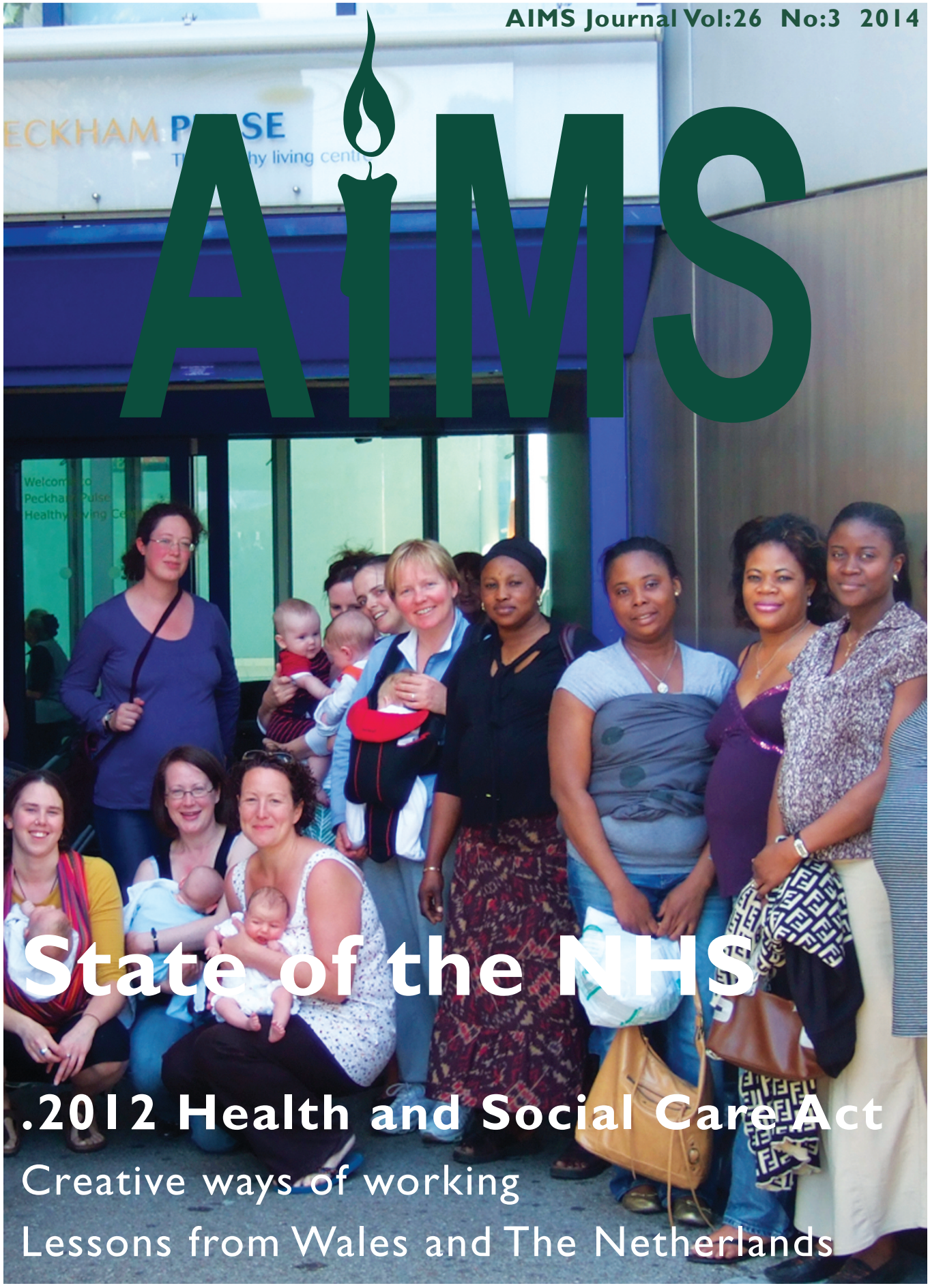
Association for Improvements in the Maternity Services

AIMS Journal Vol:26 No:3 2014

AIMS



State of the NHS

.2012 Health and Social Care Act

Creative ways of working

Lessons from Wales and The Netherlands

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Diary

AIMS Meetings

Thursday 27 November 2014
Bristol
Friday 24 April 2015
Sheffield

All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

AIMS Talks

Sara Wickham

Group B Strep

Wednesday 26 November 2014
Bristol

Mavis Kirkham
Thursday 23 April 2015
Sheffield

If you are interested in attending please email talks@aims.org.uk

Please always check our website or contact us to confirm details as sometimes things change.

Beverley Beech

Am I Allowed?

Please see the AIMS website for details of our forthcoming launch of the fully revised version of one of our most popular books.

If you are interested in attending please email talks@aims.org.uk

30th Anniversary of the Forum on Maternity and the Newborn

Look back to the future

Tuesday 25 November 2014
9am - 5.30pm
Royal Society of Medicine
1 Wimpole Street
London
W1G 0AE

The aim of this celebratory meeting is to reflect on a wide range of significant clinical, organisational and philosophical issues facing maternity care, with the purpose of providing insights as to the way forward in the future.

Themes will be addressed by nationally and internationally well renowned speakers. Much time will be devoted to audience contributions and open discussion to optimise the value of the multidisciplinary nature of the Forum.

Chairs: Luke Zander, Founder of the Forum on Maternity and the Newborn and Cathy Warwick, General Secretary, Royal College of Midwives

Speakers include:
Michel Odent, Becky Reed, Becky Brien, Kathryn Gutteridge, Jo Murphy-Lawless, Susan Bewley, Rona McClandish, Elizabeth Prochaska, Diane Jones

To register interest please email maternity@rsm.ac.uk

Association for Improvements in the Maternity Services
founded in 1960
by
Sally Willington 1931 – 2008

AIMS

campaigning for better maternity services for over 50 years

AIMS

Registered Charity Number (England and Wales) 1157845 The Association for Improvements in the Maternity Services

Hon President
Jean Robinson

AIMS Research Group
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

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Cover Picture:
Albany Mums and their babies, outside Peckham Pulse Heathy Living Centre.

Contents

There for your mother
Here for you
Help us to be there for your daughters

Charity Update

AIMS is now a Charity! After much hard work with the application, the Committee is thrilled to announce this momentous news. Charity status will enable us to remain more financially viable, whilst continuing our work to improve birth experiences for mothers and babies – we have been doing this for over 50 years and will continue as long as we are needed!

As a result of charitable status we will be able to:

- raise the profile of AIMS to gain more public support
- claim exemption from the payment of tax on most of our income
- meet the eligibility criteria to apply for grants
- be able to receive gifts made under tax effective schemes such as Gift Aid and Give As You Earn

AIMS will continue to exist with a lay committee (now comprising voluntary Trustees) and unpaid volunteers. We will continue to produce the Journal and write and sell publications and do all the other things we already do including the helplines and campaigning. One of the main advantages for AIMS is that income should increase, enabling us to expand our many voluntary activities.

In making the application for Charity Status, one subject stood out for us – Human Rights. For the application we had to consider all our work and make a case to the Charity Commission that much of it is to do with Human Rights. We have not previously used that all-encompassing term very often, however, you will see changes in the future, with AIMS using the Human Rights Act more and more to ensure that existing women's rights during childbearing are respected.

Look out for more news in the Journal and on the AIMS website in the coming weeks for information on what the change means to the AIMS Committee and our Members. For example you may be contacted with regard to Gift Aid – please respond as this will generate increased funding.

Also, look out for our new range of promotional items, featuring the image at the top of this page.

Registered Charity Number 1157845.

AIMS Trustees. From left to right: Shane Ridley, Virginia Hatton, Gill Boden
Nadine Edwards, Glenys Rowlands (non-trustee membership secretary), Debbie Chippington Derrick and Beverley Beech.
Other trustees, not pictured, are Emma Ashworth, Olivia Lester, Chloe Bayfield and Dorothy Brassington.

Good maternity care for all

Nadine Edwards and *Jo Murphy-Lawless* urge us to act now

AIMS members, like many others, have found it difficult to understand what has been happening to the NHS and to take in that the 2011 Health and Social Care Bill meant opening the door to a fully privatised NHS in England, and therefore in time for Wales, Northern Ireland, and, potentially, Scotland (depending on the referendum decision and all that will follow from the decision, for whichever way, change is in the air).

This will happen through complex funding and operations mechanisms that rest entirely with Westminster, even though legally the NHS has been a separate entity in those three jurisdictions since 1947 (Scotland), 1948 (Northern Ireland) and 1969 (Wales). The move to cloak the intent of the Bill is deliberate. Even as late as 2011, the current Government assured the public that it would not be making these sorts of changes to NHS England. Some of the articles in this issue explain why that tactic was employed and how, because of this, effective opposition came too little and too late and the Health and Social Care Act was passed in 2012.

In putting together this issue on the NHS as it relates to maternity services, we have tried to understand the issues better ourselves in order to contribute to the debate in ways that might inspire hope and effective action. In order to do this, we needed to track back, as Jo Murphy Lawless has done in our lead article, to provide a historical analysis on how the Act was a culmination of what Margaret Thatcher set in train in 1979 in her Conservative Manifesto. The NHS could not be privatised then – the very idea would have been considered preposterous at that time – but more importantly, for those who had ideas about dismantling the NHS, the structures were not in place for it to be privatised. An internal market had to be created before an external one was possible. Our two book reviews track the detail of this, and show how successive Governments, relentlessly but surreptitiously pursued this: surreptitious because large sections of the public would not have countenanced this, but at the same time the ground was shifting due to an orchestrated constant critique that the NHS was costly and inefficient, with poor staff, as Gill Boden describes in her article on NHS Wales.

provide the kind of care women need

We have also suggested that while privatisation of the NHS has enabled the development of a few private independent midwifery businesses which provide the kind of care women need, these are fragile and exclusive – either geographically or economically or both. What these endeavours have done, however, is to highlight how NHS maternity services have consistently failed to provide good services that promote positive and healthy birth outcomes for women, babies and families. As research shows, healthy women have better outcomes when supported to birth in the community, and all women benefit from being cared for by midwives they know and trust. Yet women and midwives are not being listened to, and with some notable exceptions (some of which are described herein), the research is being ignored. These exceptions show that it is possible to achieve excellence in NHS maternity services – especially for women who are disadvantaged. One of the best examples of these is the Albany Midwifery Practice, about which Jude Davis has written, see page 26.

the NHS has been far more than just a health service free at point of use

Our challenge now is to campaign both for a National Health Service, free at the point of need and paid for by our taxes, with maternity services that are responsive to women and midwives and that research shows is best. Going down the route of privatisation cannot do this, as our articles and reviews show – we need only look towards North America, where outcomes, including maternal mortality are significantly poorer than in many other wealthy countries; Ireland, where maternity services are in crisis; and The Netherlands, which had a well-respected approach to childbearing built on confidence in midwives, women and birth. The Dutch state, as Simone Valk and Rebekka Wisser demonstrate, has chosen to adopt an American approach to health care, which is systematically dismantling midwifery-led birth with all its benefits.

But all is not yet lost. Allyson Pollock and others have drafted a bill (see page 29 for more details) urging campaigners and the public to take action to re-instate the NHS. While time is of the essence, this can still be done – as yet, privatisation of the NHS is not set in stone. As Allyson Pollock urges and as Wendy Savage says in her interview with Beverley Beech, we need to join together to overthrow the Health and Social Care Act. Acting politically is in our hands, and we need to act now.

Nadine Edwards and Jo Murphy-Lawless

Anything but Simple

Jo Murphy-Lawless shows why we need to understand the 2012 Health and Social Care Act

Many thousands of articles and press reports about the changing NHS have appeared before and since March, 2012 when the Health and Social Care Act was passed. The volume of writing reflects the reality that the shift in status of the NHS, embodied in the Act, has struck a fearsome chord with a public who are feeling increasingly beset and marginalised in their daily lives.

We know we must make the best possible decisions about maintaining access to good health services which are a core need for every single family across the land. Yet in a painful affront to democratic process, we were completely locked-out from the crucial decision-making on the future of the NHS.[1] The change in status brings with it tremendous consequences for social well-being as much as individual care well into the future, yet these are not immediately apparent due to the misleading language in which the Act has been dressed by its proponents.

There are especially complex issues in respect of the maternity services which rightly have attracted fierce criticism for their failure to implement successive national framework policy documents since 1993. For at least the last six years, in the midst of a baby boom which was not predicted, services have been cut and the high-flung principles found in those official framework documents, of a woman's choice and the value of midwifery-led care, cast aside.[2]

There are several recent accounts about the NHS which we think usefully exemplify the tensions and difficulties posed in understanding how these changes are impacting on a service which has been starved of funding for frontline staff and services since at least as far back as the 1979 Tory Party manifesto.[3] We need a firm understanding of this complexity because we need to rethink how campaigning could evolve in respect of urgently needed substantive and sustainable improvements to maternity care for women across England (the Act does not apply in Wales, Scotland or Northern Ireland).

The first account comes from a 2013 article in The Practising Midwife. Unaccustomed to the official language in which the new look NHS has been set and unfamiliar with its complex history, many have possibly accepted the need to go along with the changes in commissioning and the abolition of primary care trusts which form a major plank of the Act, unsure if there can be any other course of action beyond acceptance of this fait accompli. In this vein, the authors of the TPM article tried to explain what the changes will mean. They stated:

'Reduction in budgets of £20 billion have contributed to some of the most significant service restructures in the history of the NHS.'[4]

'From April 2013 the pre-existing statutory bodies are replaced by organisations designed to embed clinical leadership in commissioning decisions.'[5]

We accept that getting to grips with the embedded meanings of the Act comes on top of huge workloads and that many rightly say they must simply get on with the work in hand. However statements like the above may contribute to making the Act sound a self-evident logical progression to a better NHS where the clinical voice and the voice of the patient or client are strongest.

Nothing could be further from the truth. Leaving aside (if one can) the swingeing budget cuts which have affected frontline workers and public services so adversely since 2010,[6] there is no evidence whatsoever that clinical leadership and stronger patient and user voices will be the outcome of the Act, in fact quite the reverse.

Rejection of these claims was at the heart of the massive protests against the Act which included every single Royal College. The details set out in these protests cast a very different light on the Act as it made its passage through Parliament. Dr Clare Gerada, chair of the Royal College of General Practitioners, condemned the bill as *'damaging, unnecessary and expensive'*, stating that it would *'cause irreparable damage to patient care and jeopardise the NHS'*[7] while a BMJ editorial declared it *'Dr Lansley's Monster'* pointing out that the *'informed opinion about GP commissioning ... has been almost universally negative.'*[8] Cathy Warwick on behalf of the RCM was even more forthright:

'We have not heard anything that convinces us that the changes are necessary. The case has not been made. We remain unconvinced too that the changes will result in improvements in care. And we are disappointed that the legitimate fears and concerns expressed by health professionals and patients have not been addressed.

