The Royal College of Midwives' submission to the First 1,000 Days of Life Inquiry

15 Mansfield Street, London W1G 9NH
September 2018

The Royal College of Midwives (RCM) is the professional organisation and trade union representing the majority of midwives and maternity support workers working in maternity services. The RCM contributed and endorsed the first Building Great Britons report and we welcome the opportunity to respond to the Committee's call for further submissions.

A national strategy for the first 1000 days is urgently needed. The UK is lagging behind its counterparts on many measures of maternal and child health. We agree with the Committee that the evidence base for investment in this time of life is beyond doubt. Recent research into the plateau in life expectancy in the UK shows how we can no longer afford to be complacent and concerted efforts to reduce health inequalities and improve the lives of children and their families must be our focus.

1. National strategy

- **The top priorities for a national strategy, based on existing evidence and lessons from other countries, particularly the devolved administrations.**
- **The current roles, responsibilities and functions across Whitehall, executive agencies and other non-departmental public bodies for the First 1000 Days, including suggestions for how these arrangements could be made more effective.**

The RCM believes a national strategy must include several priority areas for maternal and newborn health. These are breastfeeding, pre-term birth, smoking and maternal/infant mental health.

Breastfeeding

The RCM's recent position statement on infant feeding[1] emphasised the broad-spectrum and long-lasting impact on public health of breastfeeding. Known benefits include protection against diabetes and obesity and there are documented advantages to developmental performance and educational achievement. Mounting evidence supports a positive effect from breastfeeding on child behaviour and longer-term child and adolescent mental health[2]. A recent Lancet study found that infants who were breastfed for at least one year went on to stay in school longer, score higher on intelligence tests and earn more as adults than those who were breastfed for only a month. [3] Research continues to demonstrate how breastfeeding also has a maternal protective effect against certain

[1] Royal College of Midwives. 2018. Position Statement: Infant Feeding. https://www.rcm.org.uk/sites/default/files/Infant%20Feeding.pdf
[2] Unicef. Baby Friendly Initiative. 'Mental Health and Emotional Development.' https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/infant-health-research/infant-health-research-mental-health-and-emotional-development/
[3] UN news. 'UN marks World Breastfeeding Week with call for stronger workplace policies for nursing mothers'. 15 August 2015. https://news.un.org/en/story/2015/08/505612-un-marks-world-breastfeeding-week-call-stronger-workplace-policies-nursing#.VcDSkzBVhHw

cancers, Type 2 diabetes and other conditions.[4] There are also significant financial cost savings associated with breastfeeding, with data from First Steps Nutrition Trust showing that 6 months of formula feeding can cost as much as £814.20 depending on they type of formula used.[5]
At the moment, only 44% of mothers in England are breastfeeding 6-8 weeks after birth, compared to the 80% who start to breastfeed when their babies are born.[6] In Wales, 60% of mothers start breastfeeding at birth, falling to 36% at 6-8 weeks.[7] If all the mothers who started breastfeeding were able to continue, we would match and even surpass rates seen in the Nordic countries, who achieve the highest rates amongst developed countries.[8] We know the decline in England and Wales over a baby's first weeks of life is due to a number of factors including a lack of local support due to services falling victim to public health cuts, inconsistent messaging from healthcare professionals, cultural norms, social stigma and lack of family support. A national 1000 days strategy could tackle these barriers head on. One quick win would be to reinstate the UK-wide Infant Feeding surveys (which were discontinued in 2015), in order to ensure robust monitoring and to inform commissioning strategies.

Maternity units must be appropriately staffed and sufficient investment made in postnatal care to enable each woman to get the support and advice she requires to make informed choices about feeding her baby. The evidence shows that skilled and trained staff with access to adequate resources has a positive impact on breastfeeding rates[9]. The RCM is calling for an additional 3500 midwives in England and the reversal of recent austerity measures that have resulted in the closure of vital services and facilities, such as children's centres. Midwives need to be confident in the sustainability of local services that they can refer women too. Extending the hours of the national breastfeeding helpline – currently only running during the day time – would send a strong signal to mothers that someone will be there for them any time.

Mothers who want to start and continue to breastfeed must be supported and respected by wider society; providers of services, facilities and premises that are open to the public have a responsibility to ensure that women feel they can confidently breast feed in public places, when and where ever they need to. The shaming of mothers for feeding choices – bottle or breast – must end. We urge the Committee to investigate what messages the media, the high street and the workplace are telling our mothers and families about breastfeeding. Some local councils have introduced their own local 'breastfeeding friendly' schemes, and the National Breastfeeding Network too have an accreditation scheme. We would like to see more public services and private business take part.

