We support all maternity service users to navigate the system as it exists, and campaign for a system which truly meets the needs of all

Submission from AIMS to the Health and Social Care Committee's Expert Panel conducting an evaluation of the Government's commitments in the area of maternity services in England

1. Since 1960, AIMS has been a leading advocate for improvements in UK maternity care. We have national and international links and a membership of lay people, doulas, antenatal educators, midwives, health visitors and obstetricians. Collectively, our volunteers have decades of experience researching, advocating and campaigning for improvements in UK maternity care. Importantly, we also support women directly to navigate the maternity system. We use our knowledge, influence and experience to instigate policy change at local and national level. We run an email and telephone Helpline which provided support to more than 600 maternity services users over the last year. We also have a large network via our volunteers and members, who engage with mothers, health care providers and others on social media and at meetings. We provide information on our website and in a series of books. This information is produced to help women to make informed decisions about their care, and to challenge misinformation.

2. We welcome this initiative to offer a detailed and independent evaluation of the Government's commitments in the area of maternity services, although we are disappointed that this exercise is necessary. This is because we would prefer to see the Government itself (a) being clear about outstanding maternity policy commitments and (b) producing regular evaluations of its progress in implementing those commitments, and updating their implementation plans (evaluations and plans which might then be subject to external comment and scrutiny). Such transparency and accountability should be at the core of Departmental work processes. We would therefore hope that a key recommendation of this current exercise is to impress upon Ministers the importance of putting in place a more robust reporting and evaluation process.

3. It is the experience of AIMS that there has been a persistent lack of clarity in the area of maternity service commitments, with an absence of monitoring and evaluation frameworks and a disappointing lack of transparency about how much progress is being made at either local or national level. For those working to implement Government policy commitments, proper monitoring and evaluation supports an implementation programme that is sufficiently dynamic and responsive to meet the challenges that inevitably arise. Transparency also works to reassure the public and maternity services users that a robust and cost-effective roll-out is underway and ensures that the end result is not a postcode lottery.

4. We understand the desire of the Committee to evaluate progress against just a small number of maternity service policy commitments. AIMS would like to flag the dangers, however, of such a narrow focus: we suggest that this exercise must be undertaken with caution, with an accompanying careful analysis and

understanding of the possible impact of these commitments on the maternity system as a whole. The risk of unintended consequences is real: it is crucial, when seeking to improve certain safety-related outcomes in maternity that we do not unintentionally work to produce a worsening of other safety-related outcomes. On this point, we would refer the Panel to our evidence to the Health and Social Care Committee Inquiry: Safety of maternity services in England (www.aims.org.uk/campaigning/item/safety-of-maternity-services-in-england), and in particular our insistence that a broad definition of maternity safety must be considered, where "[w]e encourage[d] th[at] inquiry to take a holistic view of the meaning of safety … and to focus on a broad set of safety indicators. By this we mean in addition to focusing on reducing the risk of short-term physical - and on occasion fatal - harm to mothers and babies, it is also important to focus on reducing damage to the long-term well-being of mothers, babies and the wider family, including their mental health." In our experience, many well-intentioned changes in the maternity service have had unintended negative consequences, and we argue that this is due to changes being promoted without such a holistic view. Here, we would suggest that the Government commits to seeing improvements in a holistic measure of maternity service activity, such as the one set out in the Better Births vision. This is a broadly-based descriptor of maternity service quality, and ought to be utilised. Whilst we appreciate that it will be hard to assess the progress of individual Trusts against this vision, we believe that fit for purpose feedback tools could - and should - be developed to do so; in some cases, these could draw on information already collected via existing data collection processes, but care must be taken, if so, to ensure that these are sufficiently tailored to this question.

5. We will now comment on each of the selected policy commitments in turn, taking into account the four key questions posed by the Panel's evaluation process:

    - Was the commitment met or is it on track to be met?
    - Was the commitment effectively funded?
    - Did the commitment achieve a positive impact for patients?
    - Was the commitment appropriate?

6. The first policy commitment under scrutiny is the 'halve it' ambition: **1. By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.** In this case, the systems to collect data at national and Trust level have been put in place. In addition, the work of the MBRRACE and Each Baby Counts initiatives has enabled the development of a better understanding of key issues which impact these outcomes.

7. However, as the evaluation of the Saving Babies Lives Care Bundle found, the measures implemented in order to achieve these outcomes have had unintended consequences, in this case a significant increase in the number of maternity service users experiencing interventions such as induction of labour. These can have consequences for the physical and mental wellbeing of both mothers and babies in the short and long-term, which are seldom considered in any evaluation. As we commented above (paragraph 4), this is why it is so important to take a holistic rather than a narrow view of the effects of actions undertaken with the laudable aim of reducing perinatal and maternal mortality. AIMS is also concerned that care bundles and strategies can often mean that service users are expected to go along with a care plan which is not acceptable to them, leading to cases of coercion and failure to obtain informed consent. Not only does this potentially lead to an increase in birth trauma, but may leave Trusts open to litigation.

8. The second policy commitment is focussed on the ambition to implement a relational model of maternity care: **2. The majority of women will benefit from the 'continuity of carer' model by 2021, starting with**

20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.

