Podcast Transcript - How are evolving clinical needs impacting the future of maternity services?

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Gareth Banks

Hello and welcome to the AHR Podcast where we engage in captivating conversations about the built environment and its influence on shaping a more positive future. I'm Gareth Banks, Director at AHR, and in this episode we're exploring how maternity environments are evolving and asking how design can better respond to the real complex needs of women. Through choice and clinical care to flexibility and risk, it's a conversation that affects thousands of families every day.

Joining me today for this conversation are Victoria Shepherdson, Associate Director at AHR, who brings expertise in designing healthcare environments that respond to evolving patient and clinical needs. We also have Sandra Reading, an Associate Director at Turner Townsend and former midwife who will provide insight into how maternity services are changing on the ground.

Victoria, do you want to just expand a little bit on my intro?

Victoria Shepherdson

Yeah. Hi. Yeah, thanks Gareth. Yes. No, I'm Vicki.

I'm an Associate Director here at AHR. I have been doing healthcare now for about 25 years, ranging from kind of very, quite small breast care centres and refurbs right up to kind of really big, digital general hospitals and PFI projects or the old PFI projects.

I think Women and Children's is an area that I specialise in, and it's an area that's really very dear to my heart, obviously being, I'm a mum as well and I have two

children, but also, I think it’s fascinating for me to see it from both sides, really as a mum and as an architect. So, it's a great topic to be discussing today.

Gareth Banks

Great and Sandra, a little bit about yourself.

Sandra Reading

Thanks, Gareth. As Gareth mentioned, Associate Director at Turner Townsend, I worked in the NHS as a midwife and as a director of midwifery for many years. Now leading on strategic health planning projects and programmes, very much linking in with operational and clinical teams across the NHS to support new developments.

And I have a specific interest in maternity services and women's services.

Gareth Banks

Great. Okay. Well let's, let's jump straight in then. So maternity care is quite different from other types of healthcare. Although there's been a shift towards appreciation of wellness, maternity care currently is probably the most obvious example of a space where we're looking to not treat an illness as such, but support people in their lives as they go through that.

So how have women's expectations experiences changed, and why does that matter when we're designing health spaces? Sandra, do you want to kick us off on that?

Sandra Reading

Yeah, of course. It's really important when designing the infrastructure for the provision of maternity services specifically, that there's a very good understanding of the range of pathways of care that women have and what influence that has on the type of facilities that they need.

Particularly in terms of the quantity of those facilities and the type. Importantly a woman's place of birth is a choice and it's not a clinical need. Based on that they're coming in for a specific, operation or that they need some treatment, it's something very different to that. The shifting expectations of women, the wealth of information available to people to help them make choices can lead to a more of a medicalisation of birth and some of the options that people are choosing to have. The future infrastructure needs to be able to support this, whether that's from a midwife led units or through to facilities in hospital settings and the type of those facilities they should be. So that women can have the best experience possible.

Gareth Banks

Okay. That's great. So, Vicki, and in terms of the built environment, how do you think specifically, the environment needs to change from, as Sandra says, a more kind of

medicalised environments that we're more used to in hospitals, to one that more actively promotes this life changing experience?

Victoria Shepherdson

Yeah, I think, you hit the nail on the head when you said, Gareth, these people, women giving birth aren't ill. They're actually going in there to give birth, and I think it's quite a well-known fact that actually your mental health while you are giving birth or, in that process has a huge impact on the type of birth that you have.

So I think the environment has a massive impact on that and obviously if you are in a, quite a hospitalised, medicalised environment and everything's very sterile and white and clean, it can impact on, how you feel in that space. But if you walk into a space that seems much more cozier, like a home from home, you know, that also immediately starts to relax you, maybe the lighting is better.

And I know that when we were looking at some of the delivery rooms at Shrewsbury and Telford Women and Children's Hospital we were very much looking at the environment that the woman was giving birth in and how we could, with the lighting, make that much softer. How we can look at it some of the decorations, the interior design of that space that make it that much softer.

