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Better Births – Five Years On

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By Annie Francis

The National Maternity Review, led by Baroness Julia Cumberlege, was commissioned by NHS England in March 2015. Its report, Better Births, was published in February 2016, and its conclusions and recommendations continue to underpin maternity policy in England, under the banner of the Maternity Transformation Programme. Five years on from the publication of Better Births, AIMS is pleased to share some reflections on the programme's implementation from Annie Francis, a member of the National Maternity Review Team as well as a continuing member of the Stakeholder Council.

I am sitting at my desk writing this on January 31st, 2021. It is the second anniversary of the closure of Neighbourhood Midwives and we are in our third lockdown of the COVID-19 pandemic.

Five years ago, as the National Maternity Review's report, Better Births[1], was about to be published, I could never have imagined that this is where we would be. Back then, I was full of hope that the bold central vision of the report that 'most women would know their midwife by March 2021' was not only achievable, but could actually be made a reality. The difference this time was that lessons had been learnt from the days of Changing Childbirth[2] and that a comprehensive 'Maternity Transformation Programme' (MTP) was going to ensure that all 28 recommendations from Better Births would be implemented.

Back to 2021 and the million dollar question: Has the MTP succeeded and are we where we hoped we would be? Obviously, the last year has taken a massive sideswipe at so much – health and social care,

education, the economy – and so it is impossible to ignore the impact of this on maternity. But even before the pandemic, there were plenty of signs that we might not be on track to achieve what was set out with such clarity and hope 5 years ago.

The key word for me is 'transformation.' It was acknowledged in the Better Births report that none of the changes being recommended would be possible within the 'current staffing models' and that moving to greater continuity would require more 'radical approaches'[3]. One such radical idea was the integration of alternative midwifery providers, with a proven track record of successfully offering almost 100% continuity of carer. There were two such providers operating at the time – Neighbourhood Midwives in the South and One to One in the North.

NHS personal maternity care budgets (PMCBs) were another radical idea from the review. These were intended to be linked to an accreditation system which would have enabled Neighbourhood Midwives and One to One to be available for selection directly by women[4], given that our organisations had both successfully met the stringent requirements of an NHS contract and were already commissioned to provide NHS services. Fast-forward to 2021 and neither proposal has been rolled out – PMCBs are little more than a choice menu, where they still exist at all, and the accreditation system never moved beyond the planning stage.

The fact that neither Neighbourhood Midwives nor One to One has survived is, frankly, down to the many systemic barriers and challenges we both faced, none of which were successfully dismantled quickly enough. A major factor was the lack of significant reform of the funding and commissioning structures within the maternity services. The emphasis on competition that was a central plank of the Health and Social Care Act 2012 meant there was no incentive for other Providers to collaborate with us. The bottom line was that every woman who booked with us was a loss of income for them and we simply didn't have enough clout or sufficient resources to hang on long enough for the system to recognise and embrace what we had to offer – with catastrophic consequences for both organisations.

Apart from the failure to successfully embed new providers, slow progress on improving postnatal care and the apparent disappearance of a rapid resolution and redress scheme, what of continuity of carer (CoCr)?

NHS England produced guidance for implementing CoCr in 2017 which included this definition:

> First and foremost continuity of carer means that there is consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey:
>
> • Pregnancy
>
> • Labour

• The postnatal period

Secondly, it enables the co-ordination of a woman's care, so that a named individual takes responsibility for ensuring all the needs of a woman and her baby are met, at the right time and in the right place.

Thirdly, it enables the development of a relationship between the woman and the clinician who cares for her over time.*5*

Despite the huge amount of effort, time and money that has gone into introducing continuity of carer (based on this definition) as national policy, the overall impression is of an extremely mixed picture. There are Trusts who have relished the challenge and made significant progress, while others (the majority?) still struggle to reach the initial target of 20% of women receiving continuity of carer. The concept of 'most women' has been downgraded to mean 51% (that isn't 'most' in my book) and the postcode lottery of access to continuity of carer teams is alive and well across the country. Taking a snapshot of where we are now, even the most generous minded would hesitate to call it an unqualified success.

There are many theories and explanations put forward as to why the implementation of continuity of carer has proved so resistant to universal acceptance and rollout. Shortage of staff, the risk of burnout and midwives not wanting to be on call are probably the most common reasons given. But these are the symptoms, not the cause. For me, it is 'New Public Management' (NPM) that lies at the heart of the problem. Introduced into the NHS in the 80s, it is an approach based on marketisation, metrics and bureaucratic management techniques commonly used in the private sector, and it is an outdated and poor fit for the complex world of healthcare[6].

Recent reports – Mid Staffs, Morecambe Bay and now the Ockenden Report – all highlight the dysfunctional and toxic culture of the organisations they were investigating. It is my belief that in order to dramatically improve organisational culture, we must confront the need for system-wide change and recognise that NPM has failed. We need to look for more holistic and humane alternatives, such as the emerging Human Learning System (HLS). This is an approach based on human relationships at the heart of care provision, an environment of continuous learning and the mindful nurturing of healthy systems[7]. Until we do, we will continue to tinker at the edges of major reform – and there will be more such reports that will continue to uncover equally devastating findings.

The jury will be out for some time yet on how effectively the Maternity Transformation Programme has implemented the recommendations of Better Births, not least because of the devastating impact of the pandemic, but genuine and sustainable innovation will not take root in our NHS until we finally face the truth that the entire system needs root and branch reform.

For me, reflecting on the 2nd anniversary of Neighbourhood Midwives' closure, the future lies in the

increasingly broad and growing network of like-minded individuals and organisations working to introduce a HLS approach into all public services – in my heart, I know that is where Neighbourhood Midwives would have found a home and thrived.

Author Bio: Annie Francis qualified as a midwife in 1998, is the former CEO and co-founder of Neighbourhood Midwives and a member of NHS England's Stakeholder Council[8].

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1 National Maternity Review (2016) 'Better Births'. www.england.nhs.uk/ourwork/futurenhs/mat-review

2 McIntosh T (1993) A celebration and a warning. *AIMS Journal* [online]; 28(2): www.aims.org.uk/pdfs/journal/483

3 *Better Births* (2016), www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf, p. 76

4 *Better Births* (2016), www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf, annex C, p. 118

5 www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf(p. 13)

6 George M (2017) The effect of introducing new public management practices on compassion within the NHS. *Nursing Times* [online]; 113: 7, 30–34

7 www.humanlearning.systems/overview

8 www.england.nhs.uk/mat-transformation/council