9. AIMS believe that the key focus of this commitment is entirely appropriate: the shift to a relational model of maternity care has been called for over many years, across the healthcare sector the way in which such an approach underpins safety is increasingly evident. AIMS is keen for the maternity services to play their part in addressing persistent health disparities. AIMS is therefore pleased to support the second part of this commitment, which we believe appropriately guides the sequencing of an eventual universal offer.

10. AIMS believes that this transformation is key to a resilient and safe maternity service. We would question, however, some of the detail of the commitment:

    - the use of the term 'majority' is particularly problematic, leading as it has to an interpretation across the NHS that an end goal of offering this model of care to 51% of women is sufficient. This is disappointing and not, we believe, in line with the original policy intention: it would be preferable to make clear that this commitment extends, over time, to offering this model of care to all women.

    - we are concerned, in the absence of widespread agreement about the meaning of "a 'continuity of carer' model of care", that the commitment does not sufficiently communicate expectations around minimum care model design requirements.

    - we are also concerned about the lack of clarity of the measure of 'placing women on a continuity of care pathway'. It is not clear to us that there is a simple correlation between this 'placement' and women actually receiving Continuity of Carer in any meaningful sense throughout the perinatal period.

11. The Long Term Plan helpfully makes clear that the intention is to provide relational care, with the majority of care throughout pregnancy, labour and birth and the postnatal period being provided by a known and trusted midwife. In that context, the team is conceptualised as back-up to this core intention. In many areas, however, it appears that the 'continuity' model is understood as allowing care (especially in labour) to be provided by any one of a team of up eight midwives.Whilst this may well represent, in many areas, an improvement over the current standard model of care, AIMS does not believe that this approach will deliver the expected policy benefits. In addition, the metrics against which progress is being measured do not take into account the need for continuity of the multidisciplinary team beyond the named midwife: for many women, for example, continuity of obstetric care may be equally important.

12. In terms of whether this policy commitment was met or is on track to be met, we note that the implementation is ongoing and that we have poor information against which to judge progress and the likely trajectory of progress. As a member of the Stakeholder Council AIMS has repeatedly asked for transparency around implementation progress regarding the roll-out of the Continuity of Carer model of care, but this has not been forthcoming, with publicly available data lagging significantly (and subject to data quality issues) and in any case not offering a robust insight into the quality of implementation. Anecdotal evidence from our own sources suggests that progress around the country is extremely patchy, and not always targeted at those most in need. Nor have we seen any evidence to suggest that there is any means of assessing, and reporting on, the quality of local implementation from the maternity service user's perspective. It would be very helpful to know what regular information Ministers are receiving to enable them to monitor progress against this policy commitment, and suggest that this data should be publicly accessible.

13. Anecdotal evidence including calls to the AIMS Helpline give us cause to think that the impact of COVID-19 has also been variable. While some Trusts clearly made efforts to maintain their commitment to maternity improvement strategies such as Continuity of Carer during the pandemic, and have strengthened their implementation planning and rollout strategies, others seem to have stopped or delayed work on Continuity of Carer implementation.

14. Regarding the quality of implementation, and based on our understanding of the Better Births policy, AIMS has shared a definition of how a well-implemented model of relational care (Continuity of Carer) should feel to the maternity service user. This can be found on our website: www.aims.org.uk/campaigning/item/implementingbetterbirthscontinuityofcarer. We would like to see this considered as a tool for assessing the quality of provision, in line with the vision set out in Better Births.

15. The third policy commitment being evaluated focuses on safe staffing. **3. Safe staffing – "Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm."** The Government commitment to ensure that the maternity services have the resources they need to offer safe and effective maternity care to every maternity service user, which includes - importantly - the right mix of a multi-disciplinary staff, is extremely important. This is an issue which goes across all other maternity policy commitments. For many years, there has been the suggestion, put forward by the Royal College of Midwives amongst others, that, in many areas of England, maternity services are regularly understaffed. In recent years, some compelling maternity staff testimonies have been offered, which vividly describe the impact of understaffing on maternity service outcomes and on the wellbeing of service users and their families. Unsafe staffing has a direct impact on the ability of that service to offer safe care resulting in clear patient harm. It also impacts on the ability of Trusts to deliver effective training, to build strong teams and to ensure staff wellbeing. Staff wellbeing is well accepted to be closely linked to staff retention thus setting up a vicious circle. AIMS believes that it is time for this issue to be subject to proper scrutiny, and for the Government to make clear its commitment on this issue: it is no longer good enough for Trust Boards to be left to self-certify that they have adequate maternity staffing in place, when safety incident reviews and staff surveys regularly suggest the opposite. If the panel achieves one thing in undertaking the current evaluation, then we would suggest it is this: to underline the importance of a properly resourced maternity service to underpin improvement across a range of areas and to guide Ministers on a robust process needed to create a specific and realistic policy commitment on this key issue.

16. The fourth and final policy commitment is concerned with the vitally important issue of personalised care, which was central to the findings of Better Births, with a recommendation for "Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information". **4. All women to have a personalised care and support plan by 2021.** We are not aware of any formal local or national monitoring of progress against this commitment. We also note that the national guidance to underpin local activity in this area was not issued until March 2021, a full five years after the publication of Better Births. Calls to the AIMS Helpline allow us to say with certainty that many women still do not have personalised care, but are instead increasingly being expected to conform to standard hospital procedures. Others are being bullied into agreeing to plans that they are not happy with. Support and consideration for perinatal mental health issues or even recognition of these issues is often lacking.

AIMS Campaigns Team, 10 May 2021