As things stand, we face subjecting the NHS to full-blown competition and market forces at a time when those very same forces have thrown our economy onto the edge of the abyss. Why take the greed that almost destroyed our entire economy and choose to inject it directly into the heart of the NHS? Greed isn't good, it's bad, and it shouldn't be the driving force behind what motivates those who deliver healthcare within the NHS.'[9]

This brings us to people with a far longer reach historically who understand too well from personal experience what is being lost with the new NHS. Harry Leslie Smith has published his memoir of growing up in poverty-stricken Barnsley in pre-NHS Britain.

'In those days, there was no national health service; you either had the dosh to pay for your medicine or you did without. Your only hope for some medical care was the council poorhouse that accepted indigent patients.'[10]

Born at home in 1923, he saw his parents struggle with the care of his older sister Marion who had contracted TB. The family was too poor to pay for a doctor or medicine for her, and finally had to remove her to the local workhouse infirmary where she died. An activist at ninety-one years of age, Smith lays down a plea to his readers to discover our courage and take back what we have lost in this undemocratic heist of the NHS:

'It has always been difficult for me to listen to politicians, proud possessors of health insurance and shares in private health care companies, when they talk about how the health service that we fought so hard to build must change… This act will see the NHS stripped down like a derelict house is by criminals for copper wiring... Where will all of this end? What will be given the greatest priority in a new health care system that sends every service, from blood work to chemotherapy, out to the lowest bid tender? It ends where I began my life – in a Britain that believed health care depended on your social status. So if you were rich and insured you received timely medical treatment, while the rest of the country got the drippings. One-fifth of the lords who voted in the controversial act – which provides a gateway to privatise our health care system – were found to have connections to private health care companies. If that doesn't make you angry, nothing will.'

the NHS has been far more than just a health service free at point of use

Smith echoes the thoughts and feelings of many elderly people who joined protest marches in the weeks coming up to the vote on the bill in March 2012.[11] This unprecedented strength of feeling across so many personal and professional layers of English society deserves at the very least our attention and respect, no matter how complicated the Act is with its 309 sections.

The NHS and neoliberal economics

What are these 'tides of corporatism without conscience' to which Harry Leslie Smith refers? Where have they come from? What is their connection with the Health and Social Care Act?

First of all, the NHS has been far more than just a health service free at point of use. Dr Clare Gerada has described it this way:

'The NHS is a system of distributing resources according to need, not according to want. So it's a distribution system, amongst other things; so we also have a National Health Service that also provides care that is free at the point of use, that is held together by systems of governance, employment, structures that underpin delivering this money to where it's required… It's also a social solidarity which we all adhere to because we know that if we're in a queue we will get the care that we need, but if we're in a rush and we need it we'll get it sooner.'[12]

The bill was introduced with an overall promise to create greater clinical autonomy and individual patient choice, both valuable objectives when discussing improved care. As many AIMS members know, individual choice for women in respect of pregnancy and birth has been far more 'miss' than 'hit', with lack of resources and poor organisation frequently cited as reasons. Any route to improvement in this regard might be welcome.

GP commissioning of care was announced as the principal route to increased patient choice, implying that this would sweep away multiple layers of bureaucracy and interference with clinical decision-making. In fact the new clinical commissioning groups (CCGs) were disavowed by GPs themselves as diminishing their role. Amongst many other clinical voices, Dr Clare Gerada pointed out that GPs would not long remain in majority membership of the new CCGs because they lacked numbers, staff, and resources. Moreover the CCGs would merge into larger groups still so that the clinical involvement of GPs in a direct line with their patients would be entirely sidelined in the corporate mix.[13] The move to commission maternity services through GP consortia was questioned by the RCM as being contrary to women's needs because GPs were not in a position to know what would be best.[14] It has since been estimated that the CCGs will outsource the work of commissioning itself to private sector companies, and here responsibility to shareholders will count far more than the voice of the independent GP speaking on behalf of patient need.[15]

In any case, it is not clear how the CCGs could lead to a reduction in management costs about which there have been concerns going back to the 1990s. Critics of the bill like Allyson Pollock had already questioned how the expansion of these to behemoth-like proportions had taken place and what the future would be: administration costs, which for 40 years had accounted for only 6 per cent of the entire NHS budget, had swollen to 12 per cent by 1991, when the internal market was fully introduced, and kept swelling apace thereafter;[16] recent years have seen substantial sums of money transferred via consultancy contracts to global corporate management groups like McKinseys, KPMG and Price Waterhouse Cooper.[17]

The misleading language spills over into the use of the term 'patient choice' to describe one of the Act's intended outcomes. This sounds on the surface entirely beneficial in comparison with the rigid rules and regulations that have increasingly swamped users of the NHS. There are two crucial points to be made here. The first is that these restraints are directly related to the consistent lack of investment in frontline budgets, staff, availability, skills mix, beds, and hospital infrastructure from the 1970s onward, followed from 1990 by the introduction of the internal market through the NHS Health and Community Care Act which forced hospitals to manage and 'pay' for the care they 'bought', and mechanisms like public-private partnerships (PFIs/PPIs) [18] and payment by results. Of course it was never any

government's right to impose these: the NHS belongs to all its citizens, not to the marketplace, and these stealthy moves should have been confronted with strongest possible legal action from the outset many years ago.

What looks to be greater freedom of choice about hospitals, consultants and so on through mechanisms like 'personal budgets' is also an illusion. Because core NHS services are now so badly under-resourced, these personal budgets encourage people towards private sector services which appear more amenable and accessible, further draining the fragmented NHS which itself has been forced by legislation to adhere to trading restrictions and competitive practices as if the NHS were a public limited company (plc).[19] We repeat: the NHS is a public service, not a plc. Yet hospitals and services are now failing, because of the way the NHS has been marketised, because of these restrictions, because of the punishing interest rates for PPIs, and because of cutbacks due to falling levels of revenue stemming from waves of marketisation.[20] In relation to postnatal depression (PND), for example, it was estimated in 2011, five months before the bill was passed, that as many as 35,000 women each year are experiencing postnatal depression with no available NHS diagnosis or treatment,[21] yet AIMS members know that PND is far more likely for women who undergo birth in unsupported circumstances. Women, already beset by the burden of medicalisation,

Campaigner June Hautot Standing at Westminster, holding a photo of Aneurin 'Nye' Bevan, MP for Ebbw Vale from 1929 until his death in 1960. As Minister of Health, Bevan spearheaded the National Health Service Act of 1946 to provide medical care free at point-of-need to all Britons.

have paid the price of even poorer care and poorer outcomes, a direct result of the marketisation.

The additional problem for the unwary individual is that private for-profit providers and services themselves are highly selective as to what they will take on and are prone to cost-cutting to avoid commercial failure, as with the unsafe out of hours GP and hospital service run by Serco up to 2013 until a whistleblower exposed records of false response rates and a dangerous lack of clinical cover.[22] We already know from American figures that the introduction of for-profit providers increases administrative costs to at least 30 per cent of overall costs which detracts from clinical care in efforts to retain maximum profit for shareholders. Furthermore, performance records become part of commercial confidentiality and can no longer be subject to direct scrutiny within any given community.[23] The global corporates who dominate the contracts awarded to non-NHS providers (Care UK, Capita, Circle, Interserve, Serco, Virgin Care and United Health) with investor/shareholders who include international hedge funds completely beyond our reach or influence, have all experienced difficulties in their actual service provision. Yet by far the largest number of contracts being awarded by CCGs are going to private sector providers, starving NHS frontline services still further; in the first 21 months following the passing of the Act, while £10.7 billions of NHS services were contracted out, 35,000 NHS staff were made redundant, including 5,600 nurses, with one-third of NHS walk in centres closed, and 10 per cent of Accident and Emergency units closed as of 2014.[24]

the NHS belongs to all its citizens, not to the marketplace

Social enterprise groups setting up as service providers may seem to provide an alternative to corporate providers or failing NHS trusts, but they too are severely limited. This is because these groups are also subject to the stringent conditions of the Act and its regulations; their funding comes from the public sector purse but they need to show significant savings over and above the cost of the project in order to be seen as competitive and 'value for money' under the terms of the legislation. This means they must keep their costs as low as possible which may lead to their needing to expand their client base while cutting staff time and associated costs to remain commercially viable. Thus they also run the risk of being taken over by larger corporate non-NHS providers when they cannot cover costs.[25]

What is also important to bear in mind is that under the Act, the now hopelessly fragmented NHS cannot

provide the same level of governance over care and professional standards that it once did (however flawed that was at times), but neither can the CCGs, nor the non-NHS service providers, nor the overseeing bodies such as Monitor, which itself is compromised by its principle duty (see below), nor the Care Quality Commission.

All these uncertain outcomes are why the Royal College of Nursing (RCN) published a briefing document in 2012, in which it stated that it saw no evidence that the bill would result in clinician-led, patient-centred care, reduced inefficiencies and improved standards, that in fact the bill would increase health inequalities because of the market-driven approach to service delivery:

'The NHS already faces real issues with health inequalities, with people living in different parts of the country experiencing very different life expectancies and quality of life. Instead of solving the problem of inequality there is a fear that the reforms may actually further exacerbate these and create wider variations in quality and standards of care.'[26]

On these grounds, the College opposed the bill in the strongest possible terms. The British Medical Association has just announced at its 2014 annual conference that since the Act, investment has been cut throughout the NHS while tendering to private companies has been prioritised, making the first 12 months of the Act a 'bumper year' for multinational corporations, and that these developments have harmed patients.[27]

Despite consistent press statements from government politicians and from Whitehall that there is no government policy to privatise, the shadow operations of privatisation hang over all these developments to downgrade and outsource. An ever expanding number of routes to privatisation, some of which we have discussed above, have emerged to create this new stratified health economy.[28] As a principal policy objective, opening up the health services to privatisation first appeared in the Tory Party election manifesto for 1979 (known as the 1979 Conservative Party General Election Manifesto). The 2012 Act, with many significant global financial innovations to aid more recent moves, has brought that 1979 ambition to its fullest expression.

Clive Peedell was co-chair of the NHS Consultants' Association, when he wrote in 2011 that full privatisation was 'inevitable' under the terms of the then bill. He quoted a WHO definition which states that privatisation *'is a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services'* and went on to write that *'the government's attempts to deny privatisation of the NHS by claiming that NHS services will remain publicly funded and free at the point of delivery does not escape the WHO definition.'*[29] The Act has provided a legal route whereby to transfer our payments and taxes as citizens to the private sector, extending the basis for vast profit-taking, a classic ambition of neoliberal economics.

It is therefore no surprise that the primary duty of the new regulator of the NHS, Monitor, is to promote competition and prevent what the Act terms 'anti-competitive behaviour'. Nor should it come as any surprise that corporate greed involves a trail of influence leading straight back to key government and parliamentary politicians. Lord Carter of Coles, for example, was chair of the NHS Co-operation and Competition Panel, due to merge with Monitor after the Act was passed, but also the UK chair of the United States-owned healthcare company McKesson which has contracts with over 90 per cent of NHS organisations; Lord Carter receives a retainer of almost a million pounds for that latter post.[30] While this is not strictly illegal and is a declared interest on the parliamentary register of interests, it cannot inspire public confidence in fair-mindedness. The latest list of parliamentarians with financial links to private healthcare providers is extensive, ranging from people who are sole owners of small companies to chairmen, directors, consultants, shareholders, and so on.[31]

funding consistently leaks away from frontline care into corporate profit-taking

Finally, we want to return to the heist of democratic principles that is at the heart of the Act. At the outset of the establishment of the NHS in 1948 (and the reason why 81 year old Shirley Murgraff declared in 2011, just prior to her arrest during the Block the Bridge protest against the bill, that the NHS was 'the jewel in the crown'), the government undertook to keep the NHS as entirely a publicly protected, public good for the whole of society. From 1948 to 2012, Ministers of Health had a 'duty to provide 'comprehensive health' for all citizens and, because we elect the government, each and every minister was accountable to us through Parliament under our parliamentary system. That link is now broken. Section 9 of the Act replaced that solemn duty to provide health care for all our citizens, with a duty merely 'to promote' and the Minister relinquished all responsibility for the running of the NHS to an arms-length body, NHS England. This means that unless or until the entirety of this Act is revoked, as citizens we no longer have any democratic connection to or control over our health services. This is a grievous loss in respect of democratic process as much as for the core need of a public health service.

The brutal outline of Harry Leslie Smith's 'tides of corporatism without conscience' is becoming clearer month on month since the Act was passed. Even though we continue to pay for the NHS through our taxes, that funding consistently leaks away from frontline care into corporate profit-taking, so much so that it is currently

estimated by that same NHS watchdog on competition, Monitor, that 29 trusts were failing at the beginning of 2014 and this number was due to rise;[32] this has led to the disingenuous proposal by Lord Warner, a former health minister, that each citizen pay more through a flat upfront charge of £10 each month to *'prevent'* the NHS *'from sliding into decline.'*[33]

Again we must be clear: the way to save the NHS is to make it a fully public entity again. To paraphrase the distinguished historian, Tony Judt, we need to prioritise collective responsibility over the individual needs agenda advanced by neoliberalism, an agenda that means only those with money to pay get the services they need.

AIMS faces complex new conditions for women, midwives, and maternity care

AIMS has campaigned over many decades on behalf of pregnant and birthing women and their needs as new mothers. These same decades in the NHS saw:

- underfunding in the 1960s and 1970s
- a tendency to centralise against evidence and local need
- the growth of a managerial bureaucracy on top of never tackled and continuing, but often unacknowledged, inter-professional rivalries
- Thatcher's election manifesto in 1979 to privatise the NHS
- the bill to establish the internal market in 1989
- gradual but consistent moves to increase outsourcing
- the growth of the 'expert' culture
- the final blow of the privatisation of the NHS through the Health and Social Care Act

These developments have cumulatively taken from us the chance to respond with a mantle of care around each pregnant woman to help her on her way in the best possible manner through those first steps of motherhood.

In February 2012, former teacher Shirley Murgraff, aged 81 (on the right), padlocked herself to chained protesters, who were outside the House of Lords, stopping traffic in Parliament Square, in protest against the Government's NHS reforms. Officers used bolt cutters to separate her from fellow protestors and carried Shirley away by her arms and legs.

Out of this complexity, AIMS perhaps needs to ask some straightforward questions beginning with this: why is it that in the increasing maelstrom that has engulfed the NHS, maternity services have continued to be sidelined in respect of best evidence and care?

the way to save the NHS is to make it a fully public entity again

At a much earlier point, the renowned Albany Midwifery practice went against the implications of these malign trends; working at community level for women's individual needs, it was able to provide the collective backdrop of a group midwifery practice backed up by an NHS hospital for the individual woman-midwife partnership to unfold at its best. It did so for an impoverished community, accepting all women who came to the practice.[34] It is highly doubtful that under the terms of the 2012 Act, such a contract arrangement would have survived the current legal constraints on non-NHS and voluntary providers.[35]

Given these strictures, what is the likely outlook for groups like One to One Midwives and Neighbourhood Midwives? Can such groups really co-exist for long with the legislation as it stands? Both require paid for care, up to £5,000 per woman. The position of contracting to a CCG, as with One to One, is unsustainable in the long-term for reasons set out above. How can AIMS best support these minority undertakings? How can AIMS campaign for effective maternity services within the fragmented, privatised NHS for the vast majority of women, many of them experiencing social exclusion and poverty, who cannot pay for such services and who require best possible care? Should AIMS campaign for the 2012 Act to be repealed?

