Discussing benefits & risks with parents

A new birth centre for Lothian

Normal birth rates for England

Perspective
NCT's journal on preparing parents for birth and early parenthood

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In this issue: Communicating information

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Our theme for September is communicating information. For NCT practitioners and for midwives the ability to communicate information about childbirth and parenting clearly and accessibly is a crucial skill. But knowing how much information to give, and good ways to initiate learning and understanding, is easier said than done. Parents have different needs and preferences, and communicating the risks and benefits of particular decisions, interventions and behaviours requires judgement and sensitivity.

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Editorial team

Editor-in-chief Mary Newburn  Head of Research & Information; Honorary Professor, Thames Valley University

Editor Kim Thomas  kim.thomas@nct.org.uk

Graphic Designer Emily Harthern  emily.harthern@nct.org.uk

We welcome contributions to Perspective, so please send us your ideas. Contact the editor-in-chief, Mary Newburn, by email at m_newburn@nct.org.uk

Perspective is published by NCT, Alexandra House, Oldham Terrace, London, W3 6NH

Registered charity no: 801395

Helpline: 0300 330 0700 Fax: 0844 243 6000

Websites: www.nct.org.uk www.nctresources.co.uk www.nctshop.co.uk

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What should we teach about birth interventions?

Mary Newburn, head of research and information, and Bridget Supple, antenatal teacher, examine the challenges of talking with parents about medical procedures.

‘NCT is here to support parents. We give them accurate, impartial information so that they can decide what’s best for their family.’ So says the NCT website.

In this article we’d like to encourage all teachers to reflect on how well we communicate information while trying to support parents and counter a culture of negativity about birth. Liz McDonnell talked to some women whose experience of birth was upsetting. Their births had not been straightforward and they felt guilt, trauma and a sense of loss. Part of that seemed to stem from feeling unprepared for the realities of birth. They wanted ‘more realistic information about birth complications and unplanned caesareans’.

Antenatal teachers have a difficult balancing act to pull off. Many women who come to classes have been negatively influenced by the portrayal of birth in the media and we need to counteract that. A Swedish study found that women who were fearful of birth were more likely to have an emergency caesarean.

‘Every birth in a TV drama is an excruciating emergency.’

In order to counter a culture where every birth in a TV drama is an excruciating emergency waiting to be solved by a gowned-up doctor, teachers need to encourage women to believe in their ability to give birth. It’s important that we as teachers do not use the evidence to show the negative things that can be done in labour to help achieve a normal birth and not contribute to a culture of fear and expectation that birth can’t be done without drama, immense pain and medical intervention.

Sometimes, however, birth just doesn’t go as planned or as a woman would like it to. Expectant parents need to know what can happen and be given tools to make the right decision for them. There is considerable evidence showing that women who understand what is happening and feel they have some control feel better about their birth regardless of the outcome. How interventions are taught will have an impact on those women for whom they are necessary during labour. It is however, very hard not to show bias when discussing assisted or caesarean births; our words, body language, tone, and the focus of the discussion often convey moral messages as well as emotional, technical or procedural meaning.

‘Parents need to know about what affects the physiological process of labour.’

Messages teachers convey

So, what do we need to convey as antenatal teachers? How can we most usefully talk about different birth experiences and prepare women and their partners? Here we explore some key messages:

1. If a straightforward vaginal birth can be achieved, this is likely to be good for the mother and the baby in terms of health and wellbeing. Parents need to know about what affects the physiological process of labour and what helps to keep birth normal, based on reliable research evidence. For example, evidence from the Birthplace study shows the impact of planned place of birth and labour wards vary in the extent to which they manage birth medically. (See Kirstie Coxon’s article on page 5 and Miranda Dodwell’s article on page 16.)

2. Do what you can to minimise complications developing (see 1 above), but do not feel personally responsible for achieving the ‘perfect birth’. Childbirth is unpredictable and often does not go according to a mother’s wishes. Prepare yourself for the kind of birth you would like and for possible deviations from your ideal.

3. Spontaneous labour and birth is less common in developed countries than it used to be. Caesarean birth and assisted deliveries account for around a third to a half of all hospital births. Interventions are lower for women considered ‘low-risk’ and are lower for women having midwife-led care, planned care in a birth centre or a planned home birth.

4. Some complications can be avoided and some cannot. Some conditions and circumstances clearly indicate the need for medical assistance; other deviations from normal are less clear-cut and can be treated with ‘watchful waiting’ or can potentially be corrected with a non-invasive alteration. For example, labour may progress if the atmosphere is concentrated, quiet and calm, so it can help sometimes if distracting or tense family members leave the room. Or a change of position can help the baby to descend.

5. Think about the particular circumstances of you and your baby. If you need to talk things through with your midwife, obstetrician or paediatrician or to find out more information, do so now. You could try out using BRAIN in different hypothetical circumstances in conversations with your birth partner.
6. Medical interventions are better avoided if they are not needed, as they tend to involve side effects of various kinds but sometimes the benefits for your baby or for you outweigh the undesirable consequences (including discomfort, loss of wanted experience, fear) or any health risks. Giving women the confidence in their bodies to give birth, and providing them with knowledge about midwifery-led care options, should not preclude them from having the confidence to make use of the benefits of modern technology when the need arises. You may or may not choose to spend time discussing interventions in detail or doing a role play of a caesarean birth, according to your theoretical approach and preferred ways of working, but no NCT teacher should convey a message — intended or unintended — that medical interventions are unnecessary or carry a negative value judgement that they are bad per se.

Striking a balance
We accept the efficacy of antibiotics for treating bacterial infections while understanding the importance of strictly limiting antibiotic use to minimise and prevent unwanted side effects, such as an allergic reaction, or the development of bacterial resistance. Likewise, in particular cases, a caesarean, forceps or ventouse birth, or more intensive monitoring, may make the difference between a well mother and baby and complications. One goal of promoting informed choice which perhaps gets less discussed among NCT practitioners is to help parents feel able to receive assistance when they and their carers feel it is needed and to feel accepting of that decision.

Operative interventions during birth can have a significant impact on women, increasing feelings of grief and distress after birth.⁷ Preparing parents for what to expect if things take a different path from the one expected is important. Educators need to recognise that how they teach can minimise or add to feelings of distress.

‘Model flexibility and present various pathways positively.’

Many parents who come to NCT are healthy, have a straightforward pregnancy and are interested in giving birth using their own resources and avoiding major interventions. However, often labour proves to be more challenging physically, emotionally or clinically than anticipated. NCT also attracts:

- A high proportion of older mothers (some of whom may only have one baby)
- Couples who have been through IVF
- Women with a complicated medical history

For each woman and each couple, the balance of benefits and risks of obstetric technology will be different, and the situation is a dynamic one, subject to change throughout late pregnancy and during labour. Birth experiences and feelings about birth stay with women for decades⁸ and can affect their sense of self and wellbeing. It is often not an intervention itself that is the ‘make or break’ factor affecting how a woman feels, but how much the woman and her partner feel in control.⁹ Educators should aim to role model flexibility and present different labour pathways and options in a positive manner.

References

As a teacher, consider:
- What are you seeking to achieve?
- What are you seeking to avoid?
- How is your approach received by your clients?
- Have you observed or discussed how other teachers communicate information about interventions?
- Is your knowledge up-to-date?
- Do you need to review your approach or do more reading?
- What books, articles, reviews or websites do you find most useful?

If you would be willing to share your approach to practice, your reflections and/or your sources in an article for Perspective, please contact the editor.
Making evidence about risks and benefits accessible to parents

Kirstie Coxon, a maternity researcher at King’s College, London, discusses how practitioners can explain research findings to parents.

Nobody would welcome a return to the days when women were expected to accept advice from health professionals without quibbling or asking questions, but recognition that women should be involved in all decisions made about their health care brings its own challenges. Many kinds of information contribute to decisions made during pregnancy and birth, including our own and others’ experiences, the beliefs we hold, and our preferences about the kind of birth we might want. Sometimes, women want more formal information about pregnancy and postnatal options, such as the risks and benefits of different approaches to care.

