AIMS For a better birth...

Implementing Better Births: What's the chance of Better Births?

To read or download this Journal in a magazine format on ISSUU, please clickhere

AIMS Journal, 2018, Vol 30 No 2

By Mary Newburn



It's just over two years since *Better Births*[1] was published. Yet as many of us were part of engagement events and submitted evidence throughout 2015, by 2016, it already felt as though we'd been talking about some of the important game changers for many months. Not to mention that there had been previous policy commitments about woman-centred care since the early 1990s and the 'choice guarantee' since 20072. But the latest, hoped-for, revolution - or *transformation* process - is really still only just beginning.

The *Better Births* vision for maternity, referred to as a 'five year forward view', has been developed alongside five-year plans for other health services. The idea has been to fundamentally change the way that health services function and contribute to improved quality of life for individuals, and therefore better health for the whole population. This will be achieved by planning comprehensively across 44 Sustainability and Transformation Partnerships; geographical footprints widely referred to by NHS managers as STPs. But the vision is still in the minds of the few, and needs to reach and be adopted by many before services really *feel* different in the far-flung boroughs and counties the length and breadth of England. (NB – Scotland, Northern Ireland and Wales have similar ambitions, some more developed, and some less so.)

Better Births in context: the NHS Five year forward view

The vision for maternity transformation is one part of a broader understanding of 21st century health and health service challenges, and identified solutions.

As people live longer health needs become greater and more complex. As medical technologies develop, the costs of delivering healthcare and demands on the NHS grow. How can more be delivered to people, for more years, without the bill shooting higher than can be afforded? Generally there has been an improvement in health generation to generation, thanks in part to improved standards of living and the success of public health programmes. But other changes- such as the commercialisation of highly processed and 'fast' food, linked to rising rates of obesity, more sedentary lifestyles, a recent resurgence of poverty and inequality, and high rates of mental health problems- mean there remain huge health challenges. Some might argue that the expectations of service users are higher. In maternity services, however, the needs of women often seem to be overlooked, despite positive stated ambitions.

There is a widespread view shared by policy makers, healthcare professionals and activists that services should be clinically effective, humane, respectful, involving and empowering. Yet, there is often tension between a medically-focused risk-reduction approach and a social model of care focusing on addressing mind/body and women's autonomy issues more holistically. As a society, people tend to complain more (and take legal action). As Kennedy said:

> *"The public are no longer prepared to be passive, trusting and grateful recipients of what is made available. They are no longer prepared to hope that their views will be fully reflected by the professionals. …That is not a criticism of professionals; it is just a reflection of the way the world has changed."*[3]

Social media and newspaper reporting does influence thinking. And some voices may be louder or more effective in gaining traction – including attracting the Health Minister's attention - than others.

Women and childbirth organisations like AIMS and NCT have been influential in maternity developments in the past. We need to continue to work to ensure that women have an effective voice today and in the future, too.

The bigger picture

In principle, at a high level of planning, many health service researchers, academic clinicians and policymakers agree that the aim is to:

- Develop a systems approach to service delivery, with networks of care;
- Provide more care away from (expensive) hospitals in local communities and at home;
- Integrate acute and community services better, connecting up health and social care, and addressing physical and mental health needs so the services are more holistic with fewer gaps;

- Focus on prevention and wellbeing, creating a real 'health service' that is not just about fixing illness;
- Promote public health (more favoured by the political left) and personal agency, so that people create their own health and sustain it (more favoured by the political right);
- Integrate services around service users;
- Research experience and measuring impact on 'outcomes', so that there is proper feedback to inform future planning.

This 'bigger picture' should work well, of course, for improved maternity services. Understanding that our work fits neatly within this context, therefore, can be a lever for change for activists.

Collaboration - the key to implementing the Maternity Transformation Programme

The Maternity Transformation Programme's top line message is to both improve safety and make services more personalised. These two objectives can be unified or be in conflict with each other. As activists, we need to focus on 'win/wins' and constantly be talking 'both/and'. This is particularly important as we seek to develop broad alliances amongst the service-user community and make progress across a range of maternity improvement objectives. For example, taking an 'improve postnatal care' focus we need to BOTH improve support for breastfeeding women AND make sure that all women feel supported in caring for and feeding their baby. Thinking about pregnancy and birth, we need to BOTH introduce and sustain services and behaviours that enable physiological or 'normal' birth AND support women in making their personal choices. The push to reduce the number of stillbirths, has led to more and more women being 'offered' induction of labour at 40 weeks or as early as 38 weeks. But when does sharing evidence-based information (in this case, about the very small but real risk of stillbirth at term and beyond) become anxiety-provoking and undermining, or even coercive? Much work still needs to be done to explore this, with formal audit and research, including qualitative research and listening activities with women and families to learn from their feedback.

A few measures are so important that we all need to work to make them mainstream in NHS maternity services. Continuity of midwifery carer is one of these, and I am delighted to see that it remains at the heart of AIMS campaigning efforts. This BOTH reduces adverse outcomes AND it is reasonable to believe that the relationship enables women to feel more in control, better informed and respected. The Cochrane review of midwife-led continuity models[4] says that in addition to many clinical benefits, including significantly fewer baby deaths, women are 'more satisfied with their care' (Sandall et al, 2016).