So when your immediate approach and being in that room, you felt much more at ease. I think that has a massive impact on women giving birth, their immediate environment, what they can see, and those kind of five senses of hearing, you know, seeing, you know, touching all those things are huge.

So I think as architects, we have a massive role to play in that actually for women. I don't know what you think about that, Sandra, whether you have any kind of instances where, you know, if people are a bit more relaxed it's much easier or, I don't know. That's kind of how when I was looking into it all, that's definitely, and I did, I wanted a home birth because I wanted to feel at ease.

Sandra Reading

No, you're absolutely right Victoria. It is, the environment should be conducive to that relaxation and that good experience and it doesn't really matter what type of birth a woman is having to be able to ensure that every, person should have that exactly the same.

What we are aware of is that new pathways of care, revisions to national guidelines, and women's choice specifically, has led to a general tendency for people to be a little bit more risk averse. That's had an impact in the sense that it's had a gradual, but we are seeing a gradual, you know, significant rise in operative births, caesarean sections and interventions before birth.

And because you're having that intervention before birth, you might actually be in hospital for longer. So that environment, even though your labour's being induced needs to be conducive, like you say to that relaxation, that people should be able to

see themselves through that time, which actually can be quite long. They might be in hospital for a couple of days before they give birth to the baby.

The increasing complexity of pregnancy as well, due to a number of things such as women's underlying conditions, age, women having babies older and also ethnicity further leads to some of those interventions. When I was talking about how that has changed, we're now looking at around 40% of all births are caesarean section or interventions.

Once you've had one intervention, then the likelihood of having another obviously increases. So, the environment needs to be able to adapt to the type of births that people are having and the flexibility within that environment is really important.

Victoria Shepherdson

I think it's giving women that choice at the end of the day, isn't it?

If you want to go down that medicalised intervention route, you can. And if you're choosing to have a birth, a natural birth. You also can do that. And it's very much your personal and your own choice. And as architects, we have to design that facility around that. So, to be able to give you those choice of spaces so that you can feel at ease, I think is key.

Gareth Banks

Do you think it's inevitable, the kind of medicalisation? I mean, just picking up from Victoria's early point and one of the points that you mentioned, Sandra, clearly being risk averse and feeling that you are supported should things go wrong is one thing and doesn't necessarily lead to a caesarean section if you feel the support is there.

I'm just wondering, again, just turning it back to again that whole kind of de-stressing thing, you know, at one stage hospitals were, you know, they're all white and linoleum and bright lights, and the domestic setting that you allude to Victoria is obviously darker, softer furnishings etc.

But with the advent of hybrid spaces like spa treatment areas and things, which again, are relaxing, but they're relaxing in a more clinical way. Do you think there's a role to be played whereby we can almost reclaim some of the more natural and the many benefits? Certainly, from a recovery point of view, natural birth has got a significantly shorter recovery time. Do you think there is a place that architecture can play in creating environments where women and families and partners can feel supported and tend towards a natural birth solution when they might have otherwise opted straight for a kind of medicalised solution.

Sandra Reading

Yeah, I think it's absolutely true. It's the room and the environment that people are in is very, very important. The practicality sometimes has to be considered and centralising services has been sort of a thing that's been happening quite a lot.

The reason for that is around the practical application of making sure that they can be staffed safely. Sometimes we hear, don't we of, birth units or standalone birth units particularly that have ended up closing on occasion because midwives have been pulled to the main unit for good reason at that time if it's not busy in the other area.

I think that's, that's a key issue to consider when we are designing spaces is should they be, that they are spaces that can be easily adapted. Whether that's a co-located birth centre, right next to a labour ward, or should the whole environment be that one space that women go into one room and you can remain in that room as far as possible unless you need to move and it becomes your space.

