Strategic, systematic approach to implementing national maternity services policy
• Multi-professional programme of work
  – Focus on midwifery and models of care
• Overarching aims:
  – Maximise opportunities for women to have as natural a childbirth experience as possible through:
    • Midwives being first point of contact for women in pregnancy
    • Introducing national risk assessment tools for all women
    • Developing and implementing evidenced based pathways of care for ‘low risk’ women
    • Supporting implementation of midwife managed care programmes for low risk women
What categorises ‘low risk’?

### Fetal/Neonatal
- Previous congenital abnormality
- Complicated family genetic history

### Obstetric/Medical History
- Long term conditions on medication (except for controlled asthma)
- Require initiation or change of medication
- TSH taken by 12 weeks for women being treated for thyroid disease
- Has previously been advised to seek obstetric care
- No medical history because new to UK
- Acquired or congenital heart conditions
- Known haemoglobinopathies
- 3 or more consecutive miscarriages and/or identified cause for recurrence
- Significant mental ill health (to include perinatal psychosis)

### Obstetric History
- Assisted conception
- Pelvic floor or cervical surgery
- Women who book after 20 weeks
- Previous pre-term birth
- Pelvic girdle pain

### Medical History
- Neurological disease
- Mental ill health
- Other significant medical history
- Current history of smoking

### Women with Significant Social Needs
- Complete “Ethnic Origin, Other health-related questions, “Your mental health” and “Home circumstances and support needs” section of SWMR. Refer to appropriate agency/health professional where appropriate.
- Woman or partner in criminal justice system

### Consider Obstetric Plan for Delivery If:
- Previous mid trimester loss
- Previous postpartum haemorrhage greater than or equal to 1000mls
- Previous third/fourth degree perineal tears / female circumcision or cutting
- Previous shoulder dystocia
- Refusing administration of blood/blood products/knows Jehovah Witness

### Anaesthetic History
- Spinal injury or disease
- Needle phobia
- Anaesthetic complications e.g.
  - History of difficult/failed intubation
  - Previous anaesthetic drug reaction
  - Family history of suxamethonium aproea
  - Family history of malignant hyperpyrexia
  - Previous technical difficulties with epidural or spinal block

### Obstetric History Taking (Visit 2) Women with potential obstetric/medical/social risk factors requiring further assessment/support

### Medical History
- Significant mental ill health (to include perinatal psychosis)
- Primary family member history of bipolar disorder
- Alcohol and/or drug misuse (within last 12 months)
- Anaphylaxis
- Anti-coagulant therapy
- Active blood borne viruses
- BMI <18 or >35
- Significant gastrointestinal disorders e.g. Coelho’s disease, fatty liver of pregnancy
- Diabetes (type 1 or 2) or gestational diabetes
- Essential / secondary hypertension
- Epilepsy
- Heart conditions
- Haematological disease
- Malignancy to include previous maternity pregnancy
- Past or current use of non-inhaled steroids or deteriorating asthma / cystic fibrosis
- Renal disease
- Solid organ transplant
- Thyroid disease
- Autoimmune disease
Evaluation of EGAMS (Tucker et al 2005)
Consensus on normality?

Definition of normal birth
(2007)

“without induction, without use of instruments, not caesarean section and without general, spinal or epidural anaesthesia before or during delivery.”

Includes:
• Spontaneous onset
• Spontaneous progress
• Spontaneous birth
Challenges for Midwifery 2020 (UK)

- Unique public health role as the universal service for all women and families during childbirth
- Midwives should be rooted in communities
- Community based health improvement approach
- Multi-agency working in communities
- Identify risk
Wider Scottish Policy Context

- **Population**
  - Better Health Better Care (2007)
  - Equally well (2008)

- **Maternity & Young children**
  - GIRFEC (2006)
  - Early Years Framework (2008)

- **Consistent themes**
  - Effectively tackle health inequalities
  - Health service important *but* effective multi-agency partnership crucial
  - Early years critical to future health and inequality
“...children born to parents in the lowest income quintile are much more likely than others to have been affected by maternal smoking, drinking or drug use during pregnancy, to have a single teenage mother, not to have been breastfed, to be exposed to second hand tobacco at home, to be weaned onto an unhealthy diet, to have poor dental health, and to receive relatively little stimulation..”