---

[4] Brown, K, et al. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. 2018. *British Journal of Cancer*, https://www.nature.com/articles/s41416-018-0029-6#Sec22

[5] First Steps Nutrition Trust. *Costs of Infant Milks Marketed in the UK* . July 2018. https://static1.squarespace.com/static/59f75004f09ca48694070f3b/t/5b4af4da352f534ffb61e173/1531639004243/Costs_of_Infant_Milks_Marketed_in_the_UK_july18.pdf

[6] Public Health England. Breastfeeding at 6 to 8 weeks after birth: annual data. November 2017. https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-annual-data;

[7] Welsh Government. Births in Wales 2017: Data from the National Community Child Health Database. 15 August 2018. https://gov.wales/docs/statistics/2018/180815-births-2017-data-national-community-child-health-database-en.pdf

[8] Save the Children. Breastfeeding Policy Scorecard for Developed Countries, in *State of the World's Mothers*, 2012. https://resourcecentre.savethechildren.net/node/6006/pdf/6006.pdf

[9] Royal College of Midwives. 2014. Infant Feeding: Supporting parent choice https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Postnatal%20Care%20Planning%20-%20Web%20Copy.pdf

In particular, the RCM advocates for every workplace to be compliant with Health and Safety law and the Equality Act 2010, including flexible working and support for temporary changes to work arrangements where appropriate.[10][11][12] The World Health Organisation in particular has singled out employment rights and workplace practices as critical to improving breastfeeding rates:

> "Working mothers with adequate maternity benefits, including a breastfeeding-supportive workplace, report increased job satisfaction and greater loyalty to their employers. Breastfed children fall sick less often, so their mothers are also less frequently absent from work. These effects in turn contribute to higher productivity – ultimately benefiting businesses and the larger economies to which they contribute."[13]

Preterm birth

Over 55,000 babies were born preterm in England and Wales in 2015, with preterm births accounting for almost 8% of all births. There has been little change in the prevalence for a decade. Rates of preterm birth in the UK are higher than many other European countries (including Portugal, Bulgaria, Spain, France, Poland, Greece, Denmark, Ireland, Croatia and Sweden) and also higher than countries such as Peru, Chile and Egypt)[14]. The total costs (England and Wales) of prematurity to the public purse were estimated at £2.946 billion per annum in 2006.[15]

Babies born preterm have poorer lung function, higher blood pressure, high body fat, and higher levels of risk factors for heart disease in later life.[16][17][18] Scottish research finds that babies born at 32 weeks have twice the likelihood of having special educational needs than babies born at term (39 weeks).[19] Although babies born extremely preterm (before 27 weeks) are now more likely to survive, rates of disability amongst survivors were the same in those born in 2006 (25%) as they were in those born in 1995.[20]

---

[10] Unicef. Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK. 2012. https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources.pdf

[11] Equality Act. 2010. https://www.gov.uk/guidance/equality-act-2010-guidance

[12] Health and Safety Executive. New and Expectant Mothers: The Law. 2013. www.hse.gov.uk/pubns/indg373.pdf

[13] UN news. 'UN marks World Breastfeeding Week with call for stronger workplace policies for nursing mothers'. 15 August 2015. https://news.un.org/en/story/2015/08/505612-un-marks-world-breastfeeding-week-call-stronger-workplace-policies-nursing#.VcDSkzBVhHw

[14] March of Dimes. Born too soon global map. 2012. http://www.marchofdimes.org/mission/global-preterm.aspx#tabs-3

[15] Mangham, L.J. et.al. The cost of preterm birth throughout childhood in England and Wales. *Pediatrics*. 2009 Feb;123(2). https://www.ncbi.nlm.nih.gov/pubmed/19171583

[16] Heli-Kaisa Saarenpää, et.al. Lung Function in Very Low Birth Weight Adults. Pediatrics. 2015 Oct; 136(4). http://pediatrics.aappublications.org/content/136/4/642.long

[17] Marika Sipola-Leppänen et.al., Cardiometabolic Risk Factors in Young Adults Who Were Born Preterm, *American Journal of Epidemiology*. 2015 June, 181(11). http://aje.oxfordjournals.org/content/181/11/861.long

