AIMS For a better birth...

Implementing Better Births: The Long View

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By Margaret Jowitt



We have the late Audrey Wise MP (1932-2000) to thank for the notion that in order to improve maternity services *it would be useful to ask the users what they wanted.* In the context of her work on the Health Select Committee, which led to the Winterton Report (House of Commons Health Committee, 1992), it was Audrey who suggested that, rather than listening only to the so-called experts, the committee should also listen to service users. Audrey's inspiration may have been Jane Lewis who, in the Politics of Maternity Care (1990)[4], wrote that:

"…there has always been a gap between the perceptions and demands of women in respect to maternity policies and practices, and what has been offered by policy-makers and professionals."

All previous enquiries had listened to 'the experts', i.e. obstetricians who overwhelmingly wanted women to give birth under their own expert care. The real experts in normal birth at that time were, of course, the community midwives, and thanks to Audrey Wise, the work leading up to the Winterton Report gave them the chance to share their expertise.

After listening to women and other stakeholders, such as the RCM, the NCT, AIMS and the ARM, the 1992 Winterton Report[3] was thus produced by the Health Select Committee of the Houses of Parliament. It had three main themes: the importance of continuity of care, the importance of offering women choice of provider of care and place of delivery, and the importance of the rights of women to have control over their own bodies at all stages of pregnancy and birth.

Moreover, it was stated in that report that "…the policy of encouraging all women to give birth in hospital can no longer be justified on the grounds of safety … it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions". The Association of Radical Midwives (2013) was justifiably proud of the praise for its own blueprint in this context. First published in 1986, ARM's Vision for the future of maternity care statement was updated in 2013[1], with copies given to everyone involved in the review which led to Better Births.

In response to the Winterton Report, the paternalistic conservative government of the day did not much like the idea of women having a say in their maternity care; it thus set up its own Expert Maternity Group under the chairmanship of Baroness Julia Cumberlege. However, the findings were much the same, in particular about the importance of choice for women. Baroness Cumberlege was passionate about listening to women and we now understand that she tried her very best to get the phrase 'continuity of carer' into her final report, Changing Childbirth (Department of Health, 1993)[2], but was stymied by the Department of Health who thought it a step too far for a woman to have her own midwife. The Expert Maternity Group did manage to incorporate a suggestion that all women should have a 'named midwife', but when I was doing my research into women's experience of birth in the early 1990s I understood how hollowly this principle had been translated into practice in some areas, when an antenatal clinic proudly proclaimed to all attendees: 'Your named midwife is Sister …".

The problem for the Establishment is that if you allow women to support each other – midwives to support women and women to support midwives – they might well gang up together against the System, declining interventions that are deemed necessary!

Changing Childbirth remained official policy right up until the publication of Better Births (NHS England 2016)[5], this latest maternity review. But, as always, getting from paper to practice was the challenge. At the beginning, things looked to be going well. Shortly after Changing Childbirth was published, the Changing Childbirth Implementation Team was given 'pump priming' money and set about helping services in various locations to test different models of care. Various schemes were trialed around the country, most involving team midwifery where teams of midwives shared a 'caseload' of women. There

were ten indicators of successful implementation, among them: women carrying their own notes; the concept of a named midwife; 30% of women having a midwife as lead professional; midwives having direct access to maternity beds (i.e. midwives as well as GPs would now be able to book a hospital bed for the birth); and equipping ambulances with staff to support transfer to hospital in an emergency. It was also established that at least 75% of women should know the person caring for them during their delivery.

Passionate midwives put their all into making it work. Pilot studies showed excellent outcomes and increased satisfaction for mothers, but the schemes were not rolled out across the entire service. Many were sabotaged by caseloads being increased to the point where midwives suffered burn out. Moreover, despite increasing workloads, the team midwives were often pulled into obstetric units when these units were short-staffed. Another common pretext for closing schemes was that services were 'inequitable'. It was simply not fair, the feeling went, that some women could have continuity of care while others only had access to the traditional provision. The answer to this conundrum was not to improve care for all women by expanding continuity of care schemes (as would seem to be the obvious solution) but to close those services which women preferred and valued.

Another of the success indicators of Changing Childbirth was that antenatal and postnatal provision for women with uncomplicated pregnancies should be reviewed. Women should receive the care they needed rather than services strictly adhering to the age-old schedules for universal antenatal and postnatal visits. The UKCC, the predecessor of the NMC, made the necessary changes to the Midwives Rules. Midwifery leader Mary Cronk warned us of the dangers of abandoning these schedules, and her predictions came true, much to the detriment of women and their midwives. A daily visit for ten days after the birth now seems like unheard of luxury and yet, having so little experience of caring for babies, many women need this now more than ever, and this is perhaps borne out by the rising number of women seeking to access such support (where they can afford to do so) from the growing birth doula sector. As community midwifery services were cut, this had a knock-on effect on the logistics of providing domino care and of enabling women to give birth at home. The changing ratios of community midwives to hospital midwives also meant that there could be fewer student placements in community midwifery. Staffing labour wards always took precedence over a planned home birth. Hospital needs trumped individual women's needs. Another adverse effect of Changing Childbirth was the exit of GPs from maternity care. The old GP units morphed into midwife-led units, and now that they had no doctors to champion them, it was up to midwives to keep these birth centres open. Birth centres struggled to survive in that context and were often replaced by alongside midwifery units, which again suffered as staffing the labour ward was prioritised. On the other hand, GPs no longer needed to fear being called out to a difficult birth. Transfer to hospital now became the standard response to difficulties in labour or after the birth.

