



Dear Baroness Cumberlege

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Andy Beckingham writes to the Maternity Review Team

Dear Baroness Cumberlege and the Maternity Review Team,

I write to you as a Consultant in Public Health with a particular interest in maternal health in the UK (and also in low-income countries). Over some years I have studied the wider maternal health, and particularly the approaches that might prioritise women's choice and satisfaction ahead of professional preferences and the medicalisation of childbirth.

I would firstly like to support the request by birthrights UK - who I know have also written to you - to make the fundamental principles of respectful care a priority in your investigation of maternity services. All the national and international evidence I have studied in order to design maternity care programmes and to assist with maternal death reduction in India points to the conclusion that care quality improvement and the achievement of good satisfaction rates and low unnecessary intervention rates will only be achieved if women's preferences and respectful care are placed at the centre of all care planning. In the UK, they are not. Absolutely not. They are often paid lip-service, while managers and obstetricians determine priorities, which are more about 'risk management' instead, and which have resulted in the largely unnecessary medicalisation of birth in the UK. This has been an especially sad thing for me, working in low income countries, where I would have liked to recommend a UK approach to maternity care. Instead I have only been able to recommend a few limited UK models that had managed to resist NHS bureaucratisation, or independent midwifery services' approaches.

The first Cumberlege report back in the 1990s was hugely well-received. Unfortunately it was then largely undermined by authoritarian NHS management driven from the centre to implement a 'performance culture' that has squeezed sensitivity, listening, and choices for women into the margins. I have seen it replace the first Cumberlege report's emphasis on sensitive care, with performance targets instead, and with hostile work environments that made sensitive care an 'extra' when occasionally possible. This has sadly been reinforced by many obstetricians. As a consultant I would normally use less emotive language. But in this case, the erosion of the best aspirations of midwives by an NHS management culture over many years makes me think it is best to simply state what a dreadful thing has befallen maternity services, stifling many of their efforts to improve care.

Over two decades we have seen maternity care become a punishing work environment, where midwives often don't want to work. We have also seen 'choice' become a token set of Trust PR statements that are

meaningless when women say they want more natural birth and home birth, only to be told that those aren't available, or that the professionals know what's best for women, and sadly, sometimes blackmail about 'what's best for your baby'. Many midwives now choose not to work in the NHS because they can't provide woman-centred care there. This tends to drain the NHS of staff who want to provide woman-centred care. Their loss to the NHS will allow the culture of not listening to and not addressing the concerns of women, to go even more unchallenged, especially with a top-down belief that those who work in maternity care should dictate how maternity services are delivered and planned. Birth centres may have been one environment that has been more resistant to corrosion by bureaucracy, and might be studied as a useful model.

Since the really positive and welcome recommendations of the first Cumberlege report were largely undermined by an NHS management system and clinicians who believed they knew much better than women, I would like to recommend that this new Maternity Review anticipates that the same could happen again, and takes steps to resist and mitigate that in your recommendations. Secondly, however, I would like to propose an excellent alternative to the prevailing NHS model for maternity care. A 'gold standard' for maternity care already exists in the UK. I would like to recommend that your maternity review considers how the Albany model - once widely applauded, but now closed by bureaucrats - might be proposed as a new way of working that could be built upon, expanded, and might ultimately replace the current NHS model in some geographical areas. Women and midwives living in those areas might be consulted about whether they would like (a) the standard NHS service or (b) a community-based service based on the Albany model. This would, for once, offer women real choice. The Albany was a maternity service that provided woman-centred maternity care in South East London.

Their good outcomes far exceeded anything I have seen achieved by other services. Their episiotomy rates were probably the lowest seen anywhere. Women who wanted home births had home births, and in very large numbers.

Satisfaction among the women whose maternity care was provided by the Albany was astonishingly high. Care safety was very high, despite misguided attempts by unaccountable individuals to discredit them. At the same time, and most remarkably, these outcomes were achieved among a very disadvantaged population, having an important countering impact on health inequalities. This model is now well-known around the world as the 'gold standard' internationally, not just for the UK. It is important to also point out that the Albany service operated without the cumbersome and punitive NHS-style management system. Staff were happy to work there. Unlike many maternity services in the NHS, they had top-class staff retention rates. This could well offer your Maternity Review an alternative model to recommend for the wider provision of maternity care across the UK. It could be NHS-funded, but use its own much more benign management approach, focusing primarily on choice for women. Just like the original Albany model in London, it could be contracted by the NHS, without fears about privatisation, since it is a 'public interest' model too.

When in 2011 I designed the pilot education and training programme for India's first 'UK-style'

midwifery service, I drew on the Albany model for its basis. We couldn't have been more fortunate in our recruitment of Becky Reed, ex-Albany Centre, to come out to South India to provide the core midwifery ethos and model, by mentoring our trainees. Becky's Albany model became the main principles that our trainee midwives put into practice. Four years on, these midwives - who are now qualified - manage the majority of intrapartum care for women with low-risk pregnancies for one of India's most influential and high-quality maternity hospitals. Under this ethos, inspired by the original Albany ethos, women are encouraged to make choices about their care in labour and childbirth, and - unlike what often happens in the NHS - these choices are honoured, and helped to happen.

Breastfeeding rates within the first hour of birth reached almost 100% following Becky's intervention. A qualitative study has shown that these midwives in India have all retained the 'Albany' principles of woman-centred care and choice for women. A second recent study shows extremely high satisfaction rates among the women they assisted in childbirth. A third study shows that intervention rates are much lower, and perineal integrity rates higher, than among women attended by doctors. The safety rates were extremely high. And just like in Peckham where the Albany originally operated, these women in India include many very disadvantaged women.

With not a single maternal death among 3000 births. Although we have not yet subjected this 'international transplant' of the Albany model to a randomised controlled trial, it does seem very clear that this 'gold standard' Albany model has huge potential to transform maternity care into woman-centred care that offers choice for women. In India, this adaptation of the Albany model holds enormous potential to radically improve maternity care and reduce morbidity and mortality. I thus recommend it to your Review to propose it as a serious alternative to more mainstream, and far less successful models in the UK.

On this basis, when you are formulating your recommendations and planning to put UK-wide improvements into practice, may I also suggest that you engage Becky Reed in leading some of the practical development of national midwifery improvement.

Finally, I would like to recommend that a better regulatory approach to maternity care that fosters woman-centred care instead of persecuting it, is seriously needed in the UK. Might a more effective regulatory body replace the Nursing and midwifery Council? May I suggest that you consider recommending its replacement with a slimmed-down - and accountable - version of regulation that would focus on promoting good quality womancentred care and choice for women instead?

Sincerely,

Andy Beckingham

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