Summary of the report of the National Maternity Review ‘Better Births: Improving outcomes of maternity services in England’

Background

The report of the National Maternity Review in England was launched on 22nd February, runs to 124 pages and includes 28 recommendations or actions. Copies of the full report can be downloaded from the NHS England website - https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf. The RCM has also prepared a summary of the main findings and recommendations, which is available to download from our website - https://www.rcm.org.uk/sites/default/files/Maternity%20Review%20Summary%202016.pdf.

The report begins with a letter from Baroness Cumberlege, the Review Chair and then outlines the Review’s vision for maternity services:

“Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is woman centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.”

The introductory sections of the report outline the terms of reference, the review’s workstreams and the main sources of evidence that informed the report. These were:

- An assessment of the quality of care of maternity services in England, led by Dr Bill Kirkup.
- A review by the NPEU of evidence relating to safety of place of birth, the effectiveness of 24/7 consultant labour ward presence, the factors which influence women’s choice of planned place of birth and evidence about international maternity services.
- Lessons from the Morecambe Bay investigation.

The review team oversaw an extensive programme of engagement and the report summarises the key messages from these engagement events:

- Women and families told the review that they wanted services that were safe, they wanted to choose the services that were right for them and they wanted to be listened to and taken seriously. They also stressed the importance of knowing and forming a relationship with those caring for them and having assurance that professionals are appropriately trained and competent.
- Midwives and obstetricians highlighted the need to improve working relationships between their professions and with other groups, invest in multi-professional education and training, be more
creative and collaborative around workforce design and planning and integrate IT systems. Continuity of carer elicited various opinions, from enthusiastic advocates of caseloding models to midwives concerned about the impact of work/life balance.

- Commissioners and providers highlighted the need to improve mental health services for women, reform the tariff payment system and find a way of ensuring that small obstetric units in rural areas were both accessible and safe.

Themes

The main body of the report is then based around seven key themes:

1. **Personalised care.**

On personalised care the report is supportive throughout of the need for women to make their own choices and for these to be managed, rather than opposed. Accordingly the report recommends that:

- Women develop a personalised care plan, with their midwife, which sets out decisions about her care and is updated as her pregnancy progresses. This should apply to all women by 2020.
- In making their decisions and developing the care plan, women receive unbiased information via their own digital maternity tool about the latest evidence, an assessment of their needs and what services are available locally.
- Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising these choices through their own NHS Personal Maternity Care Budget.
- Women are able to fully discuss the benefits and risks associated with the different options for place and type of birth.
- CCGs make available maternity services that offer the options of birth at home, in a midwifery unit or at hospital.

The report recognises the vital role that maternity services have in terms of promoting public health and reducing inequalities. Accordingly, the recommendations in the report relating to information and technology to support women in making choices as well as the recommendations set out below about delivering care close to home in community hubs, more continuity of care and a systematic upgrade in mental health support and postnatal care are all designed to help maternity services to fulfil this role.

The report deliberately refers to midwifery units rather than AMUs of FMUs; the reasoning here is that specifying that a local area should have an FMU, if there was no good reason for this, was seen to be too much of an imposition. The implications for the RCM are that the best chance of advocating for FMUs is where there is no nearby AMU. It is worth noting too that the review steered away from references to midwifery or obstetric ‘led’ care, largely because it was recognised that much care in obstetric units is actually led by midwives, whilst many women using midwifery services will need some input from obstetricians.
Whilst there is little mention of ‘risk’, the report acknowledges that women’s needs change and that continuous assessment of need is important; this is consistent with the RCM position that not only should care be personalised but that a woman’s needs cannot solely be determined at the first visit.

2. Continuity of carer.

The recommendations around continuity of carer are presented as a way of ensuring that the care women receive is based on a relationship of mutual trust and respect, in line with women’s decisions about their care. The key recommendations are that:

- Continuity is provided by small teams of four to six midwives throughout pregnancy, birth and postnatally.
- Teams have a relationship with an identified obstetrician to ensure ease of consultation/referral and an understanding of their service.
- Care is joined up in the community through the provision of community hubs.

While the report makes clear that continuity of carer does mean throughout the whole period, including labour, it does not mean caseloading. There is no prescription beyond that continuity should be provided by small teams of four to six midwives. Questions such as how this will accommodate the significant proportion of the midwifery workforce that are part-time will have to be worked through locally, hence the importance of the early adopter sites.

There is no suggestion that all women can get continuity of carer immediately. The aim is to increase the proportion of women receiving continuity of carer by 20% a year from the start of the national roll out in 2018.

Most importantly, the report is clear that continuity of carer can only work if there is adequate staffing, that teams have to be protected from being pulled in to cover gaps and that core teams will still be needed.