There are some very good examples of that and how that can then cope with all the different, anomalies that can happen during the course of a 24 hour day in a busy maternity unit where sometimes the activity just fluctuates all of the time.

Victoria Shepherdson

Yes, because I think, I know, certainly when I've been looking at, you know, quite a few maternity centres and also my own experiences. You arrive at the at the hospital in various different ways, can kind of come in, can't you and you're high risk.

You come in and you're there for a period of time and then you move through to your birth or you can arrive kind of like I did mid-birth. You know, you're having people turning up at your front door in a very different ways and then once you get through that front door, your pathways can be really different, can't they?

You can kind of turn up and then you are directed towards your antenatal bed where you sit in there and you are there for some period of time while you are labour develops or not developed as a case may be. Or you've come straight through and then you're pushed straight into a delivery room and then you give birth, hopefully, you know, in an easy style kind of way and then you've moved, then from there, you may well go home, or you may go to the postnatal or you may go to NICU.

There's so many different variations, isn't there? And there's also, you come and you'd stay and then maybe you'd go to induction room and then you'd move to the delivery room and, and then maybe you'd move to theatre.

So there's so many different rooms and areas that a woman has to go through on that kind of journey. And then making those places flexible and also kind of ease to move women through is also very difficult. Because what I dislike massively as a patient, but also I think as an observer, is when a lady is moved from one area to another area because she's changed, something's happened, or then she moves to another area and then she moves to an area.

Going down a corridor, mid-birth is not ideal for anyone. You know, it's not ideal for the mom, for the baby, for the dad, for carers, or anyone. It's trying to avoid that, but there, there isn't really an easy way of doing that is there, unless you're going back to the old LDRP rooms, which were enormous, and the idea was that you would kind of come into those spaces, wouldn't you. I suppose pre-birth where you come in and

then you're going to give birth, and then you would stay in that room and recover and then you would go home because that one room had to do everything, didn't it?

Sandra Reading

Yes and I think the principle about that room was very much, it starts with labour.

Going back to the, the point earlier, a lot of women that are coming in, they're not actually in labour yet. So that 40-45% group of women that are being induced in their labour is actually the space needs to be suitable. The feedback that I'm getting a lot, more recently, is around the most difficult challenge that a lot of maternity units are having at the moment is not enough space for that first bit.

For those people that need to be in hospital and space where their family can be there, their partner can stay. All of that goes back to your point around relaxation and ensuring that you are in the right frame of mind for the next stage, isn't it? And then move into that flexible environment that those people can stay with you and be in that larger room when you need to be there.

But absolutely, thinking of your point, not moving people from room to room to room.

Victoria Shepherdson

Which I understand it is really difficult to do, because you don't want a blocker, do you? Someone is in a room, for instance, a lady who's not quite ready to give birth yet, but she's in a delivery room and there's a lady who needs to deliver straight away.

So that does become a bit of an issue, doesn't it? So you have to have and how we work that is very difficult, isn't it? You have to give that kind of flexibility rooms, but all very, very close together and then those rooms have to be big enough then to have all the carers in it.

It does become very tricky. But you know, it's certainly looking at some different examples of how we can do that, I think is, something that we need to test out properly.

Sandra Reading

Yes and the feedback from women around that as well. What's most important to them? We haven't really touched too much yet on sort of the, that postnatal bit as well.

And what's important is rest during that period and having your own space and having your partner with you and having help is probably one of the most important things. And women don't stay in very long. It is very common to be one day in hospital and getting the most out of that time that you are in there, in the best possible way is just as important, I think as that first stage.

Victoria Shepherdson

I know when we did the Shrewsbury and Telford Women and Children's Hospital, we had, a lot of feedback from mums who had just given birth and that kind of what you talk about, that kind of recovery was key to them actually.

We created a little room, just off the postnatal area, like a sitting room where mums that had just been through birth could sit and chat to each other and discuss – "actually, I had that as well, so that actually, that was quite normal. It wasn't great, but actually, you know, I'm all right now."