[18] James, R.C. et al. Preterm Birth and the Metabolic Syndrome in Adult Life: A Systematic Review and Meta-analysis. *Pediatrics* 2013 Apr, 131(4). http://pediatrics.aappublications.org/content/131/4/e1240.long

[19] MacKay DF et. al. Gestational Age at Delivery and Special Educational Need: Retrospective Cohort Study of 407,503 Schoolchildren. *PLOS Med* 2010 Jun. 7(6) e1000289. https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000289

[20] Glinianaia SV et. al. Cerebral palsy rates by birth weight, gestation and severity in North of England, 1991–2000 singleton births. *Archives of Disease in Childhood*. November 2010. https://adc.bmj.com/content/96/2/180

There is overwhelming evidence that preterm birth is correlated with social deprivation[21]. For example, very preterm births (before 32 weeks gestation) and extremely preterm births (before 28 weeks gestation) are twice as common in the 10% of the population with the most social deprivation, compared to the 10% of the population who have least social deprivation[22]. These differences were unchanged over a 20 year period from 1994.

The RCM welcomed the addition of a preterm birth goal to the Secretary of State's national maternity safety ambition (reducing preterm birth from 8 to 6% by 2025). A national 1000 days strategy must advocate for extra resources to ensure expectant mothers are properly screened for the possibility of a premature delivery. Early engagement with maternity services is essential so women with knowable risk factors for preterm birth – infection, kidney disease, multiple pregnancy, smoking – can get the care and support they need. We know women from more deprived areas and from minority ethnic backgrounds are less likely to book before 12 weeks and are at a higher risk of preterm birth.[23] A first 1000 days strategy must consider how we encourage all mothers to access NHS care as soon as possible – including those women who are now being charged for their maternity care under the NHS Cost Recovery Programme. Furthermore, capacity across the pathway needs to be better managed to ensure women deliver at the right place for them and their babies and a transport system that can move babies as quickly as possible.

The Stillbirth Care Bundle has improved care for women and outcomes for babies but smoking cessation is not having the impact as hoped (see below), which is a huge missed opportunity to reduce preterm birth.

Smoking

When a woman smokes in pregnancy or when she is exposed to second-hand smoke, oxygen to the baby is restricted making the baby's heart work faster and exposing the baby to harmful toxins. As a result, exposure to smoke in pregnancy is responsible for an increased rate of stillbirths, preterm births, miscarriages and birth defects. There is a major health inequality in this as women from more deprived backgrounds are more likely to be exposed to smoke during pregnancy. The RCM welcomes the government's ambition to reduce rates of smoking to 6% by 2022 but local authorities are struggling to provide the services needed to meet this target.

The Stillbirth Care Bundle is a package of four measures all NHS trusts are encouraged to undertake to reduce stillbirth in England. The first evaluation of the programme has concluded that the wider uptake of the Care Bundle in England during 2017 correlates with a fall in the stillbirth rate to 4.1 per 1,000 live births. This is a 5.1% decrease from the rate in 2016, and an 18.8% decrease since 2010.

However, "there seems to have been very little impact of the first element of the bundle aimed at smoking cessation. Smoking at delivery most plausibly seems to have been decreasing generally with little effect of the care bundle and in the face of anecdotal evidence of the withdrawal of smoking cessation services generally… Carbon monoxide (CO) monitoring was almost universal with high acceptance rates yet referral to smoking cessation services was poor, and even when referred many women did not attend their appointment."

[21] Alison L Weightman et.al. Social inequality and infant health in the UK: systematic review and meta-analyses. *BMJ Open*. 2012. http://bmjopen.bmj.com/content/2/3/e000964.full.pdf+html

[22] L K Smith et.al Socioeconomic inequalities in very preterm birth rates. *Archives of Disease in Childhood - Fetal and Neonatal*. 2007 (92). http://fn.bmj.com/content/92/1/F11.long

[23] Tommy's. Lifestyle factors and premature birth. October 2015. https://www.tommys.org/pregnancy-information/pregnancy-complications/premature-birth/causes-premature-birth/lifestyle-factors-and-premature-birth

The RCM endorses the recommendation from the evaluation of the Stillbirth Care Bundle that "care needs to be "joined up" between different care providers and responsible organisations… this is most relevant for smoking cessation services which are rarely provided within maternity services, preventing easy access for mothers." Studies have found that a significant minority of pregnant women who give up smoking return to the habit after their babies are born,[24] suggesting better coordination between midwives and health visitors – and the NHS and local government – could help women continue smoke free lives for their benefit.