The only Changing Childbirth scheme to survive well into the 21st century was the Albany practice, and the other King's midwifery team. The Albany was funded separately from the rest of the maternity service, with the money for the service being managed by the group itself; hence, its midwives were not managed by the Trust and could not be redeployed at will. Even the Albany was eventually closed with

indecent haste, however, following a contrived audit after its champion at King's College Hospital, Cathy Warwick, moved on to become General Secretary of the Royal College of Midwives.

However, Changing Childbirth did endorse and insist upon the notion of choice, and the revolutionary concept that the woman should be at the centre of her care.

Meanwhile, there have been enormous pressures in the opposite direction to the Changing Childbirth agenda. Litigation costs, for example, had started to rise exponentially, and professional indemnity insurance (PPI) for obstetricians was becoming unaffordable. In 1995, therefore, the Clinical Negligence Scheme for Trusts (CNST) was established. The newly formed hospital trusts, who were funding the CNST, became paranoid about keeping their premiums under control. The way to do this, they believed, was to exert ever more control over birth, which meant more control over women and midwives. This again had the effect of derailing Changing Childbirth. Although 30% of women were supposed to have a midwife as their lead maternity professional, for example, more and more women were 'risked out' of midwifery care. The newly acquired choices in childbirth were now often denied on the grounds of safety.

Looking forward in the context of Better Births: how can we avoid a repeat failure to implement?

In my view, the real battle is for the control of women, both mothers and midwives. Women are controlled in many ways, for example through the control of the time and place of their care. Putting expectant mothers in hospital at set times for consultant appointments, clinics and induction of labour, gives the hospital system control over them, rather than allowing for the healthy physiological process itself to be in control. The hospital sets limits in time and space so that it is able to plan its services for predictable events and prefers to plan its work over the normal working week. Whilst this is an understandable method of management, it is important to understand the inappropriateness of this method of control in the context of childbirth. Midwives are controlled in the same way: keeping them under surveillance by employing them in a set place at set times. This particular form of control has created a huge barrier to change: it is no co-incidence now that one of the greatest challenges of Better Births is how we encourage many midwives now used to a three 12hr days per week working pattern- to realise the importance of working in a more responsive and flexible way, to meet the needs of birthing women. Control over midwives is also exerted by threats of referral to the NMC and, unfortunately, by peer pressure. Anecdotal evidence suggests that male doctors tend to support each other against bullying management behaviour, whereas women are more susceptible to peer pressure, be they doctor or midwife.

For me, the key to a better birth is to acknowledge that quality maternity care is based around the human relationship between the mother and her midwife, encapsulated in Better Births by the key recommendation to shift to a continuity of carer model of care for most women. NHS England want to see this in operation by 2021. But what is clear is that it will be even more difficult to implement this crucial element of Better Births now than it might have been in the 1990s. Midwives have become used to fewer longer shifts, and many prefer, or have at least planned their lives around, working this way. It may be easier for them to arrange childcare with this working pattern. There are fewer 'on-call'

arrangements, which seem to be hated by many midwives. Some London hospitals rely on midwives who commute vast distances to work their three days a week because housing is so expensive in the capital. These are all explanatory factors in the difficulty in now switching to models of care that demand a certain amount of on-call working.

In order to encourage midwives to work in a different way, so that they can forge relationships with women, midwives need to have control over their diaries: when and where they do their visits, how they fit their mothers in around their own family lives. Hospital managers will hate this loss of control and CNST may well suggest that they cannot properly calculate indemnity for midwives without set hours of working. Other midwives may find it challenging to give up the certainty of shift work.

If, however, we really want to improve birth, then we need to trust our midwives! If the trusts look after their midwives, the midwives will look after the women, and the women will be in far better physical and psychological shape to look after their babies. In the end, it comes down to women, midwives and other stakeholders being united and working together for the transformational change in the maternity services set out in Better Births. Let's work on this together!

Margaret Jowitt *has been working towards making birth a safer and more rewarding experience for mothers and their babies since 1991. In 1998, Margaret gained an MPhil for her research into Mothers' Experience of Birth at Home and in Hospital. Margaret is a published author, a birth-chair designer and a past editor of Midwifery Matters, the magazine of the Association of Radical Midwives.*

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