That is just so important to women, I think, just to feel that actually what they did and what they did was a) amazing, and b), you know, maybe it did go not quite as right, but you've still got your beautiful baby and you are okay at the end of the day is just so key, I think, to your recovery mentally.

And obviously then physically.

Gareth Banks

Do you think there's an element then where instead of just considering the mother and the child is the focus that actually there's a sort, a wider part to be played both before delivery and after delivery. In the social context, a mother is often part of a family or certainly has a support network as part of that.

If that isn't the, as you say, other mothers going through that experience can provide that support, and maybe there's something in the way in which we develop schedules of accommodation and plans, which actually we can use the space that we generate or need to generate for that social interaction.

Then reduce maybe some of the spaces, which are more isolated, you know, induction room or, whatever, or that kind of triage. Maybe there's something where we can reconfigure that, that space in a way that that gives a much richer, I'm thinking more, you know, in some degree of, you know, we've got the midwifery-led units and the obstetrics-led units, but actually is there a coming together? It's a bit strange that you kind of have to choose between those two pathways, you're just giving birth and you want to give birth in a way which is the most supportive and natural for you.

Victoria Shepherdson

Yeah, I think it is around that having those, I'm a big advocate of single rooms. I don't how you feel about that, it'd be interesting to hear your view on that Sandra from a staff perspective. But from a user and a mum being in a single room was great in terms of being able to sleep without there being lots of noise and other people coming in and out, being bothered in and out, and that was great.

And then also my family could be all around me, but we have all these single rooms, and as you said, Gareth, sometimes they can be a little bit isolating because you are

in those rooms. So, I think it's about providing those rooms, but also providing a community space that you can go to if you wanted to.

Sandra Reading

Single rooms, absolutely it, you know, it's the way forward.

It's what people would expect to be able to have, but those communal spaces, absolutely, they should be there. It's interesting because you sometimes do think a single room is a little bit isolating, but if you went into an average sort of bay that women might be in postnatally, you'll usually find all the curtains are drawn because people like to feel in their own little space.

I think, yes, the single rooms it is something that I think people can be in their own space, they're with their own family, they don't feel they're disturbing other people. I think that that is the key to the way forwards. But those rooms need to have a real flexible approach to how they could be used.

Going back to your point, Gareth, I think those communal spaces where people feel they can come out of that space and mix with other people is hugely beneficial.

Gareth Banks

It's interesting, you touched on it earlier, with this move to medicalisation and kind of elective birth through, through caesarean. I suppose that the biggest challenge that we have, both the health service and as architects is that labour can be 24 hours, it can be an hour.

And how do you, therefore, if you're going in for a knee operation, we know it's going to take whether it's two hours, don't we? You know, and we know you're going to go in at nine o'clock and you're going be out at 11 and we know the recovery's going. Whereas you could come in at nine o'clock, in labour and have a difficult labour that lasts for another 12 hours.

Or you could be, I was going say, done and dusted, which probably isn't the most appropriate.

Victoria Shepherdson

I wish it was done and dusted! Done and finished!

Gareth Banks

You know, within half an hour and I suppose, I was just as we were talking there, I was just thinking about, the space hungry, critical space, as you were talking about in some of the early models, is that delivery room.It's a highly focused space, with very specific requirements, and you want that to be utilised as much as possible.

Is there a way in which you could have, you know, three rooms leading off that for instance. As long as you've got the option, because of all three of those rooms could, could go into labour at exactly the same time.

So you also need the opportunity to access three other rooms, don't you? But I'm just trying to think in, in sort of planning terms, is there a slightly more clever way that we do where we have, we don't just have a bank of triage rooms then a bank of delivery rooms, and then you go up onto the maternity ward and there is something which is closer, but again, accepting we do live in a real world and we can't have a unit that's six times the size of current units.