Emerging role for midwives: health inequalities

- Midwives are the **named person** for all babies from 0 to 10 days
- Co-ordinators of **all** women’s care: regardless of risk
- Identify those babies that might not reach full potential and instigate early interventions
- Multi-agency working
- Health inequality sensitive practice
Increasing maternal age (NHS Scotland)
Changes in the risk status of pregnant women

- Increase in maternal age, with 3.8% of women now >39 years
- Increase in multiple pregnancy rates
- One in five (16 to 19%) pregnant women are obese
- Increase in assisted conception
- More women with a history of a previous caesarean section
- 1:50 pregnancies complicated by drug misuse

Fewer women due to these risk factors eligible for midwife led care according to national and UK guidelines (QIS 2007 & NICE 2008)
Evidence based response?

Reproductive ageing

Scientific Impact Paper No. 8
May 2012

In Vitro Fertilisation: Perinatal Risks and Early Childhood Outcomes

Management of Women with Obesity in Pregnancy

March 2010
Midwife led care for obese women?

- Sample > 17,000 women
- Obese, otherwise healthy women have a modest increased risk of CS and adverse maternal outcomes OR 1.12 (CI 1.02,1.23) compared to normal weight women
- Nulliparous women (low risk) had higher risk of obstetric complications than multiparous obese women (BMI > 35)
Vaginal Birth after Caesarean Section

- Current guidance recommend obstetric-led care for women with previous CS
- Repeat CS account for 50% of all operative births.
- Fewer women now aim for a vaginal birth, despite safety (scar rupture rate 2/7 per 1000)
- Language, attitudes and behaviours of health professionals are a major influencing factor in decision-making (Fenwick, 2003).
Midwife led consultation for women with a previous CS (Quality Improvement Initiative)

• Earlier consultation (22 to 25 weeks versus 34 to 36 weeks)
• 30 min versus 10 min appointments (resource neutral)
• More women reported receiving information about benefits and risks of vaginal birth and repeat CS.
• More women received written as well as verbal information
• Less women intended to have a repeat CS (end)
• Significantly more satisfied with consultation
Implications for midwifery education

Setting the Direction
Nursing and Midwifery Education in Scotland

The Scottish Government’s strategic direction for health and social care is based on the vision that by 2020 everyone will live longer, healthier lives at home or in a homely setting, adult health and social care services will be integrated and services for children will be designed to ensure they have the best start in life [1]. The 2020 Workforce Vision [2] has been developed in recognition of the vital role of NHSScotland staff in supporting and driving these changes. New ways of working will increasingly focus on providing healthcare that is person-centred and safe [3], preventing and detecting health problems, making access more equitable and using a continuous improvement approach to improve efficiency and effectiveness that maximizes the benefits of digital technology. This can only be delivered by a workforce that is confident, competent and caring with access to the best education, training and development.

The Chief Nursing Officer’s Education Review reflected on the strengths and achievements in nursing and midwifery education and research. Based on this work, six strategic aims now set the direction to prepare the nursing and midwifery workforce, in partnership with the wider health and social care team, to deliver the 2020 Vision for Health and Social Care in Scotland[4].

‘Setting the Direction’ informs an implementation process and action plan that will identify the priorities for 2013 – 2016 and towards 2020. It will strengthen partnership working between the Scottish Government, funding bodies, NHS Education for Scotland, our universities and colleges, staff, service users and carers, professional and system regulators and professional and workforce leaders in health and social care.

Six strategic aims for nursing and midwifery education in Scotland

1. Develop a sustainable national approach to post-registration and postgraduate education and continuing professional development.
2. Embed NHSScotland values[4] and professionalism in nursing and midwifery education, research and practice.
3. Deliver dynamic pre-registration nursing and midwifery education.
4. Enhance the quality of the practice learning environment for staff and students.
5. Develop an infrastructure to deliver efficient, responsive and sustainable education.
6. Strengthen clinical academic collaboration to ensure that research and evidence underpins and drives improvements in quality.

Midwifery Education 2020 & beyond

**Recommendations for midwifery education:**

1. Revise Standards for pre-registration midwifery education (NMC) to reflect the complexity of contemporary practice.
2. Increase length of pre-registration midwifery courses to 4 years.
3. Masters level graduates (critical thinking, evidence based approaches and leadership)
4. Career progression opportunities (Clinical academic careers, Consultant posts) to achieve clinical and research excellence.
Obstetric interventions continue to rise despite policy and practice developments with no attributable decrease in maternal and neonatal mortality or morbidity

The affordability and sustainability of increasing intervention rates is doubtful

Changes in the socio-demographic and clinical characteristics mean that fewer women are categorised as normal

Re-defining normality and 'low risk' based on evidence may be a safe and affordable way of improving women’s experiences of maternity care and reducing intervention rates

Developments in midwifery education and research are essential