Practitioners have access to a wealth of information about different aspects of pregnancy, birth and childcare, but communicating research evidence is not easy. Sometimes research findings can be difficult to access and to understand. The media often provide useful information about research, but findings can be misconstrued, or stripped of important contextual information. Sometimes even the best research provides no simple answers. This article considers some key issues in making research findings accessible using an example from the Birthplace in England cohort study.

‘The media often provide useful information about research, but findings can be misconstrued, or stripped of important contextual information.’

Beware newspaper headlines

Population-based research of this kind provides good evidence about risks and benefits, but media coverage of findings can sometimes be misleading. The following headline appeared in the Daily Telegraph just after the Birthplace findings were published: ‘First-time mothers warned over home birth risks’. The accompanying article emphasised the risks of home birth for first-time mothers, and focused on the risks of complications for babies without explaining that the outcomes it was reporting were very rare.

‘The absolute risk of a poor outcome may be small even when relative risks appear high.’

Consider absolute as well as relative risk

The Telegraph headline sounded worrying, but to appreciate the findings in a balanced way, it’s useful to know the ‘absolute risk’, or the frequency of a given event within a population. Amongst women expecting their first baby, the Birthplace study found that 5.3 per 1000 babies had poor outcomes when hospital birth was planned, compared with 9.3 per 1000 following planned home birth, so the likelihood of a poor outcome (the ‘relative risk’) was almost doubled. This meant that around

NICE guidance

NICE recommends the following principles when discussing risks and benefits:

• Personalise risks and benefits as far as possible
• Use absolute risk rather than relative risk (for example, the risk of an event increases from 1 in 1000 to 2 in 1000, rather than the risk of the event doubles)
• Use natural frequency (for example, 10 in 100) rather than a percentage (10%)
• Be consistent in the use of data (for example, use the same denominator when comparing risk: 7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5)
• Present a risk over a defined period of time (months or years) if appropriate (for example, if 100 people are treated for 1 year, 10 will experience a given side effect)
• Include both positive and negative framing (for example, treatment will be successful for 97 out of 100 patients and unsuccessful for 3 out of 100 patients)
• Be aware that different people interpret terms such as rare, unusual and common in different ways, and use numerical data if available
• Think about using a mixture of numerical and pictorial formats (for example, numerical rates and pictograms).

(Source: Recommendation 1.5.24, Patient Experience in Adult NHS Services)
Working with parents

Kirstie Coxon is a maternity researcher from the Women’s Health Academic Centre at King’s College London. Over the next two years, Kirstie will be working alongside NCT and NHS colleagues exploring new approaches to communicating risks and benefits of maternity care options. Contact Kirstie at Kirstie.1.coxon@kcl.ac.uk if you would like to discuss these issues, or raise questions about discussing risks and benefits with parents.

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Is it possible to be parent-centred and evidence-based?

Postnatal leader Lucy Markes reflects on the challenges of sharing evidence on babies’ brain development with parents.

The NCT has two core aims for all services and education that it offers – to be parent-centred and evidence-based. In this article I will be looking at what it means to try to meet both these aspirations, and whether there is a conflict between the two, with particular reference to current thinking about neuroscience and its significance in terms of early childhood development.

Neuroscience is a popular current orthodoxy used to provide evidence to underpin interventions with parents and young children, and cited by policy makers and politicians9 as well as authors on child care and baby development.4 Yet close examination of the evidence on which the neuroscience claims are based appears to show that some of the deductions made are at best questionable.5,6 It is not within the scope of this article to provide a detail of critique of neuroscience, but evidence which may at first seem compelling could be flawed in some respects – and where does that leave us if we are trying to provide parents with evidence-based information?

Getting away from guilt

Even if we take the neuroscience evidence at face value, we also need to consider the impact that this information might have on parents – Alex Bollen’s account (see box) provides one powerful and salutary account of this. This resonates with a study by Wall7 who carried out qualitative research with a group of mothers who had been encouraged to adopt strategies based on improving brain development in their children. Wall’s findings showed that the women felt more anxious, guilty and stressed as a result of focusing on this approach.

The medicalisation of birth with its reliance on scientific technology has had many unforeseen consequences. Trying to move away from this approach to a social model of birth8 seems difficult to achieve. Are we in danger of going a similar way with parenting, suggesting parents turn to scientific evidence rather than rely on instinct and intuition? Using evidence from neuroscience may be useful to social workers having to make difficult decisions about when to take babies and young children into care9 but this intervention is significant. In the antenatal period it may be appropriate to point out to parents the significance of the baby’s early relationships, so that they can consider how best to access support and think about ways to improve their resilience during the early postnatal period. When they are actually in the throes of new parenthood, the impact of such information can make them feel more vulnerable and anxious, and we need to tread carefully. In any event, as Nolan10 points out, our time with parents may be morevaluably spent in helping them explore influences and beliefs rather than in adding to their already large store of information.

It is a cliché to say that we live in an age of information overload. NCT practitioners are constantly having to make decisions about what evidence and information they share with parents, and how. It seems obvious that parents who feel supported and confident, rather than anxious and judged, are likely to be in a better position to enjoy positive and responsive relationships with their children.

When we use evidence we need to be sure of its provenance and its possible consequences – and above all we need to show empathy and respect in all our dealings with mothers and fathers, in other words, to be truly parent-centred.

Research networker Alex Bollen shares her perspective as a parent.

In the early days of my son’s life, I thought I was making a real mess of motherhood. My baby cried inconsolably, I struggled with breastfeeding and felt drained and bewildered. I looked to books for the answers and came across Sue Gerhardt’s Why Love Matters2 when my son was five weeks old.

The book had a profoundly negative impact on me, making me feel like a bad mother who was damaging her son. Looking back, it feels like it took me to the edge of a dark precipice. The support of family and friends, and my son’s growing responsiveness, pulled me back.

Like many new mothers, I felt overwhelmed with the responsibility I had for my tiny newborn. I was terrified I would break him or hurt him in some way. These fears expanded into new, more chilling, areas after reading about how babies’ brains develop and the ‘delicacy’ of their physiological systems.

To give one example, Gerhardt writes of the ‘enormous power’ of negative looks. At the time, I was exhausted, teary and could barely raise a smile. I felt like I was failing my baby as a result, damaging his fragile, developing brain in ways I could not see.

Gerhardt powerfully makes the case for the importance of the early years. But the force with which she marshals her arguments helped fuel my doubts about my mothering and opened up new seams of anxiety.

My experiences have made me very conscious of the potential of evidence to undermine the confidence of parents at a very vulnerable time in their lives. I believe that information relating to neuroscience needs to be handled with particular care because parents cannot see what is happening to their baby’s brain and can easily fear the worst.

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A tricky balancing act: the role of a breastfeeding counsellor

As part of their training to be NCT breastfeeding counsellors, students are required to reflect on their personal beliefs and experiences and the tensions inherent in breastfeeding counselling practice. Kerry Radden, a breastfeeding counsellor student, offers her personal response to this challenge.

As an NCT breastfeeding counsellor student, I am developing a foundation of person-centred counselling skills to support mothers through their feeding journey, based on the core conditions expounded by Carl Rogers: unconditional positive regard, or non-judgemental warmth; congruence, or genuineness; and empathy.1 In addition, I need to offer evidence-based information, and may also play a role in the broader promotion of breastfeeding. In order to be an effective breastfeeding counsellor, it is important to reflect on these apparently contradictory elements of my role, both within my training and in my future practice.

Promoting a breastfeeding-friendly culture

In my role as a breastfeeding counsellor I will promote the conditions that support breastfeeding2 and work to bring about a breastfeeding culture3 and the services that enable it. Developing relationships with local health professionals may involve willingness to present the evidence and lobby for improvements in the breastfeeding (and possibly bottle-feeding) support offered to mothers. Improving support helps to value and normalise breastfeeding: this normalisation is key to passing on the skill of breastfeeding from mother to mother.4 Alongside my counselling work with individual parents, I have a keen interest in policy issues and see progressive policies and conditions as highly important. I therefore expect to have an influencing role on forums such as the regional breastfeeding strategy group or the maternity services liaison committee.