Would that be a practical solution? Whereby you can, I suppose, almost in the way with operating theatres, you want that maternity room to be used most of the time.

Sandra Reading

Truthfully, maternity units are sometimes they are like a mini ED, like an emergency department, that women are going to come in a whole different, lots of different reasons, and they're going to come in 24 hours a day and the other group of women are going to come in in a much more organised fashion. It's being able to work those two pathways together. And most paternity units, obviously they do it every day, they manage that.

But there are some areas where they often find challenges, and that is because of the changes that have happened. There's a higher percentage of certain groups of women that will be coming in and they haven't always got the space, so they have to be able to manipulate, move rooms around, move people around, and that's what causes the most challenge.

Future design, absolutely. Thinking about those pathways of care and making sure that the modelling fits the future is, is the way forwards.

Victoria Shepherdson

So rather than kind of zoning the induction rooms together, zoning the delivery rooms together and zoning some of the kind of triage spaces together, it might be better if, Gareth you used the analogy of the theatre and having clusters of spaces.

Rather so having an induction room close to a delivery room, which was then close to maybe an assessment bay, or which is then close to maybe a bedroom, is a better way of looking at it zones and clusters that you can easily move between those rooms without going down a whole length of induction rooms or a whole length of delivery rooms.

You're just in kind of that cluster and you're with other mums in that kind of area. Maybe that's one way of looking at it. I know that architecturally, it's probably not the easiest to design lots of different rooms of different shapes off a corridor. I'm sure there are ways that we can do that rather than doing that long corridor with all those rooms along that. Is that something that maybe could work?

Sandra Reading

I think so, thinking of like the zoning and the space, you know, putting things together and that helps with staffing arrangements as well, of course, because you are looking after a certain group of people that are all in a similar situation, and then you've obviously got to have your one-to-one care for people who are in the active phase of their labour, which is different.

But also going back to the point that women can then come out of the room, can't they? Because they're in that zone. They're in that cluster space where there are other women going through a similar stage of their labour as they are. It all comes back to the bit about people mixing and that space being conducive to families.

Gareth Banks

I suppose, as a non-mother, but as a father, it's still a traumatic time as well. You know, the stress levels are there as well and anxiety. And again, being able to support your partner. Something like that cluster arrangement might provide that, you know, you're going, father of the third child or whatever, sage words of wisdom to the new newly expectant father, could be helpful as well. You know?

So I think there's perhaps a lot to go at there really, again as you say, Sandra, if that works with the staffing, then maybe it's just a question of how do we start to kind of challenge the briefing process, which automatically takes us down the HBN route, which says there are, you know, this is the expectation.

I mean, do you think, do you think that the clinicians would be open to this as a debate? What's your sense about the kind of mood?

Sandra Reading

I think that clinicians would absolutely be open to it, to looking at what might work better, because they're very aware of the challenges that they have, and they're often working in quite older environments.

Trying to cope with the changes that have taken place, having obviously the appropriate number of single rooms for different reasons; infection, prevention, control, all of those different things that are very important and provided that’s in with the mix, but actually looking at how people could be in one area where you've then got the different, it is just not like that in hospitals at the moment.

It's difficult to imagine it, but actually thinking it through, that's what that is, what people are trying to create just in very difficult spaces.

Gareth Banks

Do you think that would also support, I'm just trying to think of, we live in a multicultural society as well, and in many sections of society birth is a much more, much greater family occasion as well. It wouldn't necessarily just be the mother and the father, it might be aunts and uncles and that kind of big supportive. I'm just

thinking again, if those kind of bigger spaces would've eased the pressure that you might get in a room that's designed for just two people, or, you know, it also can alleviate some of those stresses as well.

Sandra Reading

It absolutely does, and, you know, individualised care is for the people and making sure that people have got that private space. I mean, most hospitals will often have restrictions on how many people can come in for obvious reasons, but nevertheless, that flexibility is just as important and you get that if you create the right spaces.