Conclusion

In exploring the collapse of the structures of a once proud NHS, we are nonetheless aware that many, many thousands of frontline health care workers still endeavour to provide daily the very best care they can in dispiriting conditions, and that as a whole, morale throughout the NHS has never been as low. In broad outline, we have sketched out the conditions for failures in the Mid Staffordshire hospital, of Morecambe Bay NHS and so on.

In respect of maternity services, we know there are pockets of outstanding care for women, for example, the Serenity and Halcyon Birth Centres in Birmingham, which embody the unremitting commitment of consultant midwife Kathryn Gutteridge and her colleagues. However, readers of this Journal know all too well the extent to

which good caseloading practices, birth centres and small well-liked maternity units work under threat of closure or have already been closed down. Salford HOPE maternity unit, a beacon of excellent care in an impoverished community, lost out to the behind the scenes wheeler dealing of a commercially–oriented NHS Trust.[36] We believe that there is incontrovertible evidence that midwives do not wish to work as they are having to do at present. We also strongly believe that the English public, and the people of Northern Ireland, Scotland and Wales wish to have an NHS that is truly public, publicly accountable, freed from the vice-like grip of market profit-taking as if it were a commodity like mobile telephones or computers. We need a social, holistic, approach throughout the NHS and certainly in maternity care.

Indeed, there is general agreement among women, birth activists, many midwives and researchers about what good maternity care looks like and how it can be provided and a rising frustration that research such as the Birthplace Cohort study, and the Cochrane Review[37] on continuity of care have not been acted upon in any concerted or widespread way. We already know that under the changed terms of engagement in the NHS that maternity services have been very hard hit by cuts.[38]

Those of us working with AIMS and elsewhere have often experienced the NHS through its maternity services as cumbersome, ineffective and resistant to change. We have seen services increasingly concentrated in fewer and larger obstetric units, despite overwhelming evidence that community settings are more desirable for healthy mothers and babies. Some of us have experienced these services as brutal, even punitive, which has led to physical and emotional long term ill health. Independent Midwives and some of the new midwifery initiatives are providing the kind of maternity care that AIMS and other organisations have long campaigned for, but only a tiny minority of women can afford or have access to these, and only a tiny number of women will freebirth – another option about which women ask AIMS. AIMS' position has been to support a woman's plans, and that all women have the right to good maternity care and to be supported in their decisions about where, how and with whom to give birth irrespective of their economic situation.[39] Thus, it has always responded to the growing tensions in maternity services by focusing first and foremost on the woman seeking support and has been endeavouring to work with the tensions forced upon us.

Any activism will necessarily need to continue to challenge vigorously the increasing and debilitating focus on risk and fear which is driving the centralisation of birth into large obstetric units, the medicalisation of birth, and the 'expert' culture where women's decisions are overridden, all of which plays into the now wholesale privatisation of the NHS.

How can AIMS campaign for effective maternity services?

It is not an impossible undertaking

AIMS needs to put its thinking cap on as to how in these radically changed circumstances, to campaign for something we have never had reliably throughout the NHS: inspired, woman-centred care where the woman's voice matters most and where she finds the safety she requires to birth her baby in that relationship of trust. We need to campaign for that vision of an NHS that is reliably ours as women, mothers and citizens. AIMS must also respond to women who have been so broken by their experiences in an NHS service which has been indifferent and even cruel that they must go elsewhere to birth their baby safely.

It is not an impossible undertaking but it will require a renewed activism, a very different understanding of how this work is political and, probably, new allies. There are the beginnings of a new activism across the UK, focused on local democracy and collectivity.[40,41] John Gillies, Chair of the Scottish Royal College of GPs talks about a 'communitarian approach' and about lessons to learn from the so-called reforms in England, suggesting that all health care systems in *'Scotland, England, Ireland, Wales and internationally have to become more focused on the patient, and the person who is the patient'* and that *'these are different things'*. In Scotland, the Birth Project Group,[42] following on from John Gillies, has called for a communitarian approach which entails a genuine inclusion of the community voice in the NHS and responsiveness to community need: decision-making on health care, including maternal health needs, made within the community.

AIMS has always sustained a strongly independent and respected voice. So one final question: where and how can we begin again to use our voice most effectively?

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All references and footnotes for this article can be viewed on the AIMS website www.aims.org.uk/Journal/Vol25No4/anythingButSimple.htm#refs

Things are different in Wales

Gill Boden discusses the Welsh NHS and maternity services

Over many years I have found myself popping up in meetings in England and arguing that things are done differently in the NHS in Wales, and feeling a bit like Pollyanna. So following much hostile criticism in the press and House of Commons over the past few months, I feel that I have to justify my case about the Welsh NHS and apply that to our maternity services.

First of all, the health system in a devolved nation where the provisions of the Health and Social Care Act do not apply is now very different. In contrast to England, where the Health Secretary no longer has responsibility to secure a comprehensive health service, there is one minister with overall responsibility for both the NHS and Social Services, (currently Mark Drakeford, a professor of social work, experienced in government and described by senior civil servants as clear and decisive). There are also Local Health Boards (LHBs) and the role of the Chief Medical Officer is still a powerful one and, importantly, there is no split between purchaser and provider.

The Assembly government and, it seems to me overwhelmingly, the public, believe that public services should be centrally coordinated, and planned towards shared social goals. If a local hospital is performing badly, and of course some do, people in Wales expect state action to improve it and do not want (especially in rural areas) to exercise personal choice to go to a competing hospital elsewhere.

Most people agree that Wales has been underfunded for years

Shared responsibility for both NHS and Social Services through LHBs has made it far easier to deliver integrated services. David Sissling, chief executive of NHS Wales and director general of health and social services, said of LHBs, *'They don't have any allegiance to hospital-bed care and you can think about designing a care pathway without having to think about it in terms of transactions that bring two or three different organisations into the equation.'*[1] Interestingly in May 2013, NHS England announced its intention to integrate all NHS and social care services by 2018, without any mention of the fact that Wales was already doing this.

I won't attempt to say whether patient care and outcomes are broadly better in Wales. This is impossible to do and the argument has now become a political football, but the independent Nuffield review this year suggested that outcomes were broadly similar.[2] Of course there is plenty of genuinely bad news about health in Wales, and some (though much less) good news about health care in Wales. The Welsh have been poorer and sicker than the English for at least 300 years. They have more of the principal causes of ill health and premature death: more heavy industry, more unemployment, and lower average earnings, and money is a major issue. Most people agree that Wales has been underfunded for years under the Barnett formula, which is the method for working out how much of the 'tax take' will be returned to Wales and Scotland: the NHS takes 40% of this block grant: there is a spend per patient of £1900 compared to the best comparator in terms of 'need', which is the North East of England, which receives £2100, 10% more.

All of this applies to maternity: *'the overarching principles in a National Health Service that is cash strapped are first to do no harm, use evidence based treatments and co-produce'* [users of the service must be integrally involved in the design and delivery of the service].[3] All of these absolutely apply to maternity, particularly after the draft NICE intrapartum guideline of May 2014, which recognises the need to reduce medical intervention in birth.[4]

The underlying commitment is to an integrated service, which, with all of its faults and shortcomings, can feel very enabling in such a small country. Good leadership is possible, in a situation where Heads of Midwifery can and do meet regularly, and in turn meet with public health practitioners and obstetricians: vision and agreement can potentially be achieved.

Shortages of midwives have never been quite so damaging as in some parts of England: the Assembly government ensures that the whole of Wales is birth-rate plus compliant,[5] but despite that there is no spare capacity and midwives are, in my view often overstretched. As a result there is little room for initiatives involving training the workforce, although some initiatives have been implemented. 'Future proofing of supervision', for example, is the Welsh attempt to improve and safeguard midwifery supervision by employing fulltime supervisors of midwives who were appointed in early 2014. Like everywhere else in the UK there is much reduced antenatal education and postnatal care, but still on average three postnatal visits from a midwife compared with one in London.

There are huge on-going problems, for instance, of data collection where sometimes not enough is collected, or what is available is not helpful, patient episode data are not appropriate for maternity; and provision of specialist services in the rural north and west is difficult and expensive. Also dealing with a population comparatively

poor, and suffering from the problems that arise from that, including complications of smoking, obesity and malnourishment, has its own challenges for midwives.

Nevertheless there is much optimism and commitment to women within midwifery and one of the first demarcating moves by the new devolved government was to set a 10% target for home birth in Wales to be met by 2009, before the Birthplace Study,[6] and well before the new NICE draft guideline; and this, I think, showed the clear commitment to a belief in normal birth. The target was missed by a long way but the rise in homebirth was the fastest in the UK for a considerable time and it served to change the culture to some extent. Quietly, and often in rural areas midwives have found ways to provide quality woman-centred care.

In June 2010 I visited the Glan-y-mor team, in the quiet seaside town of Porthcawl. This is a long established team with a marvellous local record, which included a home birth rate of 25%: despite radical reorganisation they had managed to retain a working environment that they felt was successful in giving women what they needed, while safeguarding their own family life. They did this by working hard to support one another with some stunning examples of high morale and loyalty in the team. They asserted that flexibility is the key, and they described sharing the 'same brain' that is decision-making, accomplished often by phone calls from the bath at home when they were feeling creative.

'We're there to promote the best care for women in what could be the best or the worst experience of their lives, we don't know in advance what the outcome will be'. This is a group practice characterised by continuity, knowing the women and supporting them. Parents in Partnership was a new project of theirs, whereby 80 local mothers had recently been peer support trained for breastfeeding; covering preconception, diet, contraception, obesity and weaning.

Midwives in the team are socially close: they often go walking together; for many years, they have cooperated by picking up each other's children and now they are repeating that with their grandchildren.

There are other examples across Wales: the West has taken pride in its high home birth rate and the large, sparsely populated county of Powys has for many years had no obstetric unit - so women have birthed at home or in tiny MLUs and considered it the norm. In Cardiff, a dedicated home birth team was set up at the end of 2013 with the aim of raising the rate from only around 1% to 3% within the year.

Things are not rosy in Wales but a commitment to a communitarian philosophy with pooling of risk to protect the vulnerable means that for the moment at least it feels as if shared action for the common good is possible. Over 30 years ago, Welsh Valleys GP Julian Tudor-Hart, saw that areas of social deprivation, containing high proportions of people from lower social groups, tend to have access to less good health services, even though their need for such services is greater than that of higher groups. His conclusion was summed up in the 'Inverse

stunning examples of high morale and loyalty

Care Law', which states that: *'The availability of good medical care tends to vary inversely with the need of the population served.'*[7] The Welsh Government is battling against the UK and European trend to reduce universal care, a trend that results in targeted facilities for some groups and a two-tier health service. Instead the driving force underlying policy is to remember that health inequalities are not simply, or even mainly, due to failings in the Health Service, nor individual failings, but rooted in poverty and inequality in material wellbeing, and to create a politics that can counter the inverse care law.

Gill Boden

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Under Resourced

'There is evidence that many maternity services are running at a loss, or at best breaking even, and that the available funding may be insufficient for trusts to employ enough midwives and consultants to provide high quality, safe care.' Margaret Hodge, chair, Commons Public Accounts Committee following its report, Maternity Services in England, which heavily criticised the Department of Health and NHS England.

www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/776/77602.htm

www.theguardian.com/society/2014/jan/31/midwife-shortage-nhs-maternity-care

Article

The search for continuity

Nicky Wesson and Natalie Carter look at some of the issues of continuity in NHS maternity care

This is the story of a highly successful model of midwifery care, hugely popular with parents that was created not once, but twice in the same area and yet despite its success, no longer exists.

Essentially this model is one of continuity, choice and community-based care. Over the last 20 years or so, much work has shown how continuity of care from a midwife improves clinical outcomes,[1,2] both in terms of reduced intervention, and increased satisfaction with the birth experience.[3] As a result, several trusts have implemented pilot schemes incorporating this model of care.

West Middlesex hospital which is based in South West London, was one of the leaders in the field, as it pioneered the DOMINO scheme in the late 1970s. This system (which stood for DOMiciliary IN and Out), supplied community midwives who were on call, initially for women at low risk of complications, expecting a second or third child. These midwives provided women's antenatal care at home, and then went to them when they were in labour, assessed their progress, and then offered them the option of giving birth at home with their assistance, or transferring into hospital with them. The decision about where they had their baby was not made until that point. The same midwives also visited them postnatally.

The model of care was very popular and women expecting a first baby also wanted to be on the DOMINO scheme. It was not possible to provide it for everyone because not all midwives were either able, or wanted to be, on call. This led to criticism of the system being inequitable, and resulted in the head of midwifery at the time, changing it to team midwifery in the early 1990s. This involved small groups of midwives who ran antenatal and postnatal clinics for six defined geographical patches. They also did shifts on the labour ward in the hope of providing some continuity in labour. The DOMINO scheme was closed despite the protests of local parents who campaigned vigorously to retain it, and the homebirth rate dropped to around 1-2%.

More recently, during changes made at West Middlesex in 2009, two recently-qualified midwives, Natalie Carter and Amy Scott proposed a caseloading scheme involving a team of midwives who would hold their own diaries, have their own work mobile phones, and supply antenatal, postnatal and labour care for women who they would book in their own homes. Their aims were to increase the homebirth rate, and to increase the number of normal births not only at home, but in the birth centre and on labour ward. They wanted to reduce the levels of intervention in birth, including that of caesarean section, and increase the rate of satisfaction felt by women and midwives. The consultant midwife, Pippa Nightingale was in favour of the scheme, and following consultation of working groups across the hospital, including consumer groups, during the summer of 2009, the caseloading team became operational in January 2010.

A team of seven midwives, including Natalie and Amy were recruited initially, eventually reduced to six. The new system was promoted through the maternity web-site, and had its own email address and phone number, so that women could refer themselves. Midwives were meant to discuss the opportunity with every woman at her booking visit and obstetricians could also refer to the team. In fact it was mainly promoted by word-of-mouth, through friends, family, NCT groups and other birthing networks.

Word spread rapidly and very quickly resulted in interest from British, white, well-educated women. To promote equity, each geographical area in the Trust had protected provision for women of different ethnicity who experience showed, were less likely to take up the scheme. Some of these women preferred hospital birth because of their home situation, or regarded homebirth as an inferior system in a high income country (though if they used the scheme were enthusiastic and recommended it to family and friends). Places were saved until any potential woman might be 34 weeks pregnant and if they were not filled, would then be offered to women on the waiting list.

Booking visits, antenatal and postnatal visits were at home (some postnatal visits are in clinics in this area). When a woman believed she was in labour, she was assessed by a midwife at home and she could decide then whether she wanted to go into hospital or have her baby at home. The team was happy to transfer women who wanted it but the numbers of those staying at home, grew steadily. A 20% increase in normal birth was seen within a year. In the time between Jan 2010 and Dec 2012 there were 724 women on the caseload, 165 babies were born at home (23%) and the number of homebirths from a flexible birth plan was 44, that meant 27% of the homebirths were decided in labour. The caseload numbers for April 2013 to December 2013 were 113 total women, 28 planned homebirths, with two of these decided in labour.

