

A better model of care for high-risk mothers

The Royal Wolverhampton NHS Trust won an All-party Parliamentary Group on Maternity (APPGM) award in 2010 for its efforts to improve the birth experience for high-risk mothers at New Cross hospital. Kim Thomas talked to Tracy Palmer, matron of patient services at the hospital, about the work that won the award.

In 2003, the Healthcare Commission published a report instructing New Cross hospital in Wolverhampton to make 110 improvements to its maternity services after three healthy babies died. In response, the hospital made a series of sweeping changes to the service, focused on improving the rates of physiological birth. Since then, the caesarean rate has fallen from 29% to 24.4%, while the epidural rate has fallen from 31% to 26%.

Last year, maternity staff heard the good news that a new midwifery-led maternity unit had been proposed. The unit would sit alongside the existing consultant-led unit and would be responsible for approximately 1000 low-risk women who give birth at the hospital each year – about 25% of the total births at New Cross. The remaining women, in the high-risk category, would continue to give birth in the consultant-led unit. (Women may be high-risk for a number of reasons – the hospital deals with a lot of older first-time mothers and obese mothers, but there are also women who may be diabetic or have had a difficult first birth.)

After the excitement died down, says Tracy Palmer, matron of patient services at New Cross, midwives became concerned about what would happen to the high-risk women. Would the consultant-led unit return to the highly medicalised model that existed before 2004?

A new model of care

Both Palmer and Lyndsay Durkin, midwife co-ordinator at the hospital, believed that it was important to give high-risk women, in Palmer's words, 'the same choices, the same discussions, the same advice and the same support as the low-risk women get.' They drew up a model of care: 'an overarching statement that all women in our hospital and maternity unit will have choices for birth'.

They wanted midwives who were

delivering this model of care to high-risk women to have the confidence that they were supported by their shift leader and the consultant team, so they began by winning over the multidisciplinary team members who were likely to be most resistant, before launching it successfully to the rest of the team. 'The consultant obstetricians have been very positive and think it's a fantastic piece of work,' says Palmer.

The model, which is printed on small laminated cards that midwives can carry in their pockets, emphasises the importance of adapting the birth environment to meet women's needs while still maintaining a focus on safety. It requires midwives to discuss the woman's plans for birth with her and her birth partner, and to carry out a thorough risk assessment based on her plans. 'We're trying to maximise the chance of vaginal birth among this high risk group, and give women the best possible experience of birth they can have,' says Palmer. 'Among the higher numbers of women in this group who do have a forceps, ventouse or caesarean birth, leading up to that, they've been in control, they've had the support they wanted and they've had choices.'

Remaining active

Women are given the opportunity to remain as active as possible during labour: there are birthing balls and birthing pools in the delivery suite, and women are encouraged to walk about when they are not resting. They are also offered the opportunity to use aromatherapy oils, wheat bags and water for pain relief. The use of telemetry (remote monitoring systems) means that women can spend time in the wet rooms instead of being confined to the bed.

The Affinity birthing bed used in the delivery rooms can be converted into an armchair or a birthing stool. The midwives'

resources room has photos on the wall of real women using the bed to give birth in different positions, which midwives can then suggest to the women themselves. 'The idea is to keep them upright and mobile as possible to maximise their chances of a vaginal birth,' says Palmer.

The birth environment has been made less cluttered and more homelike. Women are invited to bring in their own music and wear their own clothing rather than a hospital gown. There is an increased emphasis on privacy and dignity in the new model. All staff, including consultants, are asked to knock and wait before entering a birthing room.

More job satisfaction

Since the model was introduced in January, vaginal birth rates have increased, the use of pethidine for pain relief has dropped and rates of skin-to-skin contact have increased from 73% to 80%. Consultants are happy with the model because it's keeping caesarean rates down, and midwives are enjoying the new approach: 'It gives you more job satisfaction when you've got a woman you've seen throughout labour and she's had a really great birth experience.' The women have also been positive: 'A lot of the written feedback has centred around, 'I was upright, I was active and I had support from my midwife all the time I was in labour.' One-to-one care rates in established labour are 80%.

Palmer is looking forward to sharing the New Cross model more widely. Sometimes, she says, when midwives visit women postnatally, they are still 'physically shocked by what happened to them in hospital', and the lack of choice has made them feel completely out of control. The model developed at New Cross means that even high-risk women now have a choice about how they give birth.