Gareth Banks

So I suppose just the final bit then, perhaps before we close it then. The kind of elective care and the caesarean, clearly for operations reasons, as we just discussed, if you know you've got 12 elective births, that's a far easier way to handle it. But do you think there is merit in trying to rebalance a little bit or do you think it's, it's just going to be one of those things where the nature of modern society is leading us to that, you know, you book your appointment and you know, how far should we factor that in, I suppose, into the equation?

Sandra Reading

I think it absolutely needs to be factored in because of that change and the type of both the birth and the postnatal specifically care that people need, following a major operation, which a caesarean section is. That has to be factored in to make sure, there's a number of safety reasons why you would want to make sure, that people have the right care in the right place.

I think we have to look at maternity units and what those percentages are like today to how they were 20 years ago, when the maternity unit may have been built. So, it is important, but at the same time, thinking of how you create a maternity unit that is conducive to what people would expect and what they would like to have is important for the future.

That goes back to those cluster arrangements, zoning, making sure that people are cared for in the right place.

Victoria Shepherdson

I think it's definitely a choice for a mum. If a mum feels like she wants to have a caesarean, she should have that choice to have that caesarean. You know, I thought giving birth was amazing and we've been doing it as women for a pretty long time now.

Do you know what I mean? It's nothing new and I think maybe it's a little bit around education and around saying actually, it's still pretty safe to give birth naturally. There's that kind of re-education that we need to, and certainly, you know, as a busy full-time mum, if I could schedule my birth in for next Tuesday at four o'clock, that's amazing.

Do you know what I mean? I could go and have my baby,

Sandra Reading

I think, yes, you're right it's around choice, isn't it? It's making sure that individual choice is catered for within the service and how it's designed.

Victoria Shepherdson

I think we're going to have more theatres and less delivery rooms. So in theory you may have less choice because you know you're going to get more medicalised birth. Because you can't create these like huge units full of like 15 of the obstetric theatres and 25 delivery rooms.

There's going to have to be a balance addressed there, because we can't afford all that space.

Gareth Banks

Again, I suppose like you just said it puts additional pressures which move outside the department, don't they? I mean, I suppose in summary, from an architectural perspective, it seems to me interior design is critical.

These cannot be treated as just medical spaces. They have to appreciate this is a life experience, which is valuable in its own right and needs to reflect that and value that in terms of the way we treat the internal environment. But it does seem like we can do more with the way in which we arrange the various functions of rooms.

I think we're not going to advocate a single room, which does everything. I think it is about a range of rooms, but maybe there's a better way in which we can cluster those rooms around the kind of key elements of at the birthing room, etc. And not only would that seek to maybe de-stress and support mothers in childbirth, but would also improve staffing pressures and allow staff to service those mothers more easily.

But ultimately it is about balance, as you say. It's understanding that any woman giving birth should always have a choice, and we need to make sure we accept that. But ultimately, you know, we do need to be flexible.

Victoria Shepherdson

Yeah. No, I agree and it's also involving, maybe when we do some of those stakeholder engagements, we kind of bring the clinicians and the mums together to look at how we can change some of these clustering. Getting the staff arrangements right, and also the patient's viewpoint as well.

Sandra Reading

I thought that's really refreshing. It's great to hear the sort of views of everybody around it, there's such a range of opinion and it's all very important. Because it's a life changing event as you said Gareth at the beginning, and we need to get it right.

Gareth Banks

Great. Thank you very much, Sandra and Victoria.

That brings us to the end of today's episode of the AHR podcast. Big thank you to Sandra for taking us through that and giving us your time, which I know is very valuable and joining and sharing your experiences.

We hope our listeners have enjoyed this episode. You can find all our podcasts episodes on our website, or you can subscribe via your preferred podcast platform. Thank you so much for listening, and we look forward to you joining us again next time.