Understandably, the scheme was very popular with women who said things like *'the care and information that I received was exceptional'*, *'I had an incredibly positive experience all the way through'*, *'this service was brilliant'*, *'outstanding staff'*, *'it made my pregnancy and birth a very positive experience throughout'*, *'I couldn't have wished, hoped or even paid for better antenatal, birth or postnatal care'*.

There was a discrepancy between the aims of the team

and the referrals they received from other members of staff. It became recognised that the caseloading midwives were particularly good at supporting vulnerable women who were socially isolated, had serious depression or who had experienced serious previous birth trauma and they were referred to the team. However, not many of these women wanted low-tech care, preferring elective caesarean section, epidural anaesthesia or consultant-led care. Sometimes such women might be helped to have a normal birth, but the team was not able to predict which they might be.

The scheme was popular with consultants who referred women wanting vaginal birth after caesarean section (VBAC), frightened first-time mothers and those who had a previous traumatic vaginal delivery. Some midwives were less enthusiastic, regarding the system as inequitable because it was not available to everyone. Some mothers, unable to get a place with the team were very disappointed and unhappy and wrote to complain.

As demand grew, eligibility criteria became tighter, and priority was given to women who wanted to give birth at home.

This was a hugely popular scheme, and one which women feared might be lost: *'This was an amazing and very enjoyable pregnancy/labour – please continue to provide this service', 'please keep caseload programme going - it's a fantastic service!', 'only that you should KEEP this service!'.*

However, the system did come to an end, finishing in December 2013. Several midwives were leaving the team in need of a rest, and recruitment failed to attract more midwives. The increasing numbers of women with complications being referred and the high numbers being cared for had taken its toll. The caseload team is now a dedicated homebirth team.

Given that this was a very successful way of working, with an astonishing success rate – 92% of the women felt it helped them achieve the birth experience that they wanted, 97% rated the caseload midwifery service as excellent, 98% felt supported throughout their experience, 98% found it beneficial to have their care within the home setting, 98% rated their care as excellent, 100% felt that seeing a caseload midwife was more beneficial than seeing several midwives and 100% would recommend the service to others – can we find a way for it to be sustained and available to all women?

This model of continuity is at least as cost-effective as traditional maternity services[2] and often cheaper, given the reduction in interventions such as epidural anaesthesia and caesarean sections, and also the reduction in hospital stays.

What then are the reasons for the seemingly constant failure to sustain this type of care? The two areas of difficulty appear to be – midwives' perceptions of the problems in working this way, such as being on call; and the inadequacy of their training which does not supply them with either the experience or confidence to help women give birth at home, or to have sole responsibility for managing their care.

Recruitment did prove a problem – some midwives who really wanted to do it, felt that they could not do it while they had young children of their own. Some community midwives were happy to do regular shifts including nights, but reported not being able to sleep while they were on call. Many would like to provide continuity of care but are apprehensive about autonomy and accountability. Extraordinarily, a midwife can qualify without ever having attended a homebirth – and the thought of the strain and pressure of being blamed if something goes wrong, is a considerable deterrent. If attending homebirth is not a mandatory part of training, midwives will understandably lack confidence in their ability to assist and make decisions in unfamiliar surroundings.

The ability to remain on call for long periods depends very much on the workload itself. Within this scheme, the number of women booked became too high, due both to the demand and the difficulty in saying 'no' to women. It had been anticipated that the midwives would each have 40 women per year on their books, in fact they averaged 44. Being on-call for four to five nights a week and 24-hour on-calls, provided a very high level of continuity and satisfaction for both the woman and her midwife, but it was difficult to sustain. It left few opportunities for a midwife to travel out of her area or socialise freely. This compares with other recommendations that vary between a maximum caseload of 28 to 40 women and the independent midwives suggesting no more than 28 women.

the vast majority who had established a relationship of trust with their midwife, only called when it was essential

Other midwives felt that the team would be pestered by calls from women and that caseloading was incompatible with a normal life. Some women did seem to think that the midwives were on-duty all day and all night, but the vast majority who had established a relationship of trust with their midwife, only called when it was essential.

To succeed in taking birth back from medicine and encouraging a community based approach with known midwifery care givers, Natalie and others believe that we must find a way to achieve a level of continuity with small teams of like-minded midwives. For any model to be sustainable and available to the majority of women, it must enable midwives to have an adequate work-life balance that gives them time not on-call to be with their own families. Being the sole midwife for a group of women carries a great deal of pressure, not only to 'be

there' but also of responsibility. Although it is exceptionally rewarding, it is also exhausting and requires you to give a lot of yourself. Sharing care with midwives, who have the same philosophy and values of birth, helps to shoulder these responsibilities and emotions, while still giving women high quality seamless care. Women still receive continuity but from a few known sources. It is so important that we care for the midwives too.

Midwives who do choose to work in this way require very good support from their managers. Other recommendations that the team suggest for working this way include:

- Have a passion for, and belief and trust in the birth process
- Ensure that you have excellent clinical skills
- Be a good listener
- Be able to be flexible
- Be able to share information concerning safety in a positive and unbiased way
- Be brave
- Be willing – it is hard work
- Be resilient
- Look after yourself and your team
- Be calm
- Be a lateral thinker/think outside the box
- Have a sense of humour
- Be supportive and supported
- Have like-minded colleagues
- Provide consistency of advice
- Ensure that you have ways of re-invigorating your beliefs through conferences, inspirational speakers, courses, visiting a different unit, investigating complementary therapies, reading a book.

ability to assist at homebirth being a mandatory part of their qualification

Both the DOMINO and caseloading schemes were incredibly successful, but are no longer in operation. The latest evidence-base for practice, both in terms of clinical outcomes and women's satisfaction, is to adapt a model of continuity. We know it works, but we can't sustain it. How do we reach a balance of continuity that supports women but doesn't burn-out the midwife? Small teams are a possible way forward, but much more is required. Midwives must qualify with community-led care and homebirth as their highest skill set, with experience of being on-call, and an ability to assist at homebirth being a mandatory part of their qualification.

If a midwife could not qualify without experience of this degree of autonomy, trusts would be obliged to provide midwifery students with this experience. They would have to ensure that students were familiar with the provision of a competent and confident midwife for women choosing to give birth at home. This is likely to become a priority as the recent draft Intrapartum NICE Guideline recommends, among other things, that all healthy pregnant women should be advised of the benefits of care from a midwife in a free-standing birth centre, and that women expecting a second or subsequent child should be advised of the benefits of birthing at home or in a free-standing birth centre (www.nice.org.uk/nicemedia/live/13511/67645/67645.pdf).

The government and all managers must support this model with the resources required, and midwives must be remunerated appropriately for their commitment and skills. Who else in this world gets up in the middle of the night, for hours on end, night after night to go out and keep life itself safe?

What does it say to the midwife when once again there is no pay rise this year? We don't value you? What does it say to women if we choose not to implement what we know to be the safest and most effective care in maternity services? You and your child are not worth it? Continuity is not a complicated idea, there are ways to make it work if people would just listen and take a leap of faith.

Nicky Wesson and Natalie Carter

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Natalie is a midwife working within a home birth team who believes passionately in empowering women to make their own choices for birth, whatever they may be.

STOP PRESS

The new homebirth team is up and running with limited success so far. The bookings are not increasing as quickly as Natalie had hoped but the homebirth rate is above 2%. An encouraging leaflet is going out to every woman inviting her to come and hear about her choices but few women are interested yet. The team is also losing two of its midwives and resources are not always forthcoming.

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Experiencing caseloading

Vicky Cottrill shares her birth story

Following the birth of my first baby, I was incredibly anxious about being pregnant again. My experience wasn't particularly awful compared to stories I have heard, but it was incredibly painful, quite scary and not something I wished to repeat. I was rushed from the natural birthing centre to the labour ward, as my baby's heart rate had fallen dangerously low, which after the event, I understood was down to me dilating very quickly. The transition to the labour ward, from the birthing room, was a significant change and the room was full of people, all of whom seemed to be talking to me and I wasn't sure what was going on. I ended up having an episiotomy so they could help to deliver the baby as soon as possible and following this, I had complications with the stitches and it took me far longer to recover than friends who had caesarean sections.

When attending my booking in appointment for my second pregnancy, I was asked if I would consider a homebirth and I said absolutely not as I was adamant I wanted an epidural this time. I was lucky enough to be referred onto the caseload team offered by West Middlesex which meant I had continuity of care from the same midwife throughout my pregnancy. Natalie (my assigned midwife) was incredibly supportive and enabled me to discuss what happened at the birth of my son and go through my anxieties.

As my pregnancy progressed, I became less inclined to opt for an epidural, for all the same reasons I didn't want one for my first child – I'm a control freak and don't like the idea of not being in control of my legs and I knew from last time, I'd want to be fully mobile and active during labour as that helped me to cope with the pain better. I also felt that birth is a natural process and I didn't really want too much medical intervention.

I decided that my preference would be to try for a water birth at the natural birthing centre again, as I felt comfortable there last time and knew that if I needed more pain relief, it would be available on the labour ward.

A week after my due date I hadn't felt any movement from my baby all day, so I called Natalie, who wasn't on call at the time, but her colleague Po Ying answered and suggested I came into triage to be checked as I'd tried all the usual tricks to get baby to move. Thankfully everything appeared to be fine with the baby and we went home later that evening.

That night as I went to bed about 10.30, I thought I could feel dull period pain, which is how my labour began last time. I tossed and turned until about 1am with the knowledge that things were definitely happening. By 2am, the feelings were getting stronger and I started timing them. By 3am they were less than 10 minutes apart, so I woke my husband and we called my mother to come over so we could go to the hospital. About 20 minutes later I asked him to call Natalie as the contractions were coming faster. Po Ying answered as Natalie wasn't on call, and she said to see how I go and call back when they're stronger. I spent time over my birthing ball in a darkened room and focused on my deep breathing and everything I'd practised from pregnancy yoga. 15 minutes later I told my husband to call her again, and she said she'd come over. I then got into the bath as I found this really helped with the pain last time. Po Ying arrived at 4am and I was still in the bath, managing the contractions through breathing and the feeling of the water - at each contraction I was asking my husband to run the taps full pelt as the sound and feeling was really helping!

I asked Po Ying to find out if there was a pool room free at the birthing centre, which there was, but at that point I made the decision to stay put! I knew I wasn't going to ask for any pain relief, the contractions were so close together I knew things were really progressing and I was in the zone, and the thought of dressing, getting into the car and going to hospital was totally against my natural instincts at the time. I had my husband and a very experienced midwife at my side and I was in the security of my own space where I felt comfortable.

I recognised the transition phase from last time, as I suddenly felt scared and couldn't face the prospect of continuing the birthing process! My midwife spoke calmly

to me and reassured me that I was getting ready to birth my baby. I then felt the urge to push and she guided me through the pushing phase in a very calm manner. I focused hard on using each contraction to its full advantage and listened to the midwife.

Not long after, my baby girl was born, in the bath, at 5am! I had done it, and at home! I sat in the bath and cuddled her! Shortly afterwards, my son woke up so my husband took her in to meet him, whilst I stayed with the midwife to deliver the placenta.

I then got into bed for a while and cuddled my little bundle. Po Ying then helped me to shower and dress and I got back into bed where I was joined by my husband and son. My mum made me some tea and toast.

As I hadn't planned for a home birth, I hadn't got anything prepared at home, but as it turned out, we didn't really need anything and my midwife cleaned everything up from the birth, and all the towels just went into the wash!

I was fortunate enough to just have a first degree tear this time, which we decided didn't require stitches and a week later I was scrambling around after my son at a soft play centre!

Natalie, my assigned midwife came to visit me that afternoon and every few days for the first 10 days, which was wonderful and the aftercare support and advice she gave us was absolutely fantastic and really made such a difference to the early days. It was also wonderful having the continuity of support once again.

I can't thank Natalie and Po Ying enough for the fantastic support they gave us and the experience of such a wonderful birth. On reflection, a homebirth was always my preference, but I never thought I'd be brave enough to do it! Having spoken to people locally, I discovered that three other women in my street have had home births, so it's more common than I realised.

Vicky Cottrill

Dutch Midwifery

Simone Valk and *Rebekka Visser* explain why Dutch midwifery is threatened by market forces

As many of you may know, the Netherlands, once the Mecca of independent midwifery and homebirth, are not doing particularly well in the perinatal statistics ranking.[1]

And of course the reflex reaction of many is: blame the homebirth and the independent midwife. This is despite good evidence that homebirth is safe,[2] that midwife led care is the best and the cheapest option, that most perinatal deaths occur with extreme prematurity (of before 28 weeks) and congenital defects, and that differences in outcomes between various countries can also be explained because of different means of record keeping.

We will give a brief sketch of the system.

Healthy pregnant women, that is the majority of women, will see a midwife during pregnancy. If no complications arise the midwife will help her during labour and birth and attend her during the first week with home visits while the kraamverzorgende takes care of mother and baby. Kraamverzorgenden are post partum doulas who assist the midwife during a homebirth, and who come to the house of the new parents during the first 8-10 days. They help the mother to cope with looking after her new born and with breastfeeding and do light household chores.[3] The Kraamzorg has been around for a long time: certainly before World War Two.

If a complication of any kind occurs during pregnancy or birth the midwife is supposed to refer the woman to a consultant and ask for his or her expert opinion. After a consultation, he or she will give their advice to the midwife and mother and they, between them, can decide on the best course of action. In practice the consultant tells the midwife what should be done. The midwife gives in mostly because the mother places her trust in the doctor. Midwives no longer have time to build relationships with mothers – which we will go on to explain below.

Reasons for referral to a consultant are written down in the VIL (Verloskundige Indicatie Lijst): the obstetrical indication list that some regard as set in stone. We are now on the fourth version of this list and the number of indications have tripled since the list was first published in the 1990s. In recent years the pressure on midwives to refer according to the VIL has increased, due to fear of litigation. Midwives have been reported for not obeying the VIL.

In the early years of the 21st century there was a real shortage of midwives. Too many left the field and there were not enough new midwives to replace them. Work then was extremely demanding. Midwives were burning out fast and furiously. Together, we stuck our 'fingers in the dyke'. This led to solo midwives starting to work together in shifts, part of the woman's care during labour was left to the kraamverzorgenden, and women were encouraged not to have a homebirth, but a birth centre or hospital-based birth, so that one midwife could attend more than one woman at the same time.

So personal support seriously suffered. Many a midwife has heaved a sigh of relief in the middle of the night if a complication such as meconium showed as it meant a referral and therefore a few hours of much needed sleep. Midwives who refer a woman, generally leave her to the hospital team. The workload of the average midwife in those days was 150. But please bear in mind that this did not mean 150 women but 150 financial units. Midwives are paid for parts of care. Childbirth is divided up into three parts: pregnancy, labour and birth, and postnatal care. Pregnancy itself is also divided into three parts, 0-14 weeks, 15-29 weeks and 29 weeks to birth. So if a midwife attends a woman only postnatally she gets paid for that part of care. Four women for postnatal care, make up the same amount of money as caring for one woman throughout pregnancy, birth and postnatally. In 2010 this was reduced from 150 to 105 units, which still means 130 women. This is an insane workload.