There are issues, however, with balancing promotional activity with the person-centred counselling approach. Both aim to create the conditions that help those who wish to breastfeed to do so successfully, but, whereas counselling addresses issues at the level of the individual (their experiences, feelings and challenges), promotional activity preferably addresses the historical, economic and social circumstances in which an individual feeds their baby. I think it is important to work in both ways but to keep the two aspects of the role distinct; however, the very name ‘breastfeeding counsellor’ may create assumptions that we are breastfeeding promoters rather than mother-centred supporters, and may discourage some women from seeking support with their feeding challenges. On the other hand, the name may offer hope to mothers struggling with breastfeeding and needing support.

I also feel internal tension between wanting to promote the benefits of breastfeeding (or risks of formula), and wanting to maintain empathy and unconditional positive regard towards an individual mother, for whom health concerns are only one element in her feeding decisions.2,5 A residual issue for me is my discomfort around decisions to use formula: my deep-rooted feelings around breastfeeding’s superiority alongside a lack of embodied experience of bottle-feeding could put up barriers to empathy. I feel that some of this internal tension stems from an experience I had with my first daughter being given formula, and I have become aware that I need to explore and reflect on this experience in order to counsel effectively. Should other issues like this emerge during my future training or practice, exploring them with an experienced supervisor will be critical.

Evidence-based information

Informed choice is defined by the breastfeeding counsellor Code of Practice as offering information and suggestions to enable decision-making.2 In theory, enabling informed choice involves offering ‘comprehensive information’ so that a mother may be the ‘primary decision maker’ in feeding her baby.4 However, fully informed decision-making is dependent on the ability and willingness of the mother to understand the evidence-based information being provided. In remaining person-centred, my role is to offer a mother the option of becoming more informed if she feels it will enable her decision-making. Moreover, the assumption that simply conveying information enables mothers to make autonomous decisions is part of a consumerist model which depicts the mother as somehow ‘dispassionate, thinking, calculating’.7 As a breastfeeding counsellor I need to be aware of the broader social, cultural, personal and emotional influences on her decision-making.8 A counselling approach is person-centred and regards empathic listening as the primary aspect of the relationship with the mother. Evidence-based information is shared as seems appropriate in each individual situation and information is co-created through active listening, building a two-way ‘relational’ approach to informed decision-making.8

Even as I empathise and listen, it is important to remain aware that the choice of information I offer as a breastfeeding counsellor — and the way I frame that information by the
language I use – impacts the mother and her autonomy in choosing how to use it. I may hold back information so as not to undermine the mother’s own experience or self-esteem. If she is considering offering a bottle of formula in the evening so she can tidy the house, I might offer her information on the impact of such a decision on her milk supply or perhaps information about the allergy risks of introducing cow’s milk. However, if she is happily giving a bottle of formula in the evening and breastfeeding is going well, I will have to offer any information about the impact of that bottle very sensitively and only after establishing whether that information would benefit her decision-making. This restraint can exert emotional pressure on me: I have sometimes felt sad for a baby when a mother has moved away from breastfeeding out of choice; I have sometimes felt angry when a mother has moved away from breastfeeding due to inaccurate information or lack of support. Importantly, however, neither of these emotions is directed at the mother, for whom I maintain unconditional positive regard. Offering information to enable decision-making is thus complex and dynamic, and dependent on a counselling foundation.

My approach to supporting breastfeeding is encapsulated in the NCT infant feeding messaging as ‘protecting’ breastfeeding, but I feel that ‘enabling’ breastfeeding would be more appropriate to my feelings about the role. As an NCT breastfeeding counsellor, I feel tension between the strategic aspirations of the charity to support all parents and the need to inform people fully about the normality of breastfeeding, both policy-makers and parents. Perhaps I have not yet reconciled my feelings on which matters more to me: breastfeeding rates rising or more parents having a positive feeding experience, although logic tells me that the latter is both more humane and within my circle of influence.

Reflective practice
Counselling (of any kind) presents challenges, including the risks of becoming over-involved or doubting my own usefulness. As an NCT breastfeeding counsellor, I have several opportunities for supervision, which enable me to look at my experiences as a counsellor objectively and to evolve my practice. Using my reflective diary is another tool that helps me to reconcile any concerns.

My role as a breastfeeding counsellor is to enable mothers to enact their feeding desires – in particular where they require support with breastfeeding. To reconcile the conflicts within myself in achieving this aim, I need to be able to empathise with mothers whatever their situation and ensure I am offering person-centred support, as well as influencing the wider political arena and the conditions necessary to support and increase breastfeeding. I need to be particularly aware of my boundaries and my limits, and regularly reflect on where I am with regard to my levels of frustration, anger and sadness - and where those feelings are being directed - in order to remain effective in my practice.

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Training prison officers in Holloway Prison to run antenatal preparation sessions

NCT has a contract with Holloway Prison to train prison officers on the mother and baby unit to enable them to work with and support pregnant women and mothers with babies. Mary Newburn talked to Cathy Finlay and Sarah Bradley, NCT tutors, about their work and to Sue Chatten, residential governor, about what was behind the development.

NCT was contacted by Sue Chatten, residential governor for Holloway, in the spring of 2010 about the possibility of NCT providing training for prison officers working on the mother and baby unit to lead antenatal preparation sessions. NCT has experience of running antenatal sessions in Styal Prison, so already understood some of the issues and challenges.1

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'Service development & policy

including young parents

Sue had a number of motivations in wanting NCT to train the prison officers. A visit from Her Majesty’s Inspector of Prisons (HMIP) prompted the move. HMIP suggested that it would be a good idea if women’s partners were able to attend the antenatal preparation sessions, and by doing so find out more about antenatal care and get more involved. Also, as the prison staff are with the woman day-in-day-out, it was felt it would be useful if they were more knowledgeable about pregnancy, signs of early labour and self-help approaches to working with pain in labour.

Prison rules allow staff members to provide labour and birth preparation sessions for both the women and a chosen supporter, be it a partner, a friend or family member.’

The prison-based training is very focused and enables the officers to run specific birth preparation sessions. The format is designed around six sessions to run on a rolling basis as drop-ins, so the women will be able to do the whole series, or pick one or more sessions at a time. They can come back for other sessions at a later date or even repeat some. Each session is planned and structured so the prison officers can feel confident and the idea is to facilitate the sessions in pairs.

There are 13 mother and 14 baby spaces in the unit, giving provision for a mother with twins, if necessary. ‘The unit is essentially a landing with individual rooms for each woman, but beside the bed in each room is a cot,’ says Cathy. In Holloway, the mothers who are able to keep their baby with them can do so for up to nine months; in other prisons with additional facilities babies can stay for up to 18 months. At the time of writing (June 2012), Sue Chatten explains that out of 550 women in Holloway, there are 18 on the pregnancy list: ‘Demand for the Mother and Baby Unit ebbs and flows. We were full up two months ago but we’ve got four babies in at the moment.’

Summing up her feelings about NCT’s participation, Cathy says, ‘We think it’s good that the prison are able to run antenatal sessions for women and their partners, if they want them to be there. If they’re going home after their baby is born, they’re going to need all the support they can get. Involving others and providing a supported space where they can work together focusing on the birth, the baby and the changes affecting them all gives them a positive opportunity to work on being a family together.’ She adds, ‘The women prisoners get to know the prison officers and some get quite alot of support from the staff in labour and when their babies are small.’

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Improved relations

Sue feels that the training of the prison officers and their involvement in running antenatal sessions has improved staff-prisoner and staff-family relationships. The sessions, scheduled for once a fortnight, are mainly led by officers who wear their own clothes rather than a uniform. Every six weeks a midwife comes to the session to discuss clinical aspects of care and pain relief. She provides a virtual tour of the labour ward on DVD and answers questions. Sue feels that the new arrangements, which have been running throughout 2012, ‘make officers become people again…and the women appreciate the classes’. Outside the sessions, staff make a point of contacting partners and family members when an antenatal appointment is arranged and when the women goes into labour, so they can meet up at the hospital. ‘Partners can bring money to pay for scan photographs, and we call the partners straight away now when women start in labour. Previously, we’d say ‘we’ll call when labour has been confirmed,’” Sue explains.

‘Partners can bring money to pay for scan photographs, and we call the partners straight away now when women start in labour.’

