UK Network of Professors in Midwifery and Maternal and Newborn Health

Policy Briefing

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Safe, effective, equitable, compassionate, and respectful maternity and newborn care for all

This briefing document from **The UK Network of Professors in Midwifery and Maternal and Newborn Health** summarises the issues, barriers and gaps that prevent the development of consistent, effective, safe, and respectful maternity and newborn care and services in England. The analysis draws on a wide range of evidence and resources and on the recent **Independent Report on midwifery and wider maternity services in Northern Ireland, which offers an example of a system-wide, solutions-based, collaborative, evidence-informed approach.**

England's maternity services require **urgent, evidence-based, and inclusive reform** to prevent harm to women and babies and to promote positive health and wellbeing at this critical time. **Action is needed now – women, babies, and families need a better, safer system. There are no quick fixes** – the problems are longstanding and the system is complex. **But a different approach could make a fundamental difference.** Rather than undertake further reviews, it is essential to identify effective solutions to the problems that are now well known. An evidence-informed implementation plan that builds on existing knowledge and strengths could have a rapid impact on some of the most challenging issues.

This paper proposes a new direction of travel to develop a maternity system that is safe, equitable, and fit for the future. A 3-5 year programme is proposed, to build consensus, engage stakeholders in the process of change, and develop and implement evidence-and experience-informed whole-system solutions.

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1. Why change is urgently needed

Despite real strengths in the current provision of maternity and newborn care in the UK, the health system is **not consistently delivering safe, effective, equitable, compassionate, and respectful care for all.** In England, multiple reviews including Ockenden and Kirkup have identified serious failures, but subsequent efforts to improve safety are not delivering **sustained improvement and there are concerning signs of unintended and undebated large-scale changes in patterns of childbirth in the UK**. Reviews have not examined prevention, continuity, or public health approaches that focus on promoting health and wellbeing of the woman and baby, or on longer-term outcomes. The current approach to safety is **not informed by all relevant evidence** and does not consider the inter-related aspects of **clinical, psychological, social, and cultural safety.** Crucially social determinants of health are not considered or addressed as critical safety issues.

National discussions around maternity care have become **divisive**, eroding public and professional trust, placing public discussion on a constant wheel of negative reporting. Debate centres on very challenging examples of failure, loss and trauma, **lacking both the broader context and a system-level view** of how such failures happened and what steps are needed for large-scale, sustained improvement. **Evaluation of the impact of safety programmes is limited.** To make the improvements that women, babies and families urgently need, key issues, barriers and gaps that must be addressed include:

- **Maternal mortality rates are rising** and women's postnatal physical and mental health and experiences are deteriorating. Reporting of birth trauma is rising and increasingly litigated.
- **Intrapartum stillbirth rates have not improved**; the approach to safety developed over the past ten years is not resulting in the improvements needed suggesting a wider systemic problem of the organisation of the service
- **There are persistent inequalities** related to deprivation and to ethnicity**.**
- **Women report fragmented care, with poor coordination** between hospitals and communities. This is especially difficult for women who have previously experienced trauma or who have additional clinical or social complexities. There is **silo working** not only between hospital and community, but also between labour ward and postnatal care, and between disciplines.
- **The many voices of women with a range of experiences** are missing from the recommendations arising from a focus on failures.
- The debate around mode of birth has become especially polarised. **The key facts that need urgent attention** include rising rates of induction and caesarean birth with **caesarean birth now over 50% in many hospitals**, and a concomitant decrease in rates of physiological birth, **without evidence of improved safety**. Most caesareans are unplanned and cannot be explained by women's choice, and the lack of improvement in perinatal outcomes suggests that they are not all life-saving interventions. These rates **will inevitably rise further** as women are likely to require repeat caesareans in subsequent pregnancies. Evaluation of this model of care on short and long-term outcomes and experiences for women, babies, and staff, and the impact on services, is lacking.
- **The service is not appropriately staffed and resourced** to manage the high levels of induction and caesareans, to the detriment **of other critical aspects of care,** especially

preventive care in pregnancy, skilled supportive midwifery care in labour, and postnatal care for women and babies. At the same time, **most women who die do so postnatally,** and postnatal care for women and babies following caesareans is much more complex.

- **The interdisciplinary team cannot consistently give the quality of care they know is needed;** they are affected by low morale, a punitive blame culture, and a task-focussed approach. The negative public, policy, and service discourse is contributing to staff burnout, low morale, and poor recruitment and retention.
- Despite **compelling evidence of their fundamental role in safe quality care,** midwives' practice is constrained by current models of care and lack of planned workforce numbers, depriving women and babies of essential midwifery care and support. **Midwives are the only professional who care for all women, babies, and families, at all stages of their maternity journey**, in both hospital and community, and they are often the first to identify complications. Midwives are now unable to practise the full scope of their professional standards or consistently provide the evidence-based care that women value and need, and students are struggling to gain the practice experience they need. As a consequence, women are rendered more vulnerable, lacking appropriate information to make informed decisions, and the skilled care needed to prevent complications and enable a positive childbirth experience, and support with learning to care for their baby.
- Midwives are receiving disproportionate public blame and ongoing criticism and midwifery skills have become devalued in public and sometimes professional discourse, **with a devastating effect on their morale, retention, and student recruitment.**
- **Appropriate continuing professional development,** especially interdisciplinary education, is not appropriately acknowledged or funded.
- **Litigation costs exceed care provision**, with limited systemic learning from adverse outcomes and resulting in huge burdens and trauma for families and for professionals.
- The intense focus on failure and trauma, while understandable, **obscures the positive care that exists**. Successful care and services achieve high levels of safety and positive experiences for women, but these are not acknowledged or rewarded and **learning from these is not used to inform improvement programmes. There are strengths to build on to create positive change across the system.**
- **Oversight and inspection systems are ineffective**; CQC ratings are not related to outcomes and are widely misreported in the media, increasing women's concerns.
- **There is low confidence in maternity services** among women and families and the public, creating anxiety for pregnant women and their families, a lack of trust in professionals, and dysfunctional pressures on policy makers.