Local relationships between midwives and obstetricians vary vastly. In Rotterdam for instance, there are five hospitals with maternity units, but in smaller towns, there is often just one hospital. Depending on location, the dynamics between midwives and obstetricians are totally different.

In some hospitals, obstetricians are employed while in others, doctors who are in private practice, use and pay for hospital facilities.

Hospital budgets and allocated numbers of births within each local budget have become very complicated with changes in the national health system; for instance, if the hospital has a set allocation of 2,000 births per annum, birth number 2001 actually costs the hospital money. Hospitals want women to give birth there, but they do not want to exceed their budget.

In any given geographical area, midwives and doctors are meant to work together through what is called the

Healthcare should not be a market, and access to good quality care for all should be a shared responsibility of society at large

VSV (a body that discusses clinical care and makes decisions concerning clinical rules and guidelines).

Coping strategies have led to midwifery practices, varying from two to 10 midwives. Women have little choice, because most practices refuse clients outside their postal code area. For women it is very hard, if not impossible to form a relationship with 'her' midwife if she has to see all 10 members of the team during pregnancy.

In the meantime hospitals discovered that midwives are better than untrained junior doctors and many midwives liked the idea of working in a hospital with regular hours and never alone in dire circumstances.

Reorganisation of the maternity services under new regulations about hospital structures and financing

The entire system of financing of health care services was changed by national legislation in 2006.

In 2006 the Netherlands saw a large change in health insurance. Up until then, most people had either private insurance or ziekenfonds, a form of state-funded health care. Under a certain income a person was ziekenfonds insured and above it they were required to buy their own private health insurance. In 2006 this all changed to one kind of insurance. Everybody is obliged to have a basic health insurance and health insurance companies which are private providers cannot refuse to provide basic health care insurance. Children under 18 are insured for free. The four insurance companies in the Netherlands were given the power to reform healthcare into a financially profit driven healthcare market. They were supposed to buy the best healthcare for the lowest prices for their clients but in practice it is the lowest price which determines their choice. Care during pregnancy, birth and the postnatal period and kraamzorg (postnatal doulas) are still covered by the basic health insurance.

The four insurance companies in the Netherlands were given the power to reform healthcare into a financially profit driven healthcare market. They were supposed to buy the best healthcare for the lowest prices for their clients but in practice it is the lowest price which determines their choice

These changes and accompanying administrative changes, including a shift to this mixed public-private system with private health insurance companies playing a major role, have had a major impact on health care services and their effect has been highly variable in respect of maternity services.

Midwives have their own contracts with insurance companies. As I explained midwives are paid for units of the care. So, for example, if a woman is referred to an obstetrician during pregnancy, the midwife gets paid for care from the beginning of the woman's pregnancy until 30 weeks or later, depending on the referral date and for postnatal care, from when the woman goes home after the birth. When a woman is referred during birth the midwife gets paid the whole amount, so there is no financial incentive for keeping a woman in her care who really needs a consultant. And the consultant who takes over the birth also gets paid the full amount.

Women who want a hospital birth without a good medical reason have to pay for it themselves. If she decides to have an epidural during labour this is seen as a medical reason, so both midwife and consultant get paid and the woman herself does not have to pay.

180,000 children are born each year but insurance companies pay for almost 280,000. This is largely because of all the referrals during labour and birth where both parties get the full amount of money. It is not exactly rocket science to conclude that this can be done more cheaply. And with the perinatal statistics still under debate, the solution seems easy: stop homebirths and bring midwives to heel.

Over the last decade hospitals have merged so that there are now fewer hospitals. Generally local relations between midwives and consultants are reasonably good, largely because both are independent professionals who complement and respect each other. There is a lot of personal appreciation. Most work on a basis of trust and respect. In recent years however, it has become clear that midwives with comparable populations of women have very different referral rates, varying between 35% and 70%. The reason for this remains unknown. It would seem prudent to research this phenomenon thoroughly before implementing changes.

However, the new modes of health financing are complex and under these new modes the idea is for a VSV to get a lump sum of money for all the births in their area. Midwives and obstetricians must divide this allocation amongst themselves, while the hospital is also a stakeholder in its own right. Caught in the middle of this process of change, no one knows yet what it will look like over the next number of years. One of us has a practice which covers three hospitals, but as midwives we only participate in one VSV because the rules state that midwives and obstetricians can only participate in one VSV.

And of course the party that manages the money will have the power. Most consultants work in a hospital, but not all are employed by the hospital. The hospital lobby is very forceful. While no decision has been reached as yet, there is ample reason to believe that it won't be midwives managing the money. It may mean that midwives will no longer be autonomous professionals but will have to work under the supervision of consultants. It may mean that homebirth will no longer be possible or if a woman insists, that she will have to pay for it because she wants a midwife all for herself.

More interventions, more caesarean sections and more unhappy women than ever and the costs of birth soaring

Of course this whole change to 'Shared Care', is framed as concerning safety. In all other areas of health care the GP is considered to be a gatekeeper. The GP is supposed to deal with most matters and only to refer to an expensive hospital based specialist if there is no other solution. But in pregnancy the recommendation is now for ALL healthy pregnant women to be seen by a consultant at least once. And of course for midwives to share files.

Better? No evidence for that so far. Cheaper? Who knows. Will the results be improved by constantly giving healthy women a message that we don't think she can carry her child to term and give birth like her mother, her grandmothers and all women since Genesis? Do we as a society have the right to take away from a woman choices regarding her bodily integrity?

Will we in ten years time look back and say: gosh, look what we had and look what we have now? More interventions, more caesarean sections and more unhappy women than ever and the costs of birth soaring.

Midwives at the moment are uniting and trying to influence these plans. But we see that it is very difficult for them to keep track of everything that politicians say and do. Vague language and smoke screens are difficult to navigate and not everyone is filled with a sense of urgency or is convinced that these plans are really harmful and will lead to the end of midwifery as we know it. In the last two years, an active woman's organisation, Geboortebeweging, has developed, which makes itself very visible and audible. It too fights for independent midwifery and for choice for a woman to birth where and with whom she wants.

Hospitals are merging: centralising care is the idea, and women will have to travel a larger distance to reach the hospital. In one area, where a local hospital closed, home births were 'forbidden' (in that midwives were made to understand that they were taking risks with the lives of mothers and babies if they still supported homebirth). The distance to the hospital was considered too dangerous in case of an emergency. However the midwives in this area have reported an increase in homebirths recently with no adverse effects.

We see more women these days who don't want to give birth in a hospital despite, a clear medical reason. Some mothers have been reported to social services for taking 'risks' with their babies. Midwives attending these women were reported too and have been under investigation by the Health Care Inspector. The personal impact for the midwife and the damage to her professional reputation is great and not every one can stand this strain. In general it's clear that Dutch midwives AND women feel great concern about the recent developments. And it is also clear that they will need firm political and public support in this increasingly profit driven system. Healthcare should not be a market, and access to good quality care for all should be a shared responsibility of society at large.

Simone Valk and Rebekka Visser

Simone has been a midwife since 1982 in the same practice. She works with three other midwives in the Rotterdam area attending home and hospital births.

Rebekka is a midwife. She works in a rural area in the northern part of the Netherlands.

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An Albany antenatal appointment at Peckham Pulse Heathy Living Centre, with midwife Becky Reed

Interview with Wendy Savage

Beverley Beech seeks Wendy's views on the changes within the NHS

In July, Chair of AIMS, Beverley Beech visited Professor Wendy Savage to seek her views on the changes that are happening within the NHS.

Beverley: Can we talk about the current state of the NHS?

Wendy: It's a terrible mess. One of the aims of the Health and Social Care Act was, supposedly, to remove the tinkering with the NHS by the Secretary of State. So although he no longer has a legal responsibility to secure and provide a comprehensive health service, it hasn't stopped him interfering with it all the time. It's not at all clear how the responsibilities of the Department of Health, NHS England, the CQC, Monitor and the Foundation Trust Development Authority all link in.

Originally, NHS England (it wasn't called that then) was going to commission maternity services and then they said it would go to the GPs in clinical commissioning groups. This was a pity because if you had to have this system, it seemed to me that a body that was commissioning specialist services is more likely to have the expertise than two hundred clinical commissioning groups.

Beverley: What do you think of these charades of 'consultation'?

Wendy: The government's rules for consultation say that it must be able to make a difference. So the consultation about 'Equity and Excellence' (www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf) failed that test because they didn't say that this was about whether they should do it, it was about what you thought about it when they were going to do it! The fact is that nothing else changed after this huge consultation with six thousand responses.

Beverley: Why is this government so determined to privatise health care? Apart from the obvious - they have shares in these companies and can make a fat profit for themselves.

Wendy: The government ideologically opposes the National Health Service. The Conservatives see it as Labour's greatest achievement, which it was.

Beverley: So what do you think the impact of this Health and Social Care Act is going to be, on maternity services and women and babies?

Wendy: Well, we haven't seen a lot of social enterprises springing up to provide care for women have we? One of the aims of the Health and Social Care Act is to privatise the health service and try to encourage alternative providers. But apart from the group in Liverpool, I haven't read about groups of midwives setting up alternative services to compete with the NHS.

Beverley. Our worry about the few groups we do have is that midwifery standards will be set by insurance companies and as they are private 'companies' the big boys are going to take it over and reduce everything to the lowest common denominator.

Wendy: On the whole, I think that the private companies are probably not going to be very interested in midwifery because it's very labour intensive and if something goes wrong you've got huge costs. So I think that it's unlikely that predatory companies like Serco and G4S and all those people who know nothing about medicine are going to venture in. How does Serco get contracts for out-of-hours care and Virgin get it for children's care, when they've never done it? It's shocking.

Care UK provides community services in Suffolk. They immediately cut down the number of staff, who now have to drive miles farther to get to the patients. Because managers are short of money, they fall for these smooth-talking companies

Beverley: How do you think this will affect maternity care?

Wendy: I think maternity care is not going to be very attractive to private companies. Because the costs are high and unpredictable, and the risk of something going wrong is not high but when it happens it's enormously expensive. So I feel the predatory capitalists are not going to be interested in maternity care ... but I may be wrong.

Beverley: The midwives in Holland are fighting a rearguard action. Midwifery over there has always been held as a gold standard – but it is being whittled away and it's run much more like a business.

it did have a great impact because women were really given choices

Wendy: They've had privatisation in Holland and people aren't happy about it. No doubt the midwives got caught in that as well.

When you think of the Albany Midwifery Practice in south east London, how they negotiated all those things with making contracts with the NHS and all the rest of it, and then got absorbed by the NHS, it did have a great impact because women were really given choices and over 40% opted for homebirth, which was safely achieved, and then this attack on them.

Beverley: Do you think that a system that would be sustainable could possibly work? It is clear that the midwives within the NHS are so bound by tick boxes, and protocols and everything else, that they are not giving individual care, and when they go outside the protocols there is trouble.

Wendy: We've got problems with the NHS structures and all the rest, but we've also got the problems of the midwifery profession and how confident they are about being proper midwives and how they don't support midwives who get caught up in the system very well.

One of the hopeful things is that the academic midwives seem to be very much on the side of giving women what they want and evidence-based midwifery which favours normality.

Beverley: How do we get the NHS to listen to what women want?

Wendy: I think one of the problems is that people who are making the decisions are older so their ideas about maternity care were formed twenty, thirty, maybe even forty years ago. And they tend to defer to the medical people and of course that was the whole era where home birth was considered anathema

Beverley: Are we going to have a dual system of care in which those who can pay get siphoned off and everybody else gets substandard care?

Wendy: Certainly if we don't manage to stop this Health and Social Care Act, the end result is going to be just that. Andrew Neil [TV news] asked Louise Irvine (who stood for National Health Action Party) about what services had been privatised. Two thirds of contracts have gone to the private sector since the Act came in – the NHS Support Federation did an analysis of it.

I'm just thinking join Keep Our NHS public, lobby your MP, lobby the Labour Party so that they actually come up with some proposals. See www.keepournhspublic.com. The Labour Party has said it is going to repeal the Health and Social Care Act but you've also got to restore the Secretary of State's legal responsibility for providing the service. At the moment he doesn't have a legal responsibility, he only has political responsibility so he just blathers on about things and reports to Parliament and if something goes wrong he's not legally responsible.

Beverley A Lawrence Beech

An Albany one to one antenatal 'Birth Talk' in the woman's home at around 36 weeks pregnant

Doris Buttry Haire

died 7 June 2014

Doris Buttry Haire died peacefully at her and her husband's home in Charlottesville Virginia on 7th June 2014 at the age of 88.

She was the President of the American Foundation for Maternal and Child Health, the AIMS contact in the United States of America; a medical sociologist with an honorary doctorate in medical science, the Founder of the International Childbirth Education Association in 1972, on the first Board of the National Women's Health Network in 1976, and a world renowned authority on maternity care.

In 1972 she published her landmark work *The Cultural Warping of Childbirth* which was well ahead of its time and should be read by everyone today, as much of what she questioned still needs to be questioned now. She was particularly concerned and interested in the adverse effects of medicalised birth, unevaluated medical technology, especially ultrasound and the effects of drugs in labour. She produced another landmark publication, *How the F.D.A. Determines the 'Safety' of Drugs - Just How Safe is 'Safe'?*, testified at three Congressional hearings on obstetric care and instigated an investigation into the Federal Food and Drug Administration's (FDA) regulating practices. She provided the FDA with data which resulted in the Administration removing its approval of oxytocin for the elective induction of labour in 1978. During the 1980s she brought over to the UK a video about the impact of ultrasound on cells. The interference on cells exposed to ultrasound was shocking and this provoked particular interest from AIMS in this largely unevaluated technology.

As the Founder of the Alliance for the Improvement of Maternity Services (AIMS) in the USA she vigorously promoted parents' rights, publishing the *Pregnant Patient's Bill of Rights*. She successfully fought for a *Professional Midwifery Practice Act* which enabled midwives to have their own State Board of Midwifery and practice midwifery separate from nursing and obstetrics. She played a significant role in establishing New York's *Maternity Information Act* which requires hospitals to publish their intervention rates annually. These are but a few of her many papers and activities. Other publications listed on the AIMS USA site (www.aimsusa.org) include *Implementing Family Centered Maternity Care with a Central Nursery, Drugs in Labor and Birth, Improving the Outcome of Pregnancy Through the Increased Utilization of Midwives, Maternity Care and Outcomes in a High-risk Service: the North Central Bronx Hospital Experience* and *Fetal Effects of Ultrasound – a Growing Controversy.*

She has variously been described as a 'true trailblazer', 'foremother' and 'leader' in mobilising pressure for change in childbirth practices.