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References


A new service for women affected by female genital mutilation

When Chelsea & Westminster Hospital set up its West London African Women’s service in October 2011, it was the extension of an existing service. led by consultant obstetrician Gubby Ayida, for pregnant women who had experienced female genital mutilation (FGM). Gubby has many years of experience caring for women with FGM and has lectured widely on the subject.

The new multi-disciplinary service improved and widened the existing offering. By recruiting specialist FGM midwife Deborha Alcayde, the Trust was able to provide a more dedicated FGM maternity service. It also began an open-access community service, for women who were not yet pregnant, enabling them to receive gynaecological and sexual health care and reduce the need for later intervention in pregnancy. This community service is led by Naomi Low-Beer, consultant gynaecologist at Chelsea and Westminster Hospital, and delivered at the West London Centre for Sexual Health.

FGM, usually carried out on pre-pubescent girls, refers to the removal of parts of the external genitalia, such as the clitoris and labia. In its most severe form, the vaginal opening has been stitched over and narrowed, resulting in a bridge of scar tissue.

The procedure, illegal in the UK, is mostly carried out in 28 African countries, although it occurs in some countries in Asia and the Middle East. In West London, the majority of women with FGM are from Africa, most commonly Somalia. Although a few were born in the UK, most experienced FGM as children, and migrated to the UK later.

As well as being painful, traumatic and potentially life-threatening for the child undergoing it, FGM has long-term effects, says Naomi: ‘FGM can cause recurrent urinary and vaginal infections, pain during sex and complications in childbirth. We found a high prevalence of infections such as hepatitis B (which may have been acquired during the process of mutilation).’ Many women have additional gynaecological problems like pelvic pain and infertility.

Sexual health screening

The new service can help women in several ways. Firstly, by collaborating with the sexual health team led by consultant physician Rachael Jones, all women are offered sexual health screening. Those with infections receive confidential counselling and treatment. If their vaginal opening has been sewn up, they are offered a minor surgical procedure called de-infibulation, dividing the scar tissue to restore the normal vaginal opening. This can resolve many of the problems they have been experiencing. Women also have the opportunity to discuss other gynaecological problems and concerns about pregnancy with Naomi and Debora. As Debora has expertise in perineal and pelvic floor problems she is ideally suited to support these women.

‘Offering the service in the community has fulfilled a previously unmet need,’ says Naomi. In the eight months since it opened, the team has seen 85 women. The appointment of a Somali health advocate, Sagal Ali Osman, has helped women come forward: ‘Many women come with her because they trust her and she reassures them.’ The collaboration between gynaecology and sexual health has been key to the service’s success – those working in sexual health have a long history of outreach work, connecting with vulnerable people reluctant to access healthcare via their GPs.

Women can now self-refer to the service. They come to it through Sagal, or they make direct contact by phone or email. Others are referred from a dedicated sexual health clinic for women with FGM. There has been little need to publicise the service, says Naomi: ‘It seems to be largely word of mouth.’ Take up has been rapid and the clinics have increased from once to twice a month to meet increasing demand.

An empowering decision

Women are treated with empathy and kindness, and the clinic has a non-judgemental ethos. When women have their de-infibulation carried out, they are encouraged to have a friend or partner accompany them. Although fast track referral of women to hospital to have the procedure under general anaesthetic can be arranged, Naomi says that most women choose to have it under local anaesthetic in the clinic: ‘I think many women find it empowering. FGM is something they had done to them, usually as children. They had no control over it, and it was terribly traumatic, and now they’re in control, it’s a decision they’ve taken to improve their quality of life.’

The ‘FGM service’ is still offered to pregnant women within the maternity services at Chelsea and Westminster. At all booking-in sessions midwives are trained to ask, in a sensitive way, whether a woman has experienced FGM. If she has, she will be referred to the specialist antenatal clinic co-ordinated by Deborha. If she requires de-infibulation, she can make an informed choice as to whether it is undertaken during pregnancy or at delivery.

Pregnant women are always asked if they plan to have FGM carried out on their daughters. The vast majority say no, but if a woman who has experienced FGM gives birth to a daughter, the FGM team notify the child protection midwife, the woman’s GP and health visitor. Usually this is just precautionary but it is an important step to ensure children are protected.

A collaborative model

The team meets fortnightly to review and continually improve the service. When it found out, for example, that many women found it difficult to make morning appointments, it started offering more convenient appointment times.

Naomi hopes that the success of the model will see it applied more widely: ‘It’s a service that spans hospital and community, with specialists in maternity, gynaecology and sexual health working collaboratively – that’s what makes it unique. But it’s a model that can work elsewhere.’

She has no doubt that the service has had a significant impact on local women: ‘We’ve had some great feedback. It’s always struck me since I’ve been doing this work how such a small procedure can make such a big difference to women, some of whom are accessing healthcare for the first time. It’s such rewarding work, but it’s vital that we keep listening to what women want so that our service can grow and improve, and remain truly patient-centred.’
Making services for new parents the best they can be

NCT’s senior policy advisers Elizabeth Duff & Rosie Dodds look at how NCT’s 2010-2020 strategy can reach parents and influence policy. They emphasise the importance for parents of continuity of carers, good communication, community-based services, and coordination of care.

Last year saw NCT taking active strides to roll out its newly finalised 2010-2020 strategy across the UK, to its members, supporters and volunteers.

The charity’s aim is to reach 20 million parents by 2020. Much of the activity that is fuelling this drive will be about providing information and support direct to parents, whether face-to-face, online or by telephone. However, NCT’s huge knowledge and experience of parents’ needs and wishes, gathered over more than 50 years of close contact and feedback, means we are also uniquely well-placed to have a role in influencing services for parents beyond those offered by our own workers.

‘NCT plans to become better recognised as an informed voice for parents across a broader range of policy areas.’

Shaping services, influencing policy

NCT is frequently asked by UK governments, research institutes, professional bodies and other organisations to contribute views on how best to shape, locate and promote services. We also aim to influence the development and implementation of policy so that it is better suited to parents’ diverse needs and wishes.

People in the transition to parenthood are likely to need specific services in acute and community health, public and family health, childcare and early education. In all these areas, NCT has considerable knowledge – based on recent feedback – of where the priorities lie, where there has been good practice and where there are notable gaps in provision. We are known for this expertise and are frequently asked to contribute at local, regional and national levels. Maternity Services Liaison Committees (MSLCs) provide an excellent local mechanism for input, for example, but the future of MSLCs is uncertain. NCT is determined to ensure that there are forums where parents voices are heard, and user representatives can influence development of services.

Policies and provision affecting parents and families range across many sectors: employment, income, housing, nutrition, transport, security, social support, leisure, communication and information, as well as health and education. In some of these sectors, NCT has been less active and is less well known. As part of the 2010-2020 strategy, NCT plans to become better recognised as an informed voice for parents across a broader range of policy areas.

Strategy Theme 2 - Supportive Services

Theme 2 of the new strategy says: ‘NCT wants all public services ... [used by] parents-to-be and new parents to be the best they can be. To create supportive services for new and expectant parents we will use external influencing and working in partnership to:

- Help develop solutions to address the dilemmas facing professionals between the need to meet budget and capacity constraints, whilst trying to offer excellent individualised care.
- Develop methods that allow new parents to effectively influence and improve the design and delivery of their services.
- Champion parent participation in service and policy design, delivery and evaluation.
- Ensure the treatment of parents and families is respectful when they interact with public services.’

The NCT 2020 strategy tour

As part of the NCT 2020 strategy tour, we invited members attending the tour events to discuss ‘What are families offered, what do they want and how can NCT make sure they get it?’ We were very pleased that at each event up to 30 members registered for the workshops, and all participants were keen to make suggestions to inform NCT’s work programme. The events took place in London, Glasgow, Taunton, Cardiff, Coventry and Leeds, and we received specific information and comments about services in England, Scotland and Wales. NCT members from Northern Ireland were encouraged to come to either the Glasgow or Leeds event and attend a tailored session.