A tough financial climate and cuts to public health have resulted in a postcode lottery of local stop smoking services. The RCM is aware of reduced and patchy provision from local councils for women who are pregnant. Support programmes and specialist midwives that deliver them have insecure tenures, lack of time and inadequate resources. Funding arrangements vary from area to area, with dwindling public health budgets having implications for future sustainability. To tackle stillbirth, preterm birth, growth restriction and low birth weight, and all the long-term health outcomes for children growing up in smoking households, and for their mothers' own health, we must make access to stop smoking services for pregnant women an absolute priority for the first 1000 days.

Maternal and infant mental health

The first Building Great Britons report outlined clearly the strong links between maternal and infant mental health. New research continues to prove how important bonding and attachment is for long-term health outcomes, and the impact of mental ill-health, substance misuse, domestic violence and birth experiences can have on maternal emotional wellbeing and infant development.[25] Midwives are encouraged to help mothers, fathers and partners to interact and play, and refer to specialist services when necessary. We understand the Committee's decision to not investigate new evidence, but the emerging literature on men's postnatal depression may warrant consideration in any new strategy.

The RCM has outlined recommendations for the management of women in the perinatal period and we would like to see these feature in any 1000 days strategy.[26] The recent announcements of more funding for perinatal mental health is a breakthrough but we must ensure that every penny is spent wisely to have the greatest benefit:

1. That every maternity trust has a midwife who specialises in maternal mental health at a senior level. While all midwives have a role in supporting women's health throughout the perinatal period, a midwife with a specialism in mental health can ensure women, her baby, and her family get the best possible care. Additionally they will support the wider midwifery team and have a key role within the multidisciplinary team in supporting each woman in need. The midwife specialising in maternal mental health needs structures in place to function optimally. There needs to be a well defined role, job description, development plan and clear remit for their work within a local multidisciplinary team that meets national quality standards.

[24] C Notley et.al. Postpartum smoking relapse—a thematic synthesis of qualitative studies. Addiction. Sep 2015. https://onlinelibrary.wiley.com/doi/abs/10.1111/add.13062
[25] RCM, 2012. Maternal Emotional Wellbeing and Infant Development. https://www.rcm.org.uk/sites/default/files/Emotional%20Wellbeing_Guide_WEB_0.pdf
[26] See RCM 2015. Caring for Women with Mental Health Problems: Standards and Competency Framework for Specialist Maternal Mental Health Midwives. https://www.rcm.org.uk/sites/default/files/Caring%20for%20Women%20with%20Mental%20Health%20Difficulties%2032pp%20A4_h.pdf

2. That all health professionals working with women in the perinatal period have a basic awareness, knowledge and understanding of perinatal mental health. They should know when to refer women appropriately. They need to stay abreast of new evidence and best practice post-registration. This is consistent with the ethos of the NHS Mandate regarding the delivery of high quality, effective, compassionate care and developing the right people with the right skills and the right values. Pre-registration training should equip professionals in this respect.
3. That education and training in perinatal and infant mental health is appropriate to the role. Midwives specialising in this area should be demonstrating enhanced specialist skill. They will be champions not only for the women in their care, but for highlighting the importance of perinatal mental health in the wider health, social and emotional context. Training providers for midwives should ensure that the courses designed and developed to meet the needs of those striving for specialist status are of high quality.
4. That all maternity professionals should be equally concerned with mental as well as physical health in pregnancy, childbirth and postnatal periods.

2. Current spending and barriers to investment

- **Recent public spending on services covering the First 1000 Days.**
- **Difficulties in making the case for investment nationally and locally.**

The government's decision to cut £200m from the public health budget in 2015 was widely unpopular as it was seen as a cut to vital services which directly impacted demands on the NHS and wider socioeconomic determinants of health. It has ultimately led to local councils having to make hard choices and begin to cut services, as described above.

In regards to maternity, there have been some welcome spending announcements in 2018. A pledge to train 3,000 more midwives in England over the next four years[27] and a boost of £365m towards improving mothers mental health.[28] In Wales, the government has decided to retain the bursary for student midwives and keep their studies fee-free.

However, it is important for the committee to recognise that there are elements within the NHS England Maternity Transformation Programme (MTP) in England which are specifically 1000 days-focussed and yet have progressed the least. Community hubs were a key recommendation within the *Better Births* report, which formed the basis of the MTP. Crucially, they rely on organisations across local government, primary care and maternity services to work together.