For over 40 years, campaigning tirelessly for improvements in maternity care, lecturing all over the world (she visited over 75 countries to meet parents, practitioners and observe maternity care), she was quietly supported by her loving husband of 68 years, John, who arranged all her international trips and itineraries, as she could be a little scatty at times. It was he and Doris who funded the first International Confederation of Midwives Conference in the US.

She was a generous friend who, when we discovered we were attending the same conference would offer to share a room, not that she needed to, but it was her quiet way of contributing to the stretched finances of AIMS. She was a gentle, generous, tour de force and she will be sorely missed.

Beverley A Lawrence Beech

Continuity consensus emerging

Gill Boden describes progress being made towards caseloading care in London

The year 2013 was the 20th anniversary of Changing Childbirth,[1] which set out the three Cs, choice, continuity and control. These essential elements of care often elude women in childbirth but there are some hopeful signs of a convergence of opinion, which might make continuity of care a possibility, at least in London, and enable a woman to know the midwife who will attend her birth.

In December 2013 the Care Quality Commission, (CQC), published a survey showing that women's experiences of maternity care in London needed improvement[2] and the Strategic Clinical Leadership Group (SCLG) and the Maternity Strategic Clinical Network (SCN) were set up to be driving forces behind improving the quality of care within London's maternity services.

In the same month the Royal College of Midwives, (RCM), made a submission to The People's Inquiry for London's NHS.[3] It drew attention to capacity issues; the increase in complex pregnancies; the health inequalities associated with deprivation and ethnicity and to the finding that only 40% of women in London had the name and telephone number of a dedicated midwife compared to the national average of 72%.

The RCM in its submission was concerned with the fact that the reorganisation of maternity services has been driven by the centralisation of obstetric services on fewer sites to meet the NHS London maternity services standard. This standard states that *'obstetric services should be staffed to provide the 168 hours a week (24/7) of consultant obstetric presence on the labour ward.'* In the RCM's view, while it may be desirable to concentrate obstetric-led services, particularly for women and infants who require emergency or specialist care, there is little evidence of benefit in terms of its impact on outcomes, it is expensive, and it should not be the principal driving force behind reorganisation. Catherine Calderwood, NHS England's Clinical Director of Women's Services, echoes this view and told a Public Accounts Committee hearing that investment in midwives would be more effective: what women need is obstetric services organised around the needs of women with a high risk of complications during pregnancy, birth and/or after birth, and midwife-led models of care to benefit women who are at low risk of complications with a significant expansion of midwife-led units and home birth.

Chief Executive of the RCM, Cathy Warwick in January 2014 quoted the survey carried out by the National Federation of Women's Institutes and NCT.[4] The survey found that 88% of women had not met the midwives who were to attend them in labour and although most women did get one to one care in labour this was managed by Heads of Midwifery redeploying staff continually away from essential services.

Continuity of carer has been shown, by Jane Sandall and others,[3] to be safer for mothers and babies, more cost effective, with fewer interventions and preterm births, and increased chances of normal birth. There is now a clear consensus, backed by the Birthplace Study[5] for a maternity service, which is arranged around the needs of women and babies and not the demands of a medically based hospital service. The Department of Health Mandate,[6] sets out to *'ensure that every woman has a named midwife who is responsible for ensuring she has personalised one to one care throughout pregnancy, childbirth and during the postnatal period including additional support for those who have a maternal health concern'* (p19). There is much work going on now which might mean that London will lead the way to making caseloading midwifery a reality and making birth the life-affirming event it could be.

Gill Boden

only 40 % of women in London had the name and telephone number of a dedicated midwife

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Albany Midwifery Practice

Jude Davis talks about the launch of a new website exploring the Albany model of care

A new website has been launched to *'document the achievements'* of the Albany model of midwifery care as well as to *'discuss why it came to an end, and to provide information, inspiration and support for others who would like to work in this way'*, www.thealbanymodel.com. The Albany Midwifery Practice ran from 1997 to 2009 in Peckham, London.

Outstanding outcomes for an 'all-risk' group of women

As the website states, the outstanding work of the Albany practice *'soon became both nationally and internationally acclaimed as ground-breaking.'* Most of my student midwife assignments contained references to the *'gold standard of midwifery care'* given by the Albany midwives. Statistics from the practice are eye-poppingly good. For the years 1999-2007 they show a home birth rate of 44%, a spontaneous vaginal birth rate of 80%, a caesarean section rate of 16% and a forceps/ventouse rate of 3%. During this period the caesarean section rate in England was 23.5% and the instrumental delivery rate was 11.1% according to BirthchoiceUK in 2008. Breastfeeding rates were exceptionally good too, with 92% breastfeeding from birth, in contrast to the general UK uptake of 76%. 74.5% of the women cared for by Albany midwives were still exclusively breastfeeding at 28 days.

What makes Albany's statistics even more outstanding is that this was no cherry-picked 'low-risk' group of middle class women, rich in organic vegetables and alternative remedies to complement excellent access to healthcare, but an ALL risk caseload in a population of wide ethnic diversity and outstanding social deprivation. Women from ethnic minorities and from areas of social deprivation are known to have increased morbidity and mortality[1]. According to the post code of the area served, the Albany cared for the most deprived population quintile.[2] The ethnic mix served included over 50% of the women describing themselves as Black (African, British, Caribbean or other), with a further 14% of women from ethnic groups other than White.

The Albany model was discussed in Robbie Davis-Floyd's book, 'Birth Models that Work'.[3] Besides awesomely low rates of intervention, including caesarean section and outstandingly high rates of exclusive breastfeeding, the statistics reveal a perinatal mortality rate substantially lower than the national average and in fact, less than half the rate of the surrounding area where conventional health service provision is in place.

Encouraging decision-making

Keeping birth place options 'open' until labour was established contributed to the Albany's outstanding homebirth rate. Why should a woman decide prior to labour how she is going to feel about how she will manage it and where she would want to be? The Albany worked in a non-hierarchical and truly woman-centred way.

I visited King's College in 2008 for a talk given by Nicky Leap (who had studied the way the Albany midwives worked), about pain in labour. Part of Nicky's talk focused on her filming of the midwives' practice which documented how this model of care was more humane and more informative, enabling and strengthening of women's understanding of birth physiology and choices than any other, not just within the NHS, but anywhere. The Birth Talk in the woman's home when she was 36 weeks pregnant, along with those planning to be at the birth with her, contributed to this.

Closure of the Albany Midwifery Practice

One day, I imagined, when my kids were grown I might join them, or a team like them if other teams were inspired to operate with the same ethos and structure. However, within a year of my qualifying, the unthinkable happened. King's College Hospital NHS Foundation Trust stopped the most inspirational and successful example of midwifery practice from working. Its end was sudden, shocking, demoralising, infuriating and, as articulated by numerous esteemed academics and practitioners, whose critiques are available via the links on the website, seems to have been for questionable motives and without sound justification.

A message on the King's College Hospital NHS Foundation Trust website was posted to explain the sudden closure of the Albany practice on the grounds of safety, which remains in place today. However, while the Albany Midwifery Practice contract was terminated allegedly due to 'unsafe' care, all of the Albany Practice midwives were immediately offered midwifery employment by King's College Hospital NHS Foundation Trust. This leaves one wondering quite how unsafe King's management could have thought these Albany midwives to be?

The website also describes how the campaign by the 'Albany Mums' and the Albany Action Group quickly formed and fought vigorously, but failed to reverse the decision.

NHS midwives have been forced into practising outside of their philosophy

What we have lost

I wholeheartedly want to be a part of a tax-funded, free at the point of use, National Health Service where everyone receives equal care. Simultaneously, I admire the values and skills that independent midwives have maintained whilst NHS midwives have been forced into practising outside of their philosophy when, for example, they were no longer enabled to facilitate physiological breech birth or encouraged to support women having Vaginal Birth After Caesarean in homely environments or without continuous monitoring. The Albany found a way to provide a service which was embedded within the NHS, yet within which they maintained their autonomy. This enabled them to provide authentically individualised woman-centred midwifery care for NHS service users.

Albany was a small group of self-employed previously independent midwives who negotiated a special contract with King's to provide care for NHS users. It meant that rather than women paying independent midwives for the luxury of continuity and truly individualised care, women received this as standard NHS care. The Albany midwives self-managed, and although their care was more in line with government recommendations such as choice, control, and continuity of care as described in Changing Childbirth than in most of the NHS, their autonomy appears perhaps to have unsettled the powers that were.

The past few decades have seen insidious change within the NHS and encroaching privatisation as UK health care has increasingly morphed from 'service' to 'business'. For decades independent midwives have battled to maintain their status within a world ever dominated by dictates of insurance companies via Clinical Negligence Schemes for Trusts (CNST) and Welsh Risk Pool schemes. The Royal College of Midwives appears to have been unable to support midwives to practise outside the NHS and now we are sadly witnessing the erosion of their ability to practice their profession legally.

Whilst certain alternative midwifery models are springing up and appear to provide valuable continuity of carer, as inspired by the Albany model, they are significantly different enterprises. Their caseloads will not be 'all-risk'. Many aspire to reach a point whereby their services will be free at the point of contact, but are currently far from it. Their users will also lack the clear and easy access to all support services as was the case for Albany mums, within the changed and increasingly fragmented health service as it now stands.

Lack of evidence for the closure

Despite everyone's best efforts, hopes and aspirations, there isn't a maternity service anywhere in the world that has a zero perinatal mortality rate. If the accusation of unsafe practice and high numbers of poor outcomes stood up to scrutiny, which by all accounts it doesn't, the closure of the Albany remains unjustified. Indeed, despite all its flaws described by critiques on the Albany website, the investigation into the Albany Midwifery Practice by the Centre for Maternal and Child Enquiries (CMACE) did not recommend its closure. Also, when more than twice as many babies survive under your care than in the surrounding local service, it seems inevitable that there would be an increase in the numbers of babies who survive, but with some degree of morbidity.

The website describes how the end came for Albany when management at King's College called the Albany midwives in and announced that the practice had had an unacceptably high level of babies with Hypoxic Ischemic Encephalopathy (HIE). Statistics used to justify the actions appear to have been targeted around a cluster of ill babies from which it was surmised that the Albany midwifery practice was unsafe. CMACE carried out in-depth confidential studies into perinatal and maternal mortality and this organisation was used by King's to review this cluster of poor outcomes.

Links to relevant documents, statements and critiques (including those by AIMS and the Association of Radical Midwives) of what happened are all accessible via the website (www.thealbanymodel.com/articles/) and give further insight and opinion on the termination of this inspirational service. Denis Walsh makes excellent points in his review including how the report by CMACE commissioned by King's to investigate the poor outcomes was flawed with 'hindsight bias', failed to use appropriate midwives to appraise normal midwifery, failed to acknowledge the outstandingly good and internationally acclaimed outcomes of the practice or to recognise that most cases of HIE are not thought to be related to intrapartum events as the report implies. It also failed to note that evidence supports the idea that the low rates of preterm labour and growth restricted babies that the Albany practice had could be linked to their case loading and socially supportive model of care.

Please keep this great resource of the best model of midwifery care in your 'favourites' and read beyond its pages to the wealth of information in its links. Albany should not be forgotten. It should be emulated and information about it widely disseminated just as the Albany midwives hoped it would be. It should continue to inspire generations of midwives. Students can no longer visit the practice, but at least they can read about how such a fantastic service can not only happen, but it can, within the NHS, provide cheaper, safer and more satisfying midwifery care than perhaps has ever been provided before or since.

Jude Davis

Jude Davis is a community and birth centre midwife in London

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Women's safety alerts in maternity care: is speaking up enough?

The context for this study by Suzanne Rance and colleagues includes a Care Quality Commission investigation of a maternity service where serious incidents occurred. The Commission found evidence that women had routinely been ignored and left alone in labour. In a similar vein, Rance et al's study found that women often found it difficult to raise concerns and found they were not always listened to by health practitioners.

The opening sentence of Rance et al's paper states that *'Patients' contributions to safety include speaking up about their perceptions of being at risk.'* (p348) The authors do not suggest that this idea is new or novel, but were struck by how often the women they interviewed spontaneously mentioned that they had had difficulty speaking out about their concerns and/or being heard by health practitioners. There have been some notable feminist texts suggesting that often women do 'know' best and often 'know' best in the context of safe environments and supportive relationships. The literature examined by the authors of this paper also found *'some evidence that patients can detect suspected adverse events earlier than professionals'*, but that women *'hesitated to raise concerns that they felt staff might consider irrelevant'*. (p348) They too suggested that *'Patients readiness to speak up was substantially affected by the quality of their relationships with staff.'* (p348)

This research was part of the Birthplace study and took place across four Trusts in England that were considered to be functioning well and were particularly concerned about improving safety and care. They were located in both urban and rural environments, provided a variety of settings for birth and cared for both advantaged and disadvantaged families. This paper focuses on the in depth interviews with 58 postnatal women and partners. Women were asked questions such as 'How was the birth experience for you?'

'Speaking up, defined as insistent and vehement communication when faced with failure by staff to listen and respond was an unexpected finding'. (p348) It was mentioned by 30 of the 58 women interviewed and 14 of them said that the situation was urgent. Of the 28 who didn't mention this, 15 women thought professionals had more knowledge then they did, thought they should comply, or feared they would be seen as 'over-demanding' (p349). Subsequently, some blamed themselves for not speaking out.

Nine of the women felt they didn't need to speak up as they were able to talk with staff who listened and were responsive. Their comments demonstrated the positive value of being listened to and supported, especially when they had had difficult experiences. Conversely, the comments by women who felt ignored were distressing: *'I just felt like I was being ignored … I felt like I was screaming and no one was listening. I felt like my wishes were being completely disregarded …'*

A number of factors were found by the researchers to help women to speak up, such as feeling strongly at risk, having enough information to feel more confident about their own knowledge, and/or the presence of a partner or relative. But speaking up did not guarantee being heard. The women described staff: *'ignoring requests or dismissing safety concerns; delaying or withholding information, care or support; disbelieving the woman's account of stage in labour or symptoms in self or baby; responding brusquely or rudely to requests for help; refusing labouring women admission or sending them home feeling unsafe; refusing presence of midwife to attend planned home birth.'*

The authors acknowledge that pressure on staff impacts on their ability to listen and respond to women, but also suggest that: *'The failure to listen so frequently reported in our study may be associated with institutional cultures that normalise reduced attention to women's calls for help.'* (p353) They also noted that while it is assumed that advantaged women speak up more than those who are disadvantaged, care from caseloading midwives could ameliorate this for the disadvantaged women in their care.

They concluded that support from a partner or relative was the most helpful factor for women, but asked whether or not women should have to depend on this and whether women on their own are *'more exposed to risk'*. (p353) The authors suggest that awareness among staff about the importance of listening and responding, as a safety measure, needs to be increased and that while this is difficult to do, they cite successful examples from the UK, North America and Australia.

AIMS Comments

None of these findings come as a surprise to AIMS. We hear similar comments from women who have not been listened to on our helpline and elsewhere. While it is concerning to hear about the extent of this problem, even in maternity services committed to good care, it is useful to have published findings from respected qualitative researchers, telling us that women are often ignored and disrespected during their childbearing experiences.