Workshop content

Setting the scene

The first part of each session considered the current situation: generally family incomes have declined and there is higher unemployment and rising costs. We looked at parent support services in each country and examples of how NCT has influenced policy (see NCT Achievements, www.nct.org.uk/ntcatchevers). We discussed new structures in the health services, especially in England. Clinical commissioning groups, health and wellbeing boards and Local Healthwatch are all new bodies that will be working in and around the health services, which NCT branches have the potential to influence.

In England, NCT activists have new opportunities for influencing policy-makers. Local authorities have responsibility for ensuring public health improvement, so could take a growing interest in aspects of life affecting parents and children, such as services to enhance mental health, play facilities, sports facilities and services to support breastfeeding. NCT branches and members can feed in to the development of strategic needs assessments for their area. Children’s centres are likely to be affected by Payment by Results, including targets for increasing breastfeeding rates and readiness for school.

In Scotland and Wales, it may be easier to influence policy development as administration areas are smaller, and potentially more accessible. The fierce competition between political parties vying for votes may provide a key opportunity for activists to influence the agenda, as each party wants to distinguish itself from the others. The Scottish National Parenting Strategy is an example of an initiative that ‘puts the voices of parents and carers at the heart of the strategy’ and NCT has seized the opportunity to have input into the importance of starting support for parents before birth.

In the strategy tour sessions we used three fictional families of different shapes and sizes...
to stimulate discussion. Nat, Tina and their twins were one (see Figure 1).

‘NCT will extend the range of professional and voluntary organisations it works with.’

The intention was to talk broadly about how services might be shaped and delivered with all parents in mind, those with mainstream experiences and those with more specialist needs.

**Participants’ responses**

Group members were eager to list both statutory services and voluntary sector groups who could and should be involved in the care of families. They felt that Nat & Tina would have seen at least one gynaecologist, midwife, obstetrician, paediatrician, neonatal nurse, GP and health visitor. They may have seen nursery nurses, community psychiatric nurses and other specialists. Voluntary groups who could have helped include Infertility Network UK, the Miscarriage Association, TAMBA, Mind and perhaps Scope or Mencap, as well as NCT and particularly its Shared Experiences helpline.

**Discussion focused on the need for:**

- Anxious and exhausted parents to have help to learn about and locate what is available.
- Services to be ‘joined-up’, and consistent in terms of care, information and advice.

Strong themes emerged around the qualities of services needed by families, which could be categorised as:

- **Continuity** — the need for parents, at each contact with a service, to see and speak to either (ideally) the same person or at the least a colleague who understood their situation, who will offer a ‘next step’ on the pathway.

- **Communication** — both listening to and conveying information were emphasised as essential skills, while effective communication between practitioners and services was another crucial point.

- **Community** — over and again, workshop participants stressed the need for services to be local, accessible and ‘visible in the pathway of the user’; the more that families are experiencing stress, anxiety, fatigue and frustration, the less they will be able to organise travel to large and unfamiliar institutions, with possible long waits for appointments.

- **Co-ordination** — this element brings together the three above, in that it enshrines what parents need, in particular when they are in vulnerable circumstances or experiencing problems. Families with multiple needs must be helped with signposting to sources of support and information from someone with real local up-to-date knowledge of what is available.

In terms of current services delivering on these four Cs, the health visitor was seen as the key practitioner and children’s centres were seen as a key service. However, members voiced concerns, such as ‘health visitors are so over-stretched’ or the ‘the children’s centre now targets services only to vulnerable people’. There was a consistent, strong message about the need for ‘friendly communities that enable mutual support, networking and sharing’. NCT made a real contribution to this ideal for some parents, and needs to be extended so similar kinds of networks and local knowledge sharing are available for all.

**What can NCT do?**

The 2010-2020 strategy identifies three principal ways in which the charity can increase its reach to parents and its influence on policy: growth, thought-leadership and partnership. The policy team can advise on key messages and useful alliances that will assist the work in these areas.

NCT already works closely with relevant professional associations, and has links with many voluntary sector organisations. More will be done to expand and build on these connections, so that NCT can provide direct support, where appropriate; signpost to specific support and services; and lobby for improved statutory services where these are needed. NCT can grow its number of activists, who will offer the ‘next step’ on the pathway.

**What can NCT do?**

For example, NCT is now a member of the Fuel Poverty Coalition because families with small children are especially affected by fuel poverty. NCT will extend the range of services to be local, accessible and ‘visible in the pathway of the user’; the more that families are experiencing stress, anxiety, fatigue and frustration, the less they will be able to organise travel to large and unfamiliar institutions, with possible long waits for appointments.

**Summary**

We’ll be focusing on the four Cs, working for greater continuity, better communication, enhanced community networks and co-ordination of services. These are themes repeatedly highlighted not only by the parents who attended our workshops but by thousands of other parents across the UK. We hope that strategic framework will help us make a difference for them.

**Reaching our goals**

To help reach our goals NCT will focus on more growth, increased thought leadership and developing new partnerships:

- **Growth** — we will continue to increase our reach, both geographic and social, to all parents and expand our postnatal and early years services, producing evidence-based policy positions on a wider range of areas.

- **Thought leadership** — we will use our position of influence to change the perception of parenthood and create breakthrough solutions to address the dilemmas parents face. We are currently working with the King’s Fund on innovations to enable staff to make best use of their time and improve maternity care services.

- **Partnership** — we will review and add to our key partners, to increase the support available to new parents and reach even more of the population. For example, NCT is now a member of the Fuel Poverty Coalition because families with small children are especially affected by fuel poverty.

**Feedback**

Participants gave feedback after the sessions, with comments including:

- ‘It gave me an idea about the wider work and plans of NCT.’
- ‘We have to think of creative solutions to address REAL problems within REAL constraints.’
- ‘Interesting to hear views of a wide range of NCT members and to meet Rosie and Elizabeth.’
- ‘We generated some exciting ideas.’
- ‘Inspired me to want to help more!’

A series of document summaries on reports relevant to theme 2 and 3 of NCT’s 2020 strategy, NCT position papers and other tools for NCT representatives will be produced over the next year.
A new birth centre for Lothian

Midwife Justine Craig, clinical manager for intrapartum services in Lothian, talks to Kim Thomas about how Edinburgh’s first birth centre is meeting the needs of low-risk women.

In October 2011, a new birth centre opened in Lothian – a region covering Edinburgh and surrounding areas, with a population of 800,000 people. The birth centre, Lothian’s first, is sited next to the Simpson Centre for Reproductive Health, the existing maternity unit attached to the Royal Infirmary of Edinburgh.

Planning for the centre began in 2009, when NHS Lothian carried out a maternity strategy review. The Simpson, which had originally been built to cope with 5,000 births a year, was now dealing with 7,000 births annually, and it was clear that new provision was needed. The review consulted a number of different groups, including community midwives, GPs, local authorities and other interested parties, about the form that provision should take. Efforts were made to reach out to users of the service, including traditionally hard-to-reach groups such as ethnic minorities.

The review found a lot of support for a new birth centre, with almost all the mothers consulted expressing a preference that it should be sited next to the existing maternity unit. The decision was made to go ahead with the centre, which would include six birthing rooms and a four-bedded bay. In the first year, it was planned that 1500 women would give birth in the centre, increasing later to 2,000 a year.

The £2.8m centre was built as a private finance initiative (PFI), which meant that details of how the building would look and how it was furnished had to be agreed by a team that included Consort, the private health company that would pay for and own the centre, maternity services representatives, and lay users of the service. Justine Craig, clinical manager for intrapartum services, who was heavily involved in the development of the birth centre, says that the discussions were often ‘challenging’, but ultimately worthwhile: ‘We had to get good involvement from health and safety and the infection control team, and there were all sorts of restrictions with the fabrics. And I think what we’ve got now is somewhere that’s clean and meets all the infection control measures we need for health and safety, but it’s still a really nice environment.’

A calm atmosphere

The completed centre is comfortably furnished, and every delivery room has an en-suite bathroom, a birthing pool, a ballet bar that women can use in labour, and a Resuscitaire if the baby needs emergency resuscitation. There is also a sofa bed in each room so that husbands or partners can stay in if they wish. The atmosphere, says Justine, is calm and relaxed, even at busy times.