A top priority for me is for more women to give birth in midwifery settings (at home, and in midwife led units), because women have been telling us for decades that access to giving birth in these environments makes a significant positive difference for them and their families. And we now have high quality comparative evidence on the benefits and drawbacks of planning for birth in different settings, which underpins the NICE Intrapartum care guideline CG190[5]. This issue is included in the NHS England 2018 Programme Update summary of priorities (below).

Maternity Transformation Programme – Our Aims

By working together nationally, regionally and locally we will transform maternity services so that by March 2021:

• We have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2025.

• All pregnant women have a personalised care plan.

• All women are able to make choices about their maternity care, during pregnancy, birth and postnatally.

• Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.

• More women are able to give birth in midwifery settings (at home, and in midwife led units).

Source: Implementing Better Births: Programme Update, NHS England, March 2018[6]

What you can do: top tips for activists

It's easy to get bogged down in talking rather than action. So here are some tips to help you become a positive force for change.

- **Be focused.** If you want to make a difference to the kind of quality improvement projects undertaken by your local NHS trust or 'local maternity system', I would suggest you focus on one thing and really stick with it. Hold on, like a terrier, chasing it up relentlessly. Things take a long time to change in the NHS; often activists become fatigued and walk away.
- **Co-design and regular reporting.** All trusts and/or LMSs should have 'task and finish groups' (or similar) developing and monitoring progress with transformation plans. Find out what there is in your area and make sure the Head of Midwifery and/or consultant midwives are co-designing the needs assessment and strategy with service users. Ask them to report regularly to the MVP.
- **Have a plan; make progress.** To take the example of activism around place of birth, at least one women / service user advocate on every maternity voices partnership (MVP) should be an advocate for increasing the number of women giving birth in midwifery settings. This means knowing the current numbers and percentages having home births, and giving birth in your alongside midwifery unit (AMU) and freestanding units (FMU). If you don't know the numbers, or don't have all three options in your area, work out your priorities and find others with influence to work with. Meet together and agree a project plan. See How to make the most of your MLU on the Midwifery Unit Network website.
- **Think creatively.** One option is for the place of birth 'task and finish' group to be combined with, or work closely alongside, the group overseeing increased continuity of midwifery carer. If

midwives follow women, rather than staffing beds, there is scope to achieve more and better within the same budget.

- **Ensure women have high quality evidence.** A new decision support aid for choice of place of birth, approved by NICE and NHS England, has recently been published, based on the Birthplace in England cohort study findings and other studies included in the Intrapartum Care review for NICE. Is your area using it?
- **Take action.** Write letters and blogs, visit MPs' surgeries, and talk about your priorities on social media. For example, there is a shortage of midwives and we should all be aware of this and vocal about it. Poverty and social inequalities have a huge impact on stillbirths and poor health of women. Exercise your right to vote when there are elections!
- **Get connected; get inspired.** Don't work alone. Buddy up with fellow birth activists, for mutual support and encouragement. Network. Keep reading about what others are doing. Seek out free or cheap local events and conferences: birth activists deserve professional development opportunities too! Online, there are so many useful Facebook groups now, such as National Maternity Voices for those on MVPs and MSLCs, MatExp, the Positive Birth Movement and the Midwifery Unit Network. These are open to all. And there is more on Twitter. Start following one or two people, or groups, who you know and trust, and expand if you want to. (I have social media-free days, but still find out a lot that way and support others, too.) Join AIMS!

Achieving change is slow and often hard work. But change can, and does, happen. If local developments hit roadblocks, remind people of the bigger picture, the higher-level objectives for the NHS. We need to focus more on prevention. We should work as a whole integrated, transparent, learning system. We need to BOTH enhance positive well-being and mental health AS WELL AS safe physical services. The Maternity Transformation Programme is fully aligned with these overarching objectives, so keep working for its implementation with gusto!

Mary Newburn is a service user researcher and activist, trustee of the Positive Birth Movement, co-founder of the Midwifery Unit Network and former Head of NCT Research and Information.

References

1. NHS England (2016) *National Maternity Review: Better Births - Improving outcomes of maternity services in England - A Five Year Forward View for maternity care* London: NHS England
2. Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service* . London: Crown
3. The Kennedy Report (2001) *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol* Presented to Parliament by the Secretary of State for the Department of Health by Command of Her Majesty, July 2001, CM 5207(i)
4. Sandall J, Soltani H, Gates S, Shennan A, Devane D. (2016) *Midwife-led continuity models versus other models of care for childbearing women* The Cochrane Library Apr 28 2016

5. NICE (National Institute of Clinical Excellence) (2017) *Intrapartum Care for Healthy Women and Babies* NICE Clinical Guideline 190. London: NICE; 2014 (update 2017) Available at: www.nice.org.uk/guidance/cg190
6. NHS England (2018) *Implementing Better Births: Programme Update* Presentation to the Maternity Transformation Stakeholder Council, March 2018