One of the most important aspects of the study is the authors' view that not listening to women could be due to 'institutional cultures' that 'normalise' this. We now have a wealth of research showing that trusting relationships between women and midwives develop when midwives and women get to know each other and that one of the best ways of achieving this and contributing to safe (in its broadest meaning) care is by introducing case loading midwifery.[1] But the NHS is renowned for not listening to women (or midwives). And

as services face increased cuts and privatisation, the likelihood of cultural and individual change decreases. Hard pressed staff who lack sufficient resources cannot easily listen and respond, far less design and introduce systematic initiatives for change.

Meanwhile, it is still not widely enough known among parents that a Supervisor of Midwives is on call at all times, in all areas, to support women and midwives. Any woman can contact a supervisor, even in labour, if she has concerns about or wishes to discuss her care. See: www.nmc-uk.org/patients-public/Women-and-families/How-supervisors-of-midwives-can-help-you/ www.nmc-uk.org/Documents/NMC-Publications/NMC%20Supervisor%20of%20midwives.pdf

The AIMS helpline can also be contacted any time at helpline@aims.org.uk. A group of volunteers answer queries and can suggest other sources of support and information.

Nadine Edwards

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Brand new NHS Reinstatement Bill from Allyson Pollock gives hope to campaigners

OURNHS 1 September 2014

Taken from www.opendemocracy.net/ournhs/ournhs/brand-new-nhs-reinstatement-bill-from-allyson-pollock-gives-hope-to-campaigners

Leading NHS campaigners have come together to produce an NHS Reinstatement Bill which contains all the vital ingredients to stop and reverse NHS privatisation. And they want your views.

Leading public health experts have launched a consultation on a new Bill that aims to reverse the failings of the Health and Social Care Act 2012 and fully restore the National Health Service (NHS) in England as an accountable public service.

The NHS Reinstatement Bill proposes to abolish competition and the purchaser-provider split, re-establish public bodies and public accountability, and restrict the role of commercial companies. It draws on some of the best examples of NHS administration over its history, retains some features of the reforms laid out in the Health and Social Care Act 2012, and would be implemented on a timescale determined by the secretary of state.

The Bill would

- reinstate the government's legal duty to provide the NHS in England
- re-establish district health authorities in England as a special health authority with regional committees and modified functions
- re-establish district health authorities (coterminous with local authorities), with family health services committees to administer arrangements with GPs, dentists, and others
- abolish competition and marketised bodies such as NHS trusts, NHS foundation trusts, and clinical commissioning groups, as well as Monitor, the regulator of NHS foundation trusts and commercial companies
- end virtually all commissioning and allow commercial companies to provide services only if the NHS could not do so and otherwise patients would suffer
- re-establish community health councils to represent the interest of the public in the NHS
- prohibit ratification of the Transatlantic Trade and Investment Partnership and other international treaties without the approval of Parliament (and the devolved bodies) if they would cover the NHS.

This Bill is a vital public health measure. It will both restore the NHS in England and reverse more than two decades of policies which have been intent upon privatising NHS services and funding, ultimately to its demise.

As the failures of the 2012 Act become daily ever more obvious, this Bill provides a template for very necessary reinstatement and reform.

The Bill has been drafted by barrister Peter Roderick with the assistance of Prof Allyson Pollock. They have benefitted from discussions with individuals and organisations concerned about the increasing role of the market in the NHS in England over the last 25 years. They wish to consult on the Bill with those who share their concern and our commitment to reinstating fully the NHS as an accountable public service as smoothly as possible and with only a minimal and exceptional role for commercial companies.

Responses to the Bill can be sent by email to
a.pollock@qmul.ac.uk
p.roderick@qmul.ac.uk

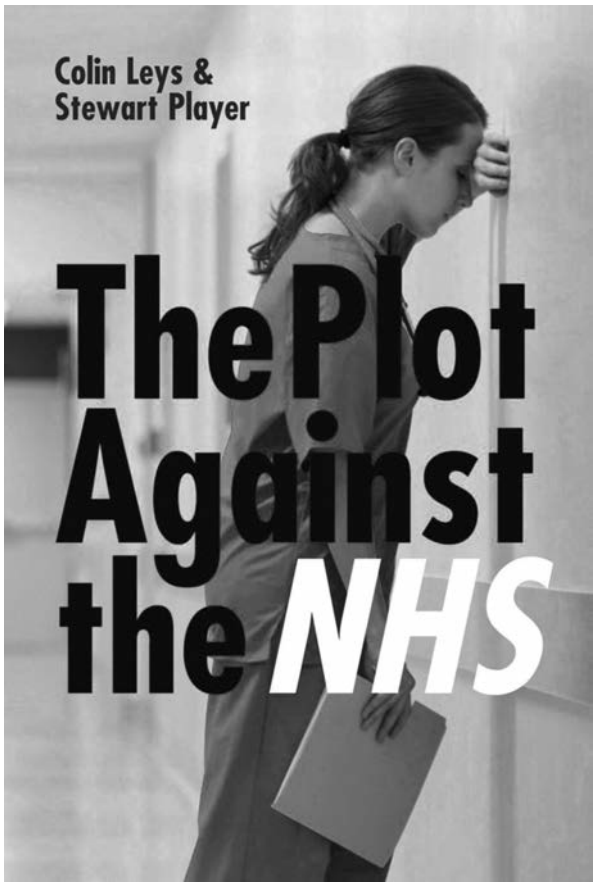
Reviews

The Plot Against the NHS

Colin Leys and Stewart Player
Merlin Press Ltd. 2011
Publisher's recommended price £12.95
ISBN: 978-0850366792

Dr Jacky Davis's forward puts the central thesis of this book thus: *'how politicians and private interests have worked patiently together behind closed doors to try to transform the NHS from an integrated public service into a mere "kitemark" attached to a system of competing private providers. The NHS – one of the most cost effective and equitable health services in the world – now stands on the brink of extinction, and many will be waking up and wondering how we arrived at this point without an outcry from the public and the media.'*

This powerful warning was published in 2011 and still many seem unaware that the intention for a long time has been the full privatisation of health – health as a commodity for those who can afford it, rather than a social good for all. This book is part of a very long story of plans to privatise health which was made plain in Margaret Thatcher's 1979 election manifesto www.margaretthatcher.org/document/110858). It contributes to a body of literature which charts a much bigger story about the commercialisation of most of our public services. Health was somewhat lower down the list of Government priorities, as it was unlikely to find widespread support but has nonetheless been worked on, often behind closed doors since the 1980s. Allyson Pollock's important book, NHS – plc published in 2006, spelled out much of what had been happening and where this would lead. The Plot Against the NHS takes up the story prior to the Health and Social Care Bill being passed in 2012.



The secrecy, deception, spin and departure from any form of democratic engagement and dialogue ensured that the background to and implications of the Health and Social Care Bill were obscure, while many who knew better hoped that it would simply not be passed.

We have been hoodwinked again and again by 'reforms' disguised by rhetoric about patient-centred, patient choice, but which have relentlessly moved towards the privatisation of health care à l'Americaine. The authors provide evidence of a Government steeped in commercial interests (conflicts of interest par excellence). The book describes an ever busier, but largely invisible revolving door between Government, private health care and the private health insurance industry amongst other associated businesses, where MPs and civil servants stand to earn vast sums of money at the expense of our health.

The book lays out just how Andrew Lansley and others have continued the plan to turn 'healthcare back into a commodity and a source of profit' (p5), against the reported wishes of the public. That the NHS needed reforming is not disputed. What is at issue here is what 'reform' means and how this could best be done in the public's interest.

Some politicians mistakenly believed that introducing limited private care could be done and that it would improve the NHS overall. But market models, when evaluated, have been shown not to work: the lessons learned by this were 'don't evaluate', or better still, abandon data collection and make more and more data commercially sensitive, so that any evaluation is impossible. For example, it has not been possible to discover what the runaway costs of a huge IT project, Connecting for Health, actually were, nor the vast and ongoing costs of PFI contracts, and there has been a deliberate failure *'to collect data that would allow the results of operations done on NHS patients by private treatment centres to be compared with NHS outcome data'* (p111).

In any case, the plan was never to stop at part privatisation and introducing a market model paved the way for full privatisation which has been relentlessly pursued, despite evidence: *'that privatisation makes health care more costly – and worse. The evidence from the US confirms what economic theory says, that markets will not produce good health care for all, as the NHS is pledged to do'* (p9). In fact, a survey for the US Commonwealth Fund found that out of 11 industrialised countries the NHS was

almost the least costly, most accessible and fairest of all healthcare systems, while the US model, dominated by HMOs (Health Maintenance Organisation) – see box opposite – is the most expensive and unequal.

The authors describe in detail the process by which the NHS continued to be made ready for privatisation. For example, Alan Milburn set in motion the move from Trusts to Foundation Trusts (competitive businesses) which were given 'managerial independence' (ready for private companies to take over). The 'private sector-like freedom' of these new businesses meant that they could 'go bust', thus *'every policy decision must be judged first and foremost on its impact on financial viability, rather than on whether, for example, it would meet the needs of this or that category of patient'* (p23). 'Payment by results' was introduced, making possible price competition (initially ruled out, but ruled in, in 2010). Having driven privatisation forward, Alan Milburn left the Government to become *'a paid advisor to a clutch of private companies interested in cashing in on the marketization of the NHS'* (p25). Doctors were also prepared for privatisation: hospital doctors were enabled to carry out more private practice and encouraged to consider forming their own companies or working for other private companies. GPs were offered a pay rise and the option to stop providing out of hours care – which 90% did. This created an opening for private companies such as Serco and Take Care Now– mostly with poor results (www.theguardian.com/society/2013/jul/11/serco-gp-out-of-hours-substandard, www.theguardian.com/business/2013/dec/13/serco-lose-contract-gp-services-nhs-outsourcing).

Importantly, while no insurance is needed within a nationalised health service free at the point of access, as there is nothing to insure against, private care and 'top up' care make insurance vital (for those who can afford it) to be able to access anything more than a very basic, under resourced public services. But it is also restrictive, as it dictates what can be treated and how. Profits must be made for shareholders and thus providing healthcare for the good of people is of secondary concern. The authors ask: *'How will the conflict between choice and rationing be resolved?'* (p122) under these new conditions?

The authors examine the various documents produced, from the NHS Plan of 2000 onwards and suggest that: *'It took a close reading and an awareness of the increasingly close relationship between the Department of Health and the private health industry to see that each of these documents concealed a new entry point for privatization'* (p107). For example, Creating a patient-led NHS in 2005 said that Primary Care Trusts must offer choice of provider, including an independent one, and that organisations would have to learn to live with risk and that failed services would be allowed to 'exit'. *'This was a veiled description of how a health care market works'*, but as the document was aimed at NHS managers it was easy to avoid public and media attention.

As bids were invited, for GP services for example, it became apparent that large healthcare businesses had experience of preparing these as well as deep pockets (preparing bids can cost upward of £40,000) and that popular, existing local providers, who have served their communities well and have better outcomes, have little chance of competing. For example, In Camden, London, UnitedHealth won three contracts against local GPs *'who scored higher on all the criteria listed in the invitation to tender, except cost'* (p110).

The focus on profit necessarily drives down quality and safety – and health care will be no exception – we need only look at the railway services, and in the health services – cleaning, nursing and care homes, GP practices, health centres etc: *'business models of healthcare provision, depending on maximizing revenue and minimizing staff costs, is sufficient in itself to destroy quality'*(p126). Indeed the 'key mandate' of the new regulatory body, Monitor, *'includes promoting competition in healthcare, drawing upon precedents from the utilities, rail and telecoms industries'* (p120). Other downward pressures on quality include *'the high cost of operating a competitive market compared to a system based on collaboration and planning'* (p127), including dividends to shareholders, high salaries

HMOs

Allyson Pollock in her article, Primary Care – From Fundholding to Health Maintenance Organisation?[1] describes HMOs in this way:

In the United States, Health Maintenance Organisations (HMOs) have become large for-profit multibillion dollar businesses. Some of them are owned by doctors, who in turn employ and salary or contract with other doctors. HMOs have three features:

First, they combine the insurance function with the provider function.

Second, they do not provide universal coverage: as provider organisations they are free to pick, choose and select the patients they will cover on the basis of risk. Because of this they neither serve local geographic areas, nor do they have any direct accountability to local communities.

Third, they are not restricted in size and are free to compete for patients and populations and buy-out competing services. In many deprived inner city areas, this has led to the buy-out and closure of local services because they are unprofitable and public hospitals are left to serve the most vulnerable groups without the benefit of pooling risk. In many cities, these public hospitals are also threatened and being closed, leaving virtually no safety net for the poor and the forty million unemployed.

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commanded by senior management, and insurance against overspending. Fraud is another significant and costly problem with a long history among some of the US healthcare businesses hovering to take on business in England. For example, the same UnitedHealth as mentioned above paid $2.9 million to settle accusations that it had charged the US Government for care to patients it falsely claimed were in nursing homes and has been involved in numbers of other scandals (p131). McKesson had to repay *'insurers and patients $350 million which it had overcharged them by manipulating the wholesale price of drugs (including drugs for cancer and other major illnesses)'* (p130-131). The authors point out that malpractice not only adds to the cost of health care, and thus lowers quality by reducing resources but also changes the culture of health care and licenses the kind of unethical behaviour displayed by Kaiser Permanente, an American HMO *'when it settled criminal charges for discharging a 63-year old patient and then dumping her on the street in a hospital gown and socks in a run-down area of Los Angeles'* (p131). Officials were said to be investigating a further 50 charges. The authors comment that while we might want to think it could not happen here, we have no factual basis to think otherwise – *'If we accept the conversion of the NHS into a market we should expect fraud and unethical behaviour to become as usual here as it is in the US. It could actually be worse, because England lacks a political and legal culture which could offer any serious check to it. Presumably health care providers are well aware of this.'* (p132).

Once healthcare providers can dictate what and how much healthcare is on offer (which they already do in parts of England), they can restrict it – for example, in the US, *'one doctor testified before the US Congress, HMSOs pay doctors doing this work a bonus related to the proportion of treatments denied.'* (p135) Not only this, but GPs themselves are being encouraged to become 'doctorpreneurs' through training by consultancies such as 'Diagnosis', which has several McKinsey-connected staff (www.theguardian.com/society/2011/nov/05/nhs-reforms-mckinsey-conflict-interest), and a quarter of GPs already had interests in health care companies at the time this book was being written. Under corporate interests, what chance is there that you will not be over or under treated (depending on your financial status), and that you will be referred for the best care for you, and that your doctor will be able to provide it?

The authors describe a three tier system for the future – a very basic service, a service requiring top ups from individuals at the point of care, and private services for the wealthy. *'In the long run it will give us something close to the most expensive and worst health system in the developed world, that of the USA ... For the private sector it will be the bonanza that its spokesmen have openly campaigned for.'* (p143).