Only low-risk women can use the centre, with ‘low-risk’ currently defined using the guidelines outlined in Keep Childbirth Natural and Dynamic (KCND), Scotland’s national maternity programme. Before the opening of the centre, about 2,500 of the 7,000 women giving birth each year were defined as low-risk and were able to give birth in a designated low-risk area of the Simpson Centre. Now they have the option of giving birth in the birth centre, and many choose to do so – the centre is on course to meet its target of 1500 births in the first year. Currently the guidelines for deciding who is low-risk err on the side of caution, and Justine is considering relaxing some of them, such as the age limit of 40.

The midwives who staff the centre are drawn from the existing Simpson Centre team. They work 12 ½ hour shifts, and birthing women are given one-to-one care. There is one permanent midwife in overall charge of the Lothian Birth Centre, but all the others are rotated between the birth centre and the labour ward. A core group of four midwives has a longer rotation, so that there is no dilution of skills, but Justine believes firmly that all midwives should work both in the low-risk birth centre and the higher-risk labour ward: ‘It’s very important to me that the midwives should rotate, because the skills that they develop in the birth centre are very important for any labour ward settings, so when they rotate to labour ward, they bring that ethos with them.’ That ethos is very much one of normality: there is no routine breaking of waters or internal examinations. Justine is also pleased at the involvement of community midwives in the centre: ‘We’ve just started having the community midwives rotating in, so they’re bringing their home birth skills, and birth centre staff are starting to go out into the community.’

Birthing pools are a hit

Initial feedback suggests that the Lothian Birth Centre has been a hit with the women who use it. ‘They say they really like the environment, they always say the midwives are lovely, that they get lots of support and their care is very good,’ says Justine. ‘They like the option of a pool – because the pool is in every room, quite a few women are saying, “I never wanted to use the pool but I tried it and it was great.”’

This is borne out by the figures: the proportion of low-risk women using the birthing pools has increased from 10% to 40%. Justine believes that the intervention rate for low-risk women has also dropped since the centre has opened. The episiotomy rate is between 5% and 9%, though comparative figures for the labour ward are not available.

If there is a problem in labour, women are transferred to the labour ward, which involves a short journey along a corridor and up the lift, either to another delivery room or to the operating theatre. The current transfer rate is about 24.8%, but this includes women who are transferred at the beginning of labour (because they have high blood pressure, for example) or after giving birth, as well as those transferred during labour.

Because the majority of women still give birth in the labour ward, Justine has also worked to offer those women a better experience, by introducing Bradbury birth mats and two birthing pools: ‘I’ve tried really hard to give both midwives working in the high-risk area and women who need to be in the high-risk area as good an experience. We don’t want them to have less of a service.’

For more information, see:
www.nhslothian.scot.nhs.co.uk / GoingToHospital/Locations/RIE/BirthCentre
Encouraging women to stay at home in early labour

Mary Nolan, professor of perinatal education at the University of Worcester, looks at recent research on early labour.

Interest in the management of early labour has increased in recent years. Women who are admitted to hospital before labour has become established are more likely to have their labour augmented, to choose epidural analgesia and to need operative help to birth their babies than those who are admitted later.\(^1\)\(^2\)\(^3\) Managing women’s expectations of early labour and encouraging them to stay at home for longer are potential strategies for reducing the number of interventions which women experience before they give birth.

However, women, especially with a first baby, are often apprehensive at home and unable to relax, eat or sleep. And partners are often anxious about ‘getting to the hospital in time’.\(^4\)

Strategies to provide support and reassurance to women at home in early labour, including inviting women to ring the hospital and speak to a midwife\(^5\) and home visits from midwives\(^6\) have proved ineffective.

**A new study**

An experimental study involving 1251 first-time mothers in 14 maternity units in Scotland assigned seven units to use a decision support algorithm to help midwives diagnose active labour.\(^7\) Midwives in the treatment arm were taught how to use the decision support algorithm to help them diagnose active labour. If, using this tool, they determined that women were not in active labour, they advised the women to go home. Women attending the seven units that comprised the control group were cared for by midwives not trained in the use of the algorithm and received usual care.

The women’s attitudes to care were investigated using a postal survey 4–6 weeks after birth. One question asked women to consider different ‘labor scenarios’ (see figure 1).

**Women’s preferences**

Discrete choice analysis revealed that women preferred to move around during labour, to use Entonox, or Entonox and an opiate, rather than to have no pain relief or an epidural, and to give birth vaginally rather than by forceps, ventouse or caesarean. Women also indicated that they would be prepared to spend an additional 3.25 hours on the labour ward if they could be admitted when they first went to the maternity unit, but they would also prefer to spend less time on the ward before giving birth.

Findings were then related to the women’s recent labours. In terms of pain relief, women who had had an epidural were far more likely to indicate a preference for this kind of pain relief than women who had not. The authors concluded that women’s preferences for the management of their next labour were likely to be influenced by their previous experience.

Use of the algorithm to help midwives determine active labour did not reduce the amount of time spent on labour ward or the number of interventions they experienced because, ‘Women sent home after labor assessment promptly returned to the hospital’.\(^8\)

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Use of the algorithm to help midwives determine active labour did not reduce the amount of time spent on labour ward or the number of interventions they experienced because, ‘Women sent home after labor assessment promptly returned to the hospital’.\(^8\)

**Figure 1** Which labor scenario would you choose if faced with the following options?

<table>
<thead>
<tr>
<th>Choice A</th>
<th>Choice B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of visits made to hospital</td>
<td>2 visits</td>
</tr>
<tr>
<td>Time spent in hospital while in labor</td>
<td>10 hours</td>
</tr>
<tr>
<td>On a drip and confined to bed for most of your labor while in</td>
<td>Yes</td>
</tr>
<tr>
<td>Pain relief required</td>
<td>Gas only</td>
</tr>
<tr>
<td>Type of delivery</td>
<td>Normal vaginal</td>
</tr>
<tr>
<td>Which labor scenario would you choose? (please tick one box)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

(Sources: Scotland et al., 2011, Fig.1, p38) \(^8\)

The study by Scotland et al. suggests that women lack confidence to remain at home in early labour.\(^9\) This is consistent with my own research. Julie Smith and I argued that a culture of distrust of women’s bodies and fear of birth determines women’s desire to be admitted to hospital early.\(^5\)

**Summary and implications**

- The experience of first labour is influential in determining women’s preferences for subsequent births.
- Educating women in how to cope with a long latent phase, and training midwives in how to support women, may be important strategies to maximise women’s chances of having a straightforward vaginal birth with their first baby and therefore, with subsequent ones.
- Childbirth educators need to help women understand the considerable variation in the length of the latent phase of labour and develop their confidence to spend time at home during early labour.

**References**

Miranda Dodwell, a researcher for BirthChoiceUK and NCT research networker, analyses the latest normal birth rates for England.

Research shows that the majority of women want to give birth with a minimum amount of medical intervention, provided their baby is safe and they are coping with labour.1 But how likely are women to give birth without having any significant intervention?

Normal birth rates have been developed to provide women with this information. These show the proportion of women who give birth without any of the following medical procedures: induction, epidural or other anaesthetic, forceps, ventouse, caesarean or episiotomy. 1

The voluntary organisation BirthchoiceUK has been given access to nationally collected data in the form of anonymised Hospital Episode Statistics (HES) records. This has enabled us to undertake a number of analyses that provide information about normal birth rates in England.

National normal birth rates
According to information collected nationally by NHS trust staff in England, in 2010-11 about four in ten women (42%) giving birth in obstetric units or in other NHS settings gave birth without any of the medical procedures listed above (see Table 1). For women having their first baby, the normal birth rate reduced to just 34% – meaning that almost two-thirds of first time mothers had some type of medical intervention. For second and subsequent babies, the normal birth rate was 49%.

About half of all women giving birth are considered to be at increased risk of complications, and these women are generally recommended to give birth in a hospital obstetric unit.2 Of these women at increased risk, on average only two in ten (20%) had a normal birth but this rate varied depending on the type of risk factor involved. For example only about four percent of women with a baby in a breech position had a normal birth, compared to over 30% of women with thyroid problems.