2. Why more reviews are not the answer

Important information has emerged from the key maternity reviews in England and there are critical lessons to learn. They have offered women and families who have experienced loss and trauma a way to have their voices heard; their experiences demand action to prevent harm to other women and babies in the future. **However, single-Trust reviews are not structured to be the main source of information for national policy development or to design a national**

safety programme. They have not incorporated data analysis or evidence to understand the context and identify what changes will work, engaged the voices of women and families with a wide range of experiences, or heard what would help staff and managers to do better. The wider system has not been analysed to understand the root causes of problems. Their attention has been focused on service failure, hospitals, birth, and emergencies, and on the women and families who have experienced trauma. **Importantly, no large-scale evaluation of the impact of resultant changes has been conducted,** including examination of unintended adverse consequences, opportunity costs, and cost-effectiveness.

These reviews have ensured that the most critical problems are well known, but to identify effective responses to address these and wider problems a different approach is needed; one which will identify effective and cost-effective solutions, and build consensus for a programme of change. The Renfrew Report from Northern Ireland **offers a model of a whole-system, collaborative, evidence-informed approach to co-design solutions and an implementation plan**; it can inform future work across the UK. Important aspects of the report methodology, which was co-designed with service users and interdisciplinary experts from across the UK, include:

- **Transparent, pre-agreed review structure and processes** to ensure effective oversight and governance and appropriate ethical standards in recruiting and interviewing women, partners and families, and staff, to minimise harm and avoid blame; and with service users, staff, educators, and researchers incorporated in oversight of the process.
- **Listening to a range of voices** in a psychologically safe environment, including women, partners and families with diverse backgrounds and range of experiences, advocacy and community groups, staff and students from all relevant disciplines, sectors, and levels of seniority, managers, commissioners, regulators, educators, researchers, decision makers and Trust Boards, **and encouraging cross-sectoral and interdisciplinary conversations to build consensus and support for change.**
- **Understanding the context and considering the whole system and the whole continuum of care**, in both community and hospital settings, encompassing public health as well as clinical perspectives and both prevention and treatment; including consideration of all relevant data and evidence on outcomes, experiences, processes, workforce, services, education, governance, regulation, and culture.
- Examination of and **learning from strengths and positive service provision** as well as problems and service failures.
- **Identification of all relevant evidence to inform effective and cost-effective actions using a structured evidence-informed analysis to identify gaps and solutions.**
- Development and monitoring of a **collaborative implementation plan**, supported by an **education programme**, and with **robust evaluation** of the current system and all changes.

3. Developing a collaborative, system-wide programme to transform maternal and newborn care and services

Rather than undertake further reviews, we propose a process to develop and implement a collaborative, system-wide transformation programme to transform maternity and newborn care and services**.** It should build on existing knowledge from reviews and from robust research evidence and include a process of **listening and consensus-building with all relevant stakeholders and sectors,** to develop **evidence- and experience-informed whole-system solutions.** An audit and evaluation framework should be developed to examine short- and long-term impact, unintended consequences, and cost-effectiveness. We propose seven key principles to guide this process:

1. **Hear all the voices - ensure inclusive engagement and participation**
   Collaborate with all stakeholders: women and families from diverse backgrounds, midwives, obstetricians, neonatologists, GPs, educators, public health, social care, researchers, students, and community and advocacy groups. Recognise the dysfunctional impact of polarised viewpoints on maternity care and enable respectful discussion between all people of influence in the maternity services to identify routes to implementing safe, effective, equitable, compassionate, and respectful care for all.

2. **Learn from what works – use all relevant, robust evidence**
   Use a systematic approach that draws on evidence on behaviour and culture change, care, public health, and organisational improvement, and on the social determinants of health. Learn from the characteristics of successful services and invest in what works as well as learning from failure.

3. **Consider the whole system and the whole maternity journey**
   To address the root causes of problems the whole system must work together to enable safe, effective, equitable, compassionate, and respectful care for all. Practice, education, management, culture, governance, commissioning, regulation, research, and data must all align, across the whole maternity journey from pre-pregnancy to postnatal and the early weeks of life.

4. **Prevention and public health as well as perinatal emergencies**
   Include a public health approach and enable midwives to implement their role in promoting health and wellbeing – ensure better information, support and assessment in pregnancy, postnatally, and in the early weeks of life, as well as effective recognition and treatment of complications when they occur.

5. **Tackle the blame culture, support and educate all staff, and value and enable midwifery**
   Ensure all staff and managers are engaged and supported, with interdisciplinary education to enable culture shift and behavioural and organisational change. Tackle the constraints on midwives; address planned workforce numbers, ensure appropriate continuing professional development, and support them to implement their full scope of practice across all settings and stages of care.

6. **Start from what women want - co-design and monitoring of services**
   Enable the genuine involvement of women, advocacy and community groups, and staff in service design, provision, monitoring, and review. Ensure women with diverse backgrounds and a range of experiences are involved, including those with social and cultural complexities.

7. **Monitor, evaluate, and review models of care**
   Fund robust audit and evaluation of current care models and new programmes, examining short- and long-term outcomes and experiences and unintended consequences for women, babies and families, staff, and services including cost-effectiveness and opportunity costs.