The authors suggested that it will be up to us (the public) to fight for the NHS, but the public remains confused and divided. What needs to be understood is that: *'The choice is not between change or no change. It is between handing over a public service to be developed by private enterprise in the interests of shareholders, and ensuring that it develops in the interests of the public …'* (p149). The authors also claim that there is no evidence that a properly resourced NHS cannot change and finally, that *'good health care for all means excluding profit-making.'* (p154).

Nadine Edwards

NHS SOS – How the NHS was betrayed – and how we can save it

Jacky Davis and Raymond Tallis
Oneworld Publications 2013
Publisher's recommended price £8.99
ISBN: 978-1780743288

The final stage of the transition to privatise the NHS began on 27 March 2012 when the Health and Social Care Act passed into law. The book NHS SOS documents the evolution of the Health and Social Care Act 2012 and the process of privatisation of the NHS which began in the 1980s and culminated in the legislative and administrative means to destroy the right to universal tax funded healthcare in England. Its chapters include essays on the failure of the British Medical Association to successfully challenge the bill, politicians' close relationships with medical corporations and consultancy firms, the failure of the media to draw attention to the devastating effects of the bill, and sociological and political analysis of the wider context in which the bill was created and succeeded in becoming law. The two chapters I found most readable and informative are Allyson Pollock's 'From Cradle to Grave' which documents the creation and death of the NHS; and 'A Failure of Politics' by Charles West which provides a retired GPs story of campaigning against the bill from the inside of the Liberal Democrat party.

Why is this bill so important? First of all, it means that universal access and equality in healthcare are no longer required by law in England (p183). The Health and Social Care Act 2012 is pivotal in the privatisation of the NHS because it only requires the Secretary of State to promote a comprehensive health service. The Secretary of State now has no legal responsibility to *'provide or secure provision of services'* or to *'ensure that the health service should be free of charge except as expressly provided by legislation'*, as was stated in previous Acts (p146). These requirements were intentionally left out of the 2012 Act in order to change the NHS from a provider of services into a commissioner of health care from independent providers (including the private sector)(p133). Of particular interest to AIMS members should be that the Act also abolished the rule that required services and facilities for pregnant women, women who breastfeed, and services for children to be mandatory and provided free of charge. (p194).

The Health and Social Care Act 2012 was motivated primarily by commercial and corporate interests and did

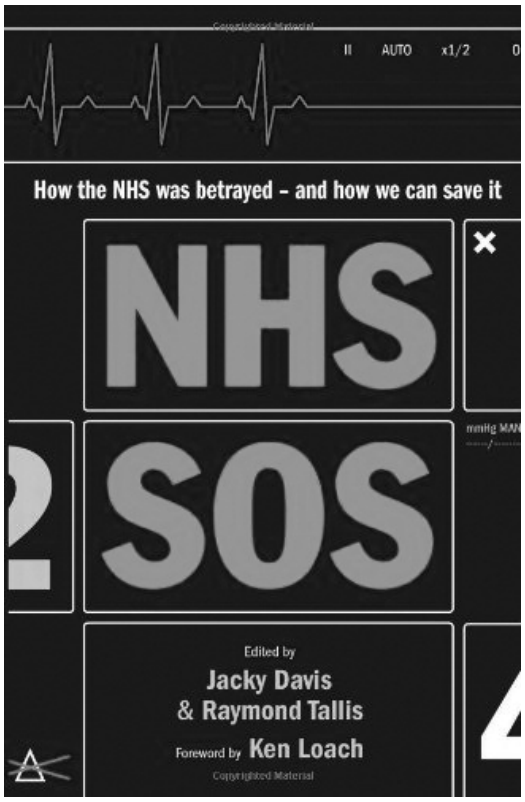
not have the support of health workers, royal colleges, or a party voted in by the majority or the public. How did this bill which bypassed legitimate government, was steeped in government corruption and collusion with private US healthcare companies and was drafted by politicians with huge conflicts of interest in private consultancy firms become reality? On 24 January 2012, twenty royal colleges (including the Royal College of Midwives) met with the BMA and RCN to draft a statement which declared, *'The Academy and medical royal colleges are not able to support the bill as it currently stands.'* (p105) However, when a draft of the joint statement was leaked, ministers warned colleges that *'they might lose their cherished charitable status if opposition became official.'* The result was that the colleges made no further public statement of opposition to the bill. Similar to the corruption seen in the government, colleges and professional organisations such as the British Medical Association were let down by their leadership who also had vested interests in the bill.

Disadvantages of private healthcare – increased patient choice? Or choice of patient?

'In the US, where the private sector delivers health care to the general population, the poor and those made poor by chronic illness, especially in old age, have been left to the government to care for, via the Medicaid programme – because they are not profitable patients. For this reason, the private sector could never be the solution to our country's health needs.' (p36)

In addition to explaining how the Health and Social Care Act 2012 came into being, NHS SOS also illustrates why private healthcare is not the answer to existing problems in the NHS. The NHS was founded on the principle that 'the poor, the chronically sick and the frail elderly would receive the best available care only if the rich received the same service' (p175). The Health and Social Care Act 2012 is in direct opposition to this principle since it *'repeals the law ensuring everyone, rich or poor, wherever they live, receives the same health care'* (p175). *'Markets and universal provision of care conflict because the private providers can choose the services they wish to provide and the patients for whom they provide them. A free market for health care does not result in "increased patient choice", but in "increased choice of patient".'* (p194) *'When political parties have promoted "patient choice" they have really been promoting "competition", in order to promote market over government control.'* (p183).

Economic theory says that the markets will keep things in check, but this is not reality, as illustrated in the American insurance industry which comes at a higher cost and creates more inequalities than a tax funded system. The comparison with the US health care system is particularly relevant because it is American health companies and consultancy firms which shaped the 2012 Health and Social Care Act to be favourable for these US companies. The bottom line is that private health care is more expensive to consumers and that the level and quality of care is driven by profits, not on individuals' needs. Instead, we need a system which is legally



accountable and driven by administrative controls rather than market forces and competition. (p179).

Already the Clinical Commissioning Groups (CCGs) who commission health care have been shown to be unaccountable either to Monitor, NHS England, or the Secretary of State. CCGs were intended as a way to increase GP involvement in decision making for local services. However this is not the reality either as soon CCGs will be required to be put to tender and therefore there is no guarantee that local people will be involved in decision making (p25). Individual members of CCGs not only have conflicts of interests and connections to private health care companies, they have the authority to decide what services patients can be charged for and to drop patients. Clinical Commissioning Groups are also not obligated to commission care based on geographic areas. Now legally, local authorities alone have a duty to provide for geographic populations and they also have the authority to charge for care. (p190,194)

When the market dictated incentive is on increased profits rather than patient needs, care providers start to 'cherry pick' healthy, profitable patients in order to minimise their financial risks. In 2011 Charles Alessi, a GP in south London, removed 48 elderly and disabled patients from his practice list 'primarily for financial reasons'. (p130) In addition, where US health companies are currently involved in private GP practices in the UK, GPs have to refer to a higher authority for referrals, and this higher authority has the power to reject the GP's referrals based on costs of care to the company. (p192) That private health care results in 'cherry picking' healthy patients is further illustrated in that *'nowhere in the world does the private sector voluntarily undertake services... which are not profit making such as emergency care, care for the chronic sick, health care for the elderly, unless they are*

generously rewarded for accepting those risks as part of a lucrative contract.' (p35-36).

Other disadvantages to private health care include *'conflicts of interest, fragmentation of care, the challenge of collaboration between competing providers, the destabilising of established services by competition from new providers, and the need for teaching, training and education.'* (p133) All of these issues are already familiar to those who campaign to improve NHS maternity services and privatisation of services will exacerbate these problems. In addition, the private sector has *'no obligation to supply or even collect information about their patient numbers or outcomes.'* (p138) Private providers or companies are not covered by the Freedom of Information Act and can block Freedom of Information Requests because of 'commercial sensitivity' of data (p143). This means information will become more difficult to obtain, including financial dealings and patient outcomes. It is already unclear where money is directed within the health care system and who is accountable to ensure government initiatives (such as increasing the number of midwives), and this will only get worse.

The next step – What you can do to change it

The Health and Social Care Act 2012 is currently law, but it can be overturned. Here is a list of ways you can take a stand to ensure that future generations in England have access to a universally accessible, tax funded health service.

Inform yourself about the changes to the NHS

Keep Our NHS Public – information about the campaign against privatisation: www.keepournhspublic.com.

NHS Support Federation – tracking changes in local services and finding out if tendering processes are transparent, reporting cuts and closures: www.nhscampaign.org.

38 Degrees – a site which connects those campaigning for change: http://www.38degrees.org.uk/.

Local Level

Write to MPs – a sample letter is available here: www.keepournhspublic.com/wycd-MPhelp.html.

Join your local Healthwatch and CCG consultation networks.

Draw the attention of Health Scrutiny and Oversight committees and Local Authority Health Overviews to cut backs and privatisation.

National Level

Spread the word – The Health and Social Care Act 2012 can be repealed without expensive or disruptive reorganisation.

Vote in the next election.

Virginia Hatton

Keep our NHS Public

People's march for the NHS

Jarrow to Trafalgar Square, London, 16 August – 6 September 2014

Following in the historic footsteps of the original Jarrow Crusade of a cold October 1936 morning we replicated the crusade. Our resolve just as strong as theirs. Our focus, to keep our NHS, guides us as we, the ordinary folk, march from Jarrow into London.

Keep up with the progress of the campaign at www.keepournhspublic.com and 999callfornhs.org.uk

My Airedale Midwife

An NHS midwifery caseloading initiative in Yorkshire

When mothers started voting with their feet and referring themselves to privately owned One to One Midwives, and campaigning for their individualised, caseloading services in Yorkshire, the NHS responded by setting up My Airedale Midwife (MAM) project.

On its website and through information leaflets, the scheme is described thus:

My Airedale Midwife is a pilot project providing a personalised midwifery service to women at Airedale starting in January 2014. MAM midwives are here to support

- *Women who choose to have their baby at home*
- *Women who choose a VBAC (Vaginal Birth After a Caesarean birth)*
- *Women under 20 years*
- *Women with complex social needs.*

My Airedale Midwives believe that the woman should be at the centre of her care. We believe that giving birth is a normal part of life and will provide continuity and support for you in your journey to motherhood making your experience positive and fulfilling.

Each MAM midwife will provide personal one-on-one care throughout your pregnancy, in labour and immediately following the birth while you are getting to know your baby.

We will help you make the decisions that are right for you using the latest evidence as a guide and we will support you in your choices.

We will be with you wherever you decide to have your baby whether at home, in our new birth centre or on the consultant led labour ward ensuring that you and your baby are safe at all times (www.facebook.com/myairedalemidwives).

The Bradford Telegraph and Argus featured the new practice, entitling its article Call the Midwife – and get the same one![1] It went on to say that, '*where requested, the midwife can accompany the person to clinics and provide all antenatal care.*

'Women who want a homebirth or who have had a previous caesarean section and wish to consider a vaginal birth, or have complex social needs, will be able to use the scheme.

'Claire Mathews, head of midwifery at Airedale NHS Foundation Trust, [now former Head of Midwifery] *said: "The MAM project recognises that for some women, having one midwife they can get to know and trust can make a huge difference to how they cope with their pregnancy, labour and the birth of their baby."*

The MAM team will also provide hypnotherapy classes in the community.

Professor Lesley Page, president of the Royal College of Midwives said, 'Expectant women can benefit from the continuity of care they will receive from the MAM project, which can mean less intervention during the birth.

'The trust and the midwifery team should be congratulated for this enhancement to their maternity service.'

New mum Katrina Smith told AIMS:

'I joined the MAM team following my previous emergency section back in 2010 after my induction stopped at 8½ cm. I was determined to have a natural delivery this second pregnancy but seen as both my pregnancies are through ICSI/IVF I was consultant-led from the start. The consultant advised me it would be best to have another section as there were too many risks involving my uterus rupturing. Once I met the MAM team they gave me all the information involving the risk and I decided against another section. I have also been on the hypnobirthing class that the MAM team offered for free which was a fantastic course and was very helpful for my delivery. I am so pleased with the service from MAM team and also so pleased to have a midwife I can contact via a phone call or even a text and get a response back. So we did eventually end up having a natural delivery. I used my hypnobirthing CDs and Caroline Allen came and supported both me and my husband from the start until delivery. I did end up having to be cut and I did loose some blood but I did it all on just gas and air. I had a beautiful daughter Isla Keziah Joy who weighed 9lb 11oz so not on the small side. I have had continuous support from Caroline even after delivery. I can not recommend the team more and feel that every woman out there should have the same service.'

Isla Keziah Joy Smith

Local childbirth groups and activists are concerned that this is a pilot project and that these kinds of projects often come to an end after the time alloted to them. This can be due to funding not being made available, key people leaving and other reasons. They also point out that only 10% of women are served by this project, but that all birthing women want and would benefit from this type of midwifery care, and that caseloading care was guaranteed by the CCG in Airedale by the first half of 2015. We hope that caseloading will become the norm and that it will be extended to all women in Airedale and elsewhere. We await further developments.

References

1. www.thetelegraphandargus.co.uk/news/local/localbrad/11021423.Thank_you_MAM_for_new_Airedale_midwife_care_scheme/)

Funding AIMS

AIMS has just become a Charity so please watch out for notices as we explore new ways of raising money. Please remember that AIMS has no paid staff – our committee and volunteers give their time freely. All monies raised go towards providing women with support and information.

How you can help AIMS

If you are not already a Member you could join.

The benefits of Membership include four AIMS Journals a year – these provide valuable updates and information including research on childbirth and related issues. Authors of articles are from a wide range of backgrounds and countries, giving their insights, views and experiences.

visit www.aims.org.uk

As a member you will be given access to the AIMS Members Yahoo Group. You will be able to stay in touch and have more of a say in what AIMS is doing. You will receive updates from committee meetings, early notice of events such as AIMS talks, as well as being able to contribute to discussions of current issues.

Join at health.groups.yahoo.com/group/aimsukmembers or email egroup@aims.org.uk

If all our Members just encouraged one other person to join we would double our membership and income!

If you do not already have our range of AIMS Publications you could buy them.

Are you sure you have the up-to-date version?

Our publications cover all main aspects of pregnancy, including second and third stages, breech, vaginal birth after caesarean (VBAC) and inducing labour. There are publications helping you to plan the birth you want – the best selling Am I Allowed? and What's Right for Me? – others cover the safety of childbirth, ultrasound and Vitamin K. There is also one for helping you to make a complaint about your care. We sell other authors' books on Home Birth.

Most of the publications are on Kindle – don't worry if you don't have a Kindle, they can also be read on other devices.

We are always adding to our collection of publications and books so visit our website for up-to-date information and catch the latest special offers for discounted bundles of books.

If you are a member and you have all our publications…

Please think about fundraising for us or donating. Now that we are a charity we can benefit even more from your efforts. Other people have done sponsored cycle rides or sold our publications at conferences. If you come up with an innovative fundraising event please let us know! We may be able to offer small raffle prizes.

A really easy way for everyone to help AIMS is to order your Christmas cards or notelets from our website www.aims.org.uk and consider giving the new canvas bag or mugs for presents.

A big thank you, whatever you can do!