Table 1: Summary of normal birth rates.
Source data: HES records

<table>
<thead>
<tr>
<th>Normal birth rate for England 2010-11</th>
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<tbody>
<tr>
<td>For whole country</td>
<td>42%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First time mothers</td>
<td>34%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second+ time mothers</td>
<td>49%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher-risk women</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-risk women</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest maternity unit rate</td>
<td>54%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest maternity unit rate</td>
<td>29%</td>
<td></td>
<td></td>
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</tbody>
</table>

Approximately half of all women giving birth are considered to be at increased risk of complications, and these women are generally recommended to give birth in a hospital obstetric unit. Of these women at increased risk, on average only two in ten (20%) had a normal birth but this rate varied depending on the type of risk factor involved. For example only about four percent of women with a baby in a breech position had a normal birth, compared to over 30% of women with thyroid problems.

There appear to be some regional differences in normal birth rates, with averages for Strategic Health Authorities (SHAs) varying between 40% in London and 47% in Yorkshire and Humber, including births in freestanding midwifery units. However, because there is a large variation between maternity units within SHAs around the country, and rates for units that submitted poor quality data are excluded, regional averages may not be meaningful.

Local rates
Hospitals vary in their ability to send complete and accurate data to HES, and therefore we have done some data cleaning to identify and exclude maternity units that submit low-quality data that do not reflect the care they provide.

For hospitals providing data of adequate or good quality, there is a wide variation in normal birth rates in obstetric units across England, from 54% overall down to 29% according to the data submitted to HES.

Figure 1: Normal birth rates for maternity units by Strategic Health Authority (SHA) in England, 2010-11

Explanatory note: Each diamond on the figure represents a hospital site with an obstetric unit (OU), or with both an OU and an alongside midwifery unit (AMU). Results for an OU and an AMU on the same site are aggregated. Freestanding units are not shown. The sites are arranged by region and the diamond is placed on the line according to the unit’s rate of ‘normal births’. This is a process measurement designed to show how labour is managed in different settings. It indicates the extent to which women are able to give birth without the aid of medical interventions.

Source data: HES records 2010-11. Figure copyright, BirthChoiceUK 2012.
Some of the variation in rates will be due to socio-demographic factors, such as maternal age, ethnicity or social deprivation of women giving birth. In addition some of the variation may result from inaccurate recording of information by the trusts, despite our data cleaning methods.

However, some of the variation in local maternity rates is likely to be due to differences in the structure and quality of maternity care that women receive. Research shows that a number of practices recommended in national guidelines and policy can increase normal birth rates in NHS settings. These include:

- Providing the opportunity to give birth in a midwife-led unit, either alongside or free-standing.
- Providing continuity of care from a small number of midwives during pregnancy and labour.
- Ensuring women have one-to-one care during established labour.
- Supporting the use of natural and low-tech comfort aids during labour, such as the use of water, or encouraging the use of upright positions and mobility.

Because of this, normal birth rates can be seen as a measure of the quality of maternity care that women experience. Researchers at BirthChoiceUK are currently working to ascertain how much variation is due to such differences in maternity care.

**Trends over time**

Due to a change in methodology in analysing mode of delivery and anaesthetic data in 2006-07, it is not possible to have a continuous trend of normal birth rates. BirthChoiceUK has been able to analyse data on a consistent basis from 2004-05 to 2010-11 that shows a normal birth rate of about 42% throughout this period. Although earlier figures are not directly comparable, rates have dropped significantly from those seen in the 1990s, due to increases in interventions such as caesareans, instrumental deliveries and inductions.

**Where to find normal birth rates**

Although normal birth rates were published by the NHS Information Centre for the years 2003 to 2006, the information is no longer published by them as they consider there to be no clear definition of ‘normal birth’. This is despite the published work of the Maternity Care Working Party, which sets out clearly a consensus definition of normal birth, agreed by the RCOG, RCM, NCT and other interested parties.1 BirthChoiceUK is in discussion with the Information Centre to have this important statistic reinstated as part of national maternity statistics.

In the meantime, normal birth rates for maternity units in England can be found on the BirthChoiceUK website, alongside other maternity statistics, at www.birthchoiceuk.com/Access.htm. More information on national trends can be found at www.birthchoiceuk.com/Professionals/PDFs/Normalbirth2010_11.pdf. The HES records from which data in this article have been derived are subject to copyright of the Health and Social Care Information Centre.

**References**


**Figure 2: Trends for normal birth rates in England 1990-2011.**

Explanatory note: A new methodology for analysing and presenting maternity data was introduced by the Health and Social Care Information Centre in 2007 which affected the calculation of normal birth rates. Both methodologies were used for the years 2004-05 and 2005-06 to show the effect of this change.

Source data: HES records. Figure copyright: BirthChoiceUK 2012

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**2012 NCT Practitioners Forums, sponsored by lights by TENA**

University of Aston in Birmingham, Saturday 29 September 2012.

Speakers include:
- Oliver James, clinical psychologist and author
- Mike Brady of Baby Milk Action
- Professor Ian St-James Roberts, speaking on infant and child development

Full booking details are on NCT intranet www.babble.nct.org.uk/
Research overview: Is there evidence to support the use of soft slings?

Rebecca Glover, an MSc student at the Institute of Child Health, University College London, looks at the evidence on the effectiveness of soft slings.

Carrying babies in a sling is normal practice in many non-western and traditional societies. Holding a newborn in a sling is practical, as it enables mothers to return to their daily activities while keeping their newborn with them and breastfeeding frequently. Constant carrying is rare in western societies; however, the use of slings appears to be increasing in popularity, and is promoted on parenting websites such as babywearinginternational.org and naturalmamas.co.uk. Advocates suggest a number of benefits derived from sling use — for example that sling use promotes attachment between mother and infant, that babies held in slings are more content and cry less and that it makes frequent breastfeeding easier.

While evidence on the effects of sling use is still limited, some of the benefits derived from skin-to-skin contact may apply. Skin-to-skin contact immediately after birth results in significant improvements in temperature regulation, breastfeeding, weight gain and attachment for both term and preterm infants.1,2 The close contact may allow parents to detect subtle discomfort cues so they can respond before crying begins.

Review of the evidence

To identify and evaluate the available evidence for any effects of sling use, a research review was carried out. Online databases were searched for relevant published literature, and reference lists of relevant papers were manually searched. Paper titles and abstracts were assessed for relevance. Articles were considered relevant if they referred to carrying, the use of slings or baby carriers in the title or abstract. Observational and experimental studies were included, and articles looking at any effects on infant and/or caregiver health, wellbeing and behaviour were included. Six randomised control trials (RCTs), one observational comparative trial, one qualitative study, two cross-cultural studies and one literature review were identified as relevant studies, and their key findings are summarised below.

Qualitative studies

Anthropological studies provide a useful point of reference from which to consider modern childcare practices. Among the Zinanteo (Mayan Indians), babies are carried at all times in a fabric shawl, with frequent breastfeeding until nine months. In an observational study of infant care and behaviour, no periods of intense crying were observed, and infant cries were rare and brief.3 Among the !Kung San (hunter gatherers), babies are also continuously carried in a sling during the day. An observational study found that the frequency of crying episodes was similar to American and Dutch infants, but the duration and intensity of crying episodes was significantly less.4 Bleah & Ellett’s qualitative study of recent African migrants to America explored mothers’ responses to infant crying, and found that all the mothers carried their babies whenever possible.5 Mothers who worked outside the home attributed their infant’s crying to spending less time with them, and to the American custom of giving toys rather than holding in response to crying. The mothers also reported feelings of stress due to separation. As this study indicates, in developed countries, societal expectations in relation to babycare and carrying of infants have changed. Rather than being the norm, it is now seen as an alternative approach to putting the baby in a cot or buggy.

‘Societal expectations in relation to babycare have changed.’

Studies have assessed outcomes for babies regularly carried in a sling compared with control groups receiving what is now considered ‘standard care’. Four RCTs directly testing the effect of sling use on crying were identified. The earliest study6 randomly assigned 99 mothers — 49 to an intervention group who were given a soft sling to use for at least three hours a day, and 50 to a control group. Infant behaviour was recorded in a diary by parents, noting time spent sleeping, feeding, crying or fussing, and content and awake during a 24-hour period at two-week intervals from age four to 12 weeks. In the intervention group the frequency and duration...
of crying and fussing was significantly less, and content, awake behaviour significantly greater, compared to the control group. The authors concluded that sling use reduces the frequency and duration of infants crying and fussing.