3. Safer care.

The focus of the safer care theme is on culture, learning, reviewing data and good communication. The need for openness, honesty and good review processes are all highlighted. Key recommendations:

- Women should be informed of risks and be supported to make decisions which would keep them as safe as possible.
- Rapid referral protocols between professionals and across organisations should ensure that women and babies should have access to more specialised support when they need it.
- Professionals should learn, train and work together in multi-professional teams and time should be made available for multi-professional training.
- Teams should routinely collect data on quality and outcome measures in order to benchmark and compare their performance.
- Boards should promote a culture of continuous learning and improvement, routinely monitor information on safety and quality and appoint a board level champion for maternity services.
• Providers should work together in Local Maternity Systems in order to ensure that services both meet women’s choices and are as safe as possible.

The report also addresses the lasting impact on women, babies and families when things go wrong during pregnancy or birth and proposes that:

• There should be a national, standardised investigation process, to get to the bottom of what went wrong and make recommendations for how future services can be improved.
• A Rapid Redress and Resolution Scheme should be established, based on the concept of a no-fault compensation scheme.


On postnatal care, the report describes current postnatal services as under-resourced, overlooked and unfit for purpose, and calls for:

• Postnatal care to be resourced appropriately, with women being able to access their midwife as they require after giving birth.
• A smooth transition between midwife and obstetric and neonatal care, and when appropriate to ongoing care in the community from GPs and health visitors.
• A dedicated review of neonatal services.

On perinatal mental health, the report calls for significant investment in perinatal mental health services in the community and in specialist care and strongly supports the recommendations contained in the recent Mental Health Taskforce report, in particular that at least 30,000 more women each year should have access to evidence-based specialist mental health care by 2020/21.

5. Multi-professional working.

Multi-professional working is a core theme of this review, and the report sets out an ambition for multi-professional teams to work effectively and respectfully within and across organisational boundaries to provide seamless, high quality, responsive and kind care to women and their babies. The report recommends that:

• The NMC and RCOG should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible.
• The NHS increase training opportunities for shared learning and reflection, encourage teams to proactively ask for help and follow a consistent process for serious incident investigation.
• Multi-professional training should become a standard part of CPD.
• Multi-professional peer review of services should be available to support and spread learning
• A nationally agreed set of indicators should be developed to assist with tracking, benchmarking and improving the quality of maternity services.
• National roll-out of electronic maternity records.

This section of the report considers how the NHS can better organise services around the needs of women and families and makes recommendations in three areas:

- Bringing care together in community hubs: local centres that could be located in children’s centres, GP practices or midwifery units, where women can access elements of their care with different providers working together to offer midwifery, obstetrics and other services i.e. ultrasound, smoking cessation, weight reduction.
- Providers and commissioners collaborating in local maternity systems, covering populations of between 500,000 and 1.5 million people. Local maternity systems would support all providers and commissioners in an area in co-designing services, promoting community hubs and developing common protocols and guidelines.
- Regional networks, covering geographically larger areas and bringing together professionals, providers and commissioners to share information, best practice and learning and to provide support and advice.

The review discussed the issue of the entry of new providers operating different models of care into networks and a need to ensure they are not excluded, but this is not entirely clearly articulated in the report.

7. A fairer payment system.

The report calls for reform of the current payment system, so that the funding of maternity care more fairly and adequately compensates maternity providers. Proposed changes to funding should take account of, among other things, the need for money to follow the woman, quality incentives and the particular needs of services in remote and rural areas.

This is an area where the detail and implications of these proposals will need a great deal of working through but the clear preference is for a model which assumes fixed costs, variable costs, the needs of remote and rural services and incentivisation.

Implementation

This section of the report sets out some of the key delivery actions that will be required over the next five years and how the actions relate to people, models of care and resources.

Critical points to note:

- Some actions will need to be implemented centrally and implementation will be led by NHS England and both the National Clinical Director for Maternity and the Head of Maternity at NHS England will be closely involved in this. Other recommendations will require action from providers, commissioners, arms length bodies and us.
- However, the report is clear that implementation depends on the active engagement of individual professionals. If they don’t take responsibility for supporting improvement then change will be very
difficult to achieve. The RCOG and RCM are encouraged to promote and support a multi-professional grassroots movement.

- Strong local leadership will be key to supporting individuals to make a difference; hence the recommendation for board level leads for maternity services.
- The strong advocacy of multi-professional training throughout the report is underpinned by the availability of funding (£1 million from the Halve It Campaign and additional money from the Transformation Fund) for Health Education England to develop training.
- Funding, as yet unspecified, will also be available to help with the development of the electronic solutions proposed in relation to information giving, communication, notes etc.
- There will be four early adopter sites who will be supported and funded to test and develop the concepts outlined in the report. There will be a total of £8m from the Transformation Fund over three financial years, commencing September 2016.
- It is expected that three/four CCGs or groups of CCGs will act as pioneer sites to test the Personal Budgets model, with work starting in 2017 and £0.6m allocated. These sites could be in the same areas as the early adopter sites or entirely separate.
- Whilst national roll-out doesn’t begin until 2018, local changes can be introduced before then. In any event, CCGs will be expected to build the expectations of the Maternity Review into their Sustainability and Transformation Plans for 2016-21.
- Once national roll-out starts there will be funding (from the Transformation Fund) for project management and local leadership in relation to the development of continuity of carer.
- Development money will also be available for the new initiatives around personal budgets, the rapid redress and resolution scheme and the standardised perinatal review.
- The funding for perinatal mental health is that already identified by the Treasury and referenced in the Mental Health Taskforce report.
- Opportunities for savings that were identified, included: a reduction in serious incidents and avoidable harm (following the rapid resolution and redress scheme and more multi-professional training); less staff time on data processing, following the roll-out of the electronic care record; fewer births in costly settings, if there is an increase in births in community settings; and lifetime health costs to women if complications are better managed, staff satisfaction improves and there is reduced staff turnover.

