Association for Improvements in the Maternity Services - Written evidence (PRT0038)

Introduction

1. AIMS (the Association for Improvements in the Maternity Services) was founded in 1960 and since then has been the leading advocate for improvements in UK maternity care. We support women, pregnant people and those who support them through our helpline and by sharing objective, evidence-based information through our books, Journal and website. We also campaign at a national level for service improvements, including actions to reduce the risk of preterm birth and optimising support for those affected by preterm birth. In 2014 we became a registered charity and in 2017 adopted the strapline "Supporting you, Campaigning for all". Our mission is to support all maternity service users to navigate the system as it exists, and campaign for a system that truly meets the needs of all.

2. AIMS welcomes the Committee's focus on preterm birth, in the context of the Government's commitment to significantly reduce preterm birth. We would like to submit evidence to highlight the potential contribution that a relational model of midwifery care (also known as Continuity of Carer) could make to the prevention of preterm birth. This is a model of maternity care in which a relationship based on mutual trust and respect can develop between midwife and woman, enabling clear and accurate communication, and a highly focused attention on individual needs and the autonomy of the service user. We believe this model of care is key to safe, equitable and personalised care[1], as recommended in the UK National Maternity Review Better Births report[2]. It is Government policy to introduce this model of care, but so far implementation has been slow. We would urge the Committee to investigate the importance of the continuity of carer model of care for all, as a key plank of a maternity strategy which aims to (a) significantly reduce preterm birth and (b)

better care for babies who have been born prematurely and improve support for their families.

3. In addition, in our evidence we ask the Committee to review the extent to which a more robust physiologically-informed approach[3] might contribute to reducing poor outcomes in the case of preterm birth. We offer the examples of optimal cord clamping and kangaroo mother care in this context.

Variation in care and health inequalities

• The ethnic and socioeconomic inequalities seen in relation to preterm birth and how these could be reduced.

4. AIMS has long campaigned for equitable maternity services, to mitigate, as far as possible, inequalities in outcome, including the chances of having a preterm birth. Unfortunately, there are large disparities in the current rates of preterm birth in the UK, especially along the lines of ethnicity and socioeconomic status, with Black babies having the highest rate of preterm birth[4].

5. We believe that a continuity of carer model of care could help to mitigate these inequalities, although we acknowledge that the evidence in this area is conflicting[5]. Some recent studies suggest that continuity of midwifery carer could reduce the preterm birth rate for those women most at risk. For example, women receiving caseload midwifery as part of The Lambeth Early Action Partnership (LEAP), an area of social disadvantage and ethnic diversity, had less than half the preterm birth rate compared with women in standard midwifery care (5.1% compared with 11.2%)[6]. Women who receive support from known midwives are also more likely to disclose social or medical risk factors[7] and there is evidence that women with social complexity particularly value this model of care[8]. Overall, the Australian Preterm Birth alliance concludes that there is "good evidence of efficacy in preventing preterm birth in specific populations of

pregnant women, such as those from vulnerable or disadvantaged groups”[9].

- Additional support, such as language support, that may be needed to remove barriers to receiving high-quality care in relation to preterm birth.

6. Maternity services need to communicate with all women they serve, effectively, in a format accessible for each person and provide them with unbiased, personalised information. AIMS supports recommendations to remove barriers to equitable care, such as those made by the recent MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) report, so that all service users can make truly informed decisions about their care. This would include recommendations such as “Provide national support to help identify and overcome the barriers to local, equitable provision of interpretation services”[10], for example.

Prevention

- Primary prevention and treatment for preterm birth.

Primary prevention of preterm birth

7. There is strong evidence that continuity of midwifery carer (care from a named midwife, or small team of midwives, with additional care from other professionals as needed) can prevent preterm birth[11]. A Cochrane review[11] found that women receiving care from a named midwife or a small group of midwives were 24% less likely to experience preterm birth. This is considered high quality evidence, involving eight studies with 13 238 participants, although the authors note that the causes of preterm birth are “complex but potentially influenced by models of care”[11] and a variety of mechanisms are suggested[12]. Based on this study, a recent overview of Cochrane reviews found that midwifery continuity of care was

the only health system intervention shown to reduce preterm birth among women of low or mixed risk of complications[13]. There would likely be additional benefits for women receiving this model of care, including clinical outcomes such as a reduced risk of miscarriage[8] and increased maternal satisfaction[14].

Neonatal and longer-term care and support

- How neonatal care can improve outcomes for babies born preterm.

8. AIMS supports the practice of **Optimal Cord Clamping**, providing the newborn with a full blood volume, important in helping the transition to extra-uterine life and improves many outcomes for preterm infants, including reducing the risk of intraventricular haemorrhage[15]. We believe further support needs to be given to implement optimal cord clamping, given that a delay of 60 seconds in clamping the cord after birth is only currently used on around 60% of premature babies[16]. We recommend the committee to consider recent evidence that waiting for two minutes or longer to clamp the umbilical cord reduces the mortality rate in premature babies, noting that the authors state that this will also depend on whether the hospital is able to provide safe initial breathing help with the cord intact[17,18,19]. We would therefore also support recommendations to increase the provision of bedside resuscitation.

9. We recognise the value of **breastmilk** and **breastfeeding** for preterm babies, which offer many well-documented benefits including optimal nutrition and protection from infections including necrotizing enterocolitis[20]. We would therefore strongly support any recommendations to increase breastmilk provision to preterm babies, whether through support for breastfeeding or increased availability of donor breast milk through milk banks[21].

• Integration between neonatal care for babies born preterm and postnatal care for women.

10. It is still routine to separate newborn premature infants from their parents in the UK. AIMS agrees with the following statement from European Foundation for the Care of Newborn Infants "Throughout Europe there is evidence that parents do not have 24-hour access to their infant. Early separation is harmful for both newborn infants and their parents, since it disrupts the biological and emotional bonding that has developed already during gestation. Researchers have suggested that parent engagement… has the potential to be a low cost, high quality intervention with a positive influence on the health outcomes of preterm or ill infants and their parents."[22] AIMS believes that all parents or caregivers should be given access to neonatal units 24 hours a day, without exception.

11. We would also recommend further support for the provision of **Kangaroo Mother Care** (KMC) care for preterm babies. This is generally defined as early, continuous, and prolonged skin-to- skin contact, exclusive breastfeeding or breast milk feeding and early discharge with continuation of KMC at home and adequate support and follow-up[23]. KMC first originated in 1978 in Colombia, as an alternative to incubator care, however, it has been since shown to have numerous benefits for stable preterm infants, including on thermal control, breastfeeding rates, neurodevelopment and family relationships[23,24] and reductions in mortality rate[25]. Although recommended internationally, there remains a lack of training or research into its use in the UK[24]. Only around 50% of parents of babies in neonatal care report having as much kangaroo mother care with their babies as they would have liked[26].

12. **Mother-Newborn Couplet Care** is an extension of this, where premature infant/s are cared for entirely together with the mother, in the same ward, aspiring for "zero separation" between the mother or caregiver and newborn[27]. Couplet care was first developed in Sweden in the late 1990s and is currently implemented in around a third of neonatal

units there[27]. Although included in international standards, it has not yet been widely implemented either internationally or in the UK, and would require service reorganisation[27]. We would recommend the committee to fund further research into this model of care and the possibility of piloting it within the UK.

Other topics

• Learnings from the devolved administrations and other countries around the world.

13. Please see our submission above regarding lessons from Sweden around Mother-Newborn Couplet care.

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27 March 2024