Barr et al also investigated whether the reduction in crying reported in normal infants could be replicated in infants with colic. The same study design was used with 66 infants aged four to 12 weeks with excessive crying or colic. The intervention group used a sling for at least three hours per day, but there was no significant difference in duration of crying and fussing between the groups. The authors conclude that sling use is ineffective as a treatment for colic when it is introduced after the crying pattern has been established; they suggest it could be effective as a preventive measure but this has not yet been tested.

Two groups attempted to replicate Hunziker & Barr’s positive result. Walker & Menahem used a similar study design but sling use was only required for two hours a day, and the sample size was small, with only 22 infants in the experimental group and 21 in the control group. The results showed no significant difference in crying frequency and duration between the intervention and control groups. This negative finding could be due to the lower dose of sling use in the intervention group, as the control group reported spending approximately the same amount of time carrying their infant as the group using the sling. St James Roberts et al. used the same study design as Hunziker & Barr but their results also contradicted the original findings, and showed that sling use did not have a significant effect of frequency or duration of crying. It should be noted that in the 1986 study ‘participants were unaware of the study hypothesis and specific objective’, whereas this was not the case in the more recent studies. In the St James Roberts study participants were explicitly told that the study was to assess the effect of supplementary carrying on excessive infant crying. This could have introduced respondent bias into the results of this study, making the participants more likely to report a positive effect of the intervention, or the control group to carry their babies more often. However this does not appear to have occurred as the study failed to identify a significant effect of sling use on crying, in contrast to the earlier study where participants were unaware of the hypothesis.

St James Roberts et al used an observational study design to assess if different forms of infant care are associated with differences in crying patterns. Parents were recruited to the study from London and Copenhagen hospitals. Parents who self-identified as using proximal care were recruited from England and Denmark through natural parenting networks and websites to make up the third group in the comparative study. Sample sizes were 113, 75 and 57 respectively for the three groups. Parents recorded infant behaviour in 24-hour diaries. The average length of time infants were held and carried varied significantly between the groups. Proximal care parents held babies for an average of 15 hours per day, Copenhagen parents for 10 hours and London parents for eight hours. Overall London parents had about half the amount of physical contact with their infants compared with proximal care parents. The results showed that differences in caregiving were associated with differences in crying. At two and five weeks of age, London infants cried 50% more than infants in Copenhagen and proximal care groups, and proximal care infants cried more frequently at night at 12 weeks of age than the other groups. This study suggests that the type of infant care typically used by London parents is associated with significantly more crying overall, compared to Copenhagen and proximal care parents. The authors suggest that the key common feature in Copenhagen and proximal care parents is the high levels of holding and responsivity, and that the difference in crying between these groups and the London group is attributed to this difference. However, bouts of ‘unsootheable crying’ occurred in all three of the groups, and the groups did not differ in unsootheable bouts or in colicky crying at five weeks of age.

Anisfeld et al tested the effect of sling use on the development of attachment between mother and baby in a population of low-income mothers in the USA. The authors expected these women of low socio-economic status to have a number of social risk factors that would negatively influence the development of attachment. The study was small: 49 mothers were randomised, 23 to receive a soft baby sling to use every day, and 26 to the control group. At 13 months there were significantly more securely attached babies, measured using the Ainsworth strange situation assessment, in the intervention group (83%) than control group (38%). The sling using mothers also had significantly higher responsivity scores (a measure of vocal responsiveness based on maternal vocalisations and co-acting after infant vocalisations) than control group mothers. These results demonstrate that in this group of mothers and infants sling use did contribute to better levels of attachment, but replication of the result would give greater certainty.

Safety

Two studies were found investigating the safety of carrying infants in slings, both of which gave positive results. Frisbee and Hennes conducted a literature review of injuries resulting from baby carrier use. They found no reports of injuries associated with baby carriers in peer reviewed literature and only a small number of injuries reported to the USA National Injury Surveillance System. Stening et al investigated the effect of carrying newborns in slings on cardiorespiratory stability. In a randomised control trial 36 healthy newborns (12 term, 24 preterm) experienced three different methods of carrying (vertical in a sling, horizontal in a sling, in a pram). The infants’ breathing and oxygen saturation was measured during the carrying periods. Overall, no clinically significant changes in breathing or oxygen saturation were recorded with either of the sling methods. However, lower oxygen levels were seen in preterm babies, so the authors advised that slings should be used with caution for carrying preterm babies before they reach an age equivalent to 40 weeks gestation.

An important finding from this research review is the scarcity of research on sling use. There is an absence of qualitative research exploring the experiences and feelings of western parents using slings, and a lack of research involving fathers and other caregivers. Research on attachment could be usefully extended to investigate whether particular groups of mothers or caregivers could benefit, for example those who may experience difficulties bonding. It would be interesting to explore the effect of sling use on aspects of behaviour and wellbeing other than crying and attachment, in particular relating to breastfeeding. Skin-to-skin care is associated with short-term improvements in breastfeeding.

‘Skin-to-skin care is associated with short-term improvements in breastfeeding.’

Limitations

There are important limitations of this review. Only published studies were included and experts in the field were not consulted for information on unpublished data, therefore there is a risk of publication bias. The review only assessed articles published in English so relevant findings from different cultural backgrounds may also have been omitted.
While efforts were made by the researcher to assess studies based on objective criteria to ensure inclusion of relevant studies, these decisions were not validated by other researchers.

Conclusions

The findings do not give conclusive evidence of the effects of sling use on infant and parental behaviour and wellbeing. The evidence for a positive effect of sling use on attachment is suggestive, but a lack of replication of the results prevents firm conclusions being drawn. Similarly, the results of the five studies investigating the effect of sling use of at least three hours a day on infant crying are mixed. As several unsuccessful attempts have been made to replicate the positive results originally reported, it is not possible to conclude definitively that sling use does result in less crying. The cross-cultural comparisons provide an interesting basis for further study, but cannot demonstrate a causal relationship between types of infant care and particular behavioural outcomes.

References


Key points

• Studies of soft sling use have looked at outcomes of crying, attachment and safety. Most studies are small so strength of the evidence is limited.
• Sling use appears to be a safe practice, though lower oxygen levels were seen in babies who were still preterm so additional caution has been advised for this group.
• More holding and responsiveness is associated with less crying overall but not bouts of ‘unsoothable crying’.
• Positive results from a small study showing that soft sling use has a positive impact on attachment and the responsibility of disadvantaged mothers suggest that further research in this area should be a priority.

Safe sling use

Bag-style slings have a deep pocket and an elasticated top with a strap to go across the wearer. These slings have not been shown to be safe as a few babies in the US have died in the sling. Some have been recalled or withdrawn but there may be second-hand bag slings available.

A bag-style sling is deeper than other slings and the shape makes it harder to ensure the baby can breathe easily. As noted in the article, most slings are safe to use, if they hold baby snugly. The Sling Guide website www.slingguide.co.uk recommends that babies are:

• Tight to you
• In view at all times
• Close enough to kiss
• Able to keep chin off chest
• Supported with a straight back

Next issue: Preparation for birth and beyond

NCT confirms its position as developer and provider of best practice perinatal education and support with the introduction of its new preparation for birth and beyond (PBB) programme.

As part of the development of PBB, NCT was at the centre of an expert reference group that worked with the Department for Health to establish an up to date, evidence-based perinatal programme.

NCT has built on the work initiated by the Department, and created a programme quality assured through the NCT College that explores six common themes with mothers and fathers-to-be: the development of my unborn baby; changes for me and us; our/my health and wellbeing; giving birth and meeting my baby; caring for my/our baby; and who is there for us — people and services.

Using tried and tested participatory teaching and learning methods, the new programme will help mothers and fathers acquire the practical skills they need to cope with labour and care for their baby, and an understanding of how to nurture their own relationship across the transition to parenthood and to co-parent their baby.

The next issue will explore NCT’s PBB offering from both the policy and delivery perspective as it is rolled out through NCT’s traditional classes route, as well as through the NHS and children’s centres.