Commentary

The RCM strongly welcomes the National Maternity Review report and we are delighted that the review’s recommendations focus on putting women at the centre of care while also acknowledging the need for maternity staff to work in positive, supportive cultures. We absolutely agree with the vision statement, which in our view represents everything that midwives should be aiming for and so we hope they will welcome it in principle. We should be particularly pleased with the inclusion of the second paragraph on the need to support staff.

The recommendations on continuity of carer are particularly significant and, given the consistent messaging on this by the RCM over many years, should come as no surprise to most members. Women want it and the evidence supports it producing better outcomes. Whether the stated aim of a 20% year-on-year increase in
women receiving continuity is achievable is open to debate, particularly as there is little understanding of what the current benchmark might be. An important message to get across to members will be that not all midwives will have to work this way at once or indeed ever. At the same time, the RCM will be encouraging a ‘can do’ approach, to point out that this is phased, that local models need to be determined to meet the broad principles and that we and others will develop support to assist with implementation.

The recommendations on safety are also to be welcomed, particularly given the focus on culture, openness, reviewing data and on learning and improvement. It is important that these recommendations are considered alongside other national initiatives, such as the Government’s ambition to reduce stillbirths, neonatal and maternal deaths in England by 50% by 2030, the RCOG’s Each Baby Counts quality improvement programme and the Care Bundle for stillbirth reduction being developed by NHS England. Whilst work is needed to put flesh on the bones of the proposed Rapid Resolution and Redress Scheme, the RCM should be positive about making it work, particularly if it means parents are spared a long drawn out legal process, if it helps early learning from mistakes and if it mitigates against a blame culture.

It is also pleasing to read the support for postnatal care and the recognition that postnatal services need to be appropriately resourced, something the RCM has consistently campaigned for.

Multi-professional working and learning are dominant themes throughout the report; the RCM is already closely involved in discussions around developing multi-professional training programmes and we will be arguing that such programmes should include training about what leads to a positive culture. Both the RCM and RCOG have continuously pointed out the current problem of releasing staff for CPD, so we will need to closely monitor what happens when staff put in for release to attend these programmes.

The recommendations around working across professional and organisational boundaries stresses everything the RCM believes in about collaboration being better than competition and the concept of community hubs came directly from us. This reflects a welcome acceptance in the report that community becomes central and the hospital less so.

So there is much to be pleased about in the report, with its focus on improving the quality of local maternity services for all women, for making care more personalised and for ensuring they get to know a small team of midwives they know and trust. Unfortunately, these proposals have tended to attract less media attention and commentary than the proposal for women to have their own personal budget and this has resulted in a predictable distortion of what the Review actually says.

The idea of personal budgets is merely one small lever in trying to make the changes happen; it is an idea that is still to be fully thought through, tested and evaluated. Furthermore, women will only be able to ‘buy’ services from accredited providers who have to meet specific standards around both governance and financial security. Providers will also have to participate in maternity networks to train with other providers and to agree uniform guidelines and standards. So although in the past the RCM has not been strongly supportive of this proposal, our position is that we are keeping an open mind while it is being piloted.
On the debit side, the report has virtually nothing to say about the importance of Maternity Support Workers (MSWs). However, this should in no way be seen as undermining their role and the RCM is very involved in discussions about their future role and contribution.

Whilst much of the language in the report around continuity, personalisation, choice and safety is not dissimilar to the concepts set out in earlier reports, such as Maternity Matters or Changing Childbirth, it would be a mistake to simply regard this as case of déjà vu. There is a distinct flavour to this report and it addresses issues in a different way to previous policy documents. What it does is provide a real opportunity to shape services differently, albeit in the context of tough financial constraints and at a time when many professionals may be feeling tired and jaded. The RCM will therefore have a critical role to play in helping members to take an active part in making change happen and in clarifying for them what the plan is for implementation.

The RCM will now focus on drawing up its own implementation plan, which will identifying the key actions we need to take, allocate staff responsible for leading on these actions and establish lines of communication with the key people in NHS England, other arms length bodies, our colleagues in the other royal colleges and other stakeholders with a role in implementing the recommendations.