The concept is that "it is a local centre where women can access various elements of their maternity care, such as the Portsmouth Birth Centre. They could be located in a children's centre, or in a freestanding midwifery unit. Hubs will act as "one stop shops" for many services, and provide a fast and effective referral service to the right expert if a woman and her baby need more specialised services. These might be ultrasound services, smoking cessation services or voluntary services providing peer support. Women may also be able to meet professionals who will be involved with them after childbirth, for example, their health visitor. In some community hubs there may be birthing facilities." Moving more healthcare into the community is also an aim of the *Five Year Forward View*.

[27] Department of Health and Social Care. Women to have dedicated midwives throughout pregnancy and birth. 27 March 2018. https://www.gov.uk/government/news/women-to-have-dedicated-midwives-throughout-pregnancy-and-birth

[28] NHS England. Funding boost for new mums' mental health. 5 Feb 2018. https://www.england.nhs.uk/2018/02/funding-boost-for-new-mums-mental-health/

Our understanding is that progress on this recommendation is slow. Early Adopters – specific geographical areas given funding to implement aspects of the MTP – have made progress due to the impetus given by the funding and dedicated commitment to recommendation. Other areas of England have made far less progress despite their willingness. Existing community birth centres, such as the Portsmouth noted above, continue to provide excellent community-based services for women, but basic problems with finding physical spaces in the NHS estate, or using GP practices, have stalled progress. The closure of an estimated 1,000 Children's Centres since 2009[29] has exacerbated the problem. The concept requires imaginative commissioning, which in this strained financial climate has been difficult (and the Early Adopters – with funding – have been able to overcome). Dedicated funding support to get these community hubs off the ground would go some way to giving commissioners and providers the space to think creatively.

3. Local provision

- **The scope, scale and current performance of provision for First 1000 Days of life, including universal and targeted approaches.**
- **Barriers to delivery (e.g. workforce shortages, financial constraints on councils)**
- **What a high-quality evidence-based approach to service provision would look like for the First 1000 Days of life.**

As described above, community services have been cut since councils have been forced to deal with shrinking budgets and greater demands. This year the RCM has again surveyed Heads and Directors of Midwifery across the UK to ascertain staff working in specialist services, such as teen pregnancy, weight management, smoking cessation, mental health and bereavement. The data from the survey will be available later this year and this will allow us to better understand how the first 1000 days agenda is staffed in maternity across the country. The shortage of 3,500 midwives in England, plus the increasing number of women who require more care for pre-existing conditions means the capacity of NHS maternity services is stretched to breaking point. Basic standards of maternity care – every woman receive one-to-one care in labour, every woman has a named midwife to help navigate her care – are not met.

Both the Scottish and Westminster Governments have committed to continuity of midwifery care for every woman during pregnancy, labour and birth. The benefits of this kind of 'relational care' are well evidenced and for this reason the RCM is fully supportive of rolling out this model of care to all women, making sure that our midwife members are working in supportive teams, avoiding burnout. Continuity of midwifery care has the potential to not only directly impact clinical outcomes such as preterm birth and caesarean sections, but also to enable midwives to better assess women's changing needs and circumstances over time and deliver more personalised care. It will ultimately increase service user satisfaction. This will benefit the first 1000 days agenda and the RCM is supporting our members to transition to this way of working. However, a key component of moving to continuity is having enough midwives. The RCM is monitoring the workforce situation and will continue to press for the workforce we need to deliver the care women and babies need for the best start in life.

In regards to the last point, "*What a high-quality evidence-based approach to service provision would look like for the First 1000 Days of life*", from our perspective representing members working in maternity services, we would endorse the vision for maternity services as outlined in the *Better Births* national maternity review report. It is focussed on personalised, safe care for every woman. She would be able to access co-located services in her local community and get to know her midwife. Midwives would have the time to care for women and their families, coordinating the care

[29] The Sutton Trust. Stop Start: Survival, decline or closure? Children's centres in England. April 2018. https://www.suttontrust.com/wp-content/uploads/2018/04/StopStart-FINAL.pdf

needed from other services and professionals to make a woman's journey seamless with quick identification and referral. Babies requiring neonatal care would not be separated from their mothers and all mothers given skin-to-skin contact with newborns to facilitate bonding and breastfeeding. All mothers would have timely access to specialist perinatal mental health support and there would be no stigma in asking for help. GPs would be given the resources they need to carry out the 6-week check, bringing the baby and the mother back into primary care with a full information handover with a life-course approach.

Royal College of Midwives
September 2018