Written evidence submitted by Donna Ockenden (EPE0025)

Dear Previn Desai

Thank you for requesting that the Independent Maternity Review Team provide commentary on the 4 maternity commitments. Our multidisciplinary team comprises obstetricians, midwives, neonatologists and specialist colleagues from more than 20 Trusts across England. These colleagues work within maternity services in the NHS on a daily basis with an additional commitment to the Maternity review chaired by Donna Ockenden.

Taking into account that our work continues with the independent Maternity Review at the Shrewsbury and Telford Hospital NHS Trust we have unanimously agreed that we wish to respond to commitment 4: 'The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by 2019' as follows:

Introduction

As a team of clinicians who are passionate about providing safe and high quality care within maternity services we welcome the opportunity to reflect our observations and experiences of working within the system during these early years of Continuity of Carer (CoC) implementation. We appreciate the intention to place the woman and her family at the heart of this model. The reality to us is a model which has been introduced with little attention or acknowledgement as to its impact on an already overstretched and pressured maternity system. To date, as far as we are aware the CoC model has been introduced without any additional funding in order to implement this change.

Heads of maternity services tell us they have been heavily criticised by their Trust Boards for trying to restructure their services in order to embrace this system. As experienced senior leaders they identified at its inception, CoC means a budgetary overspend. The Heads of maternity services have then subsequently been criticised by their regional CoC leads for not meeting the CoC ambition and percentage targets.

The observations and experiences of the Maternity review team of CoC

1. The ideas underpinning CoC of control, choice (personalised care) are not new and have been part of the strategic vision for maternity care since Changing Childbirth in the early 1990s. It is also championed within the Framework for Quality Maternal and Newborn Health from The Lancet Series on Midwifery. However whilst there appears to be compelling evidence to support CoC models it is unclear to the Maternity review team what components of CoC can be attributed to the improved outcomes found within the research.

2. The Maternity review team believe that CoC is being used as the panacea for improving maternity care provision, maternity care outcomes and women's birth experiences. The reality of trying to implement it successfully and safely is only with very considerable difficulties, not least because currently the infrastructure or resources available to fully support its implementation are scarce. There are also differing interpretations as to what is actually meant by CoC. Some interpretations mean a midwife just saying "hello" to a woman in an antenatal clinic to count as continuity.

3. Midwives especially, as the main caregivers in maternity, find themselves in fraught environments where they try to promote choice, provide personalised care, and deliver CoC whilst working within increasingly complex and challenging environments. Whilst the Midwifery Standards for Education sets out the expectations around midwifery competencies at the point of registration, midwives do go on to hone and develop their skills and confidence within particular working environments, be it community, midwife- led units or Labour Wards. CoC requires midwives to be comfortable and fully competent in all clinical environments and many find it stressful with feelings of being out of their depth when working within an area they are not familiar with. This is particularly so if they find the wider culture of care unsupportive and there is little opportunity for orientation and support due to the activity, acuity and resultant work load in any one clinical area.

4. Staff want to do their best and work within a framework of messaging that is realistic and woman-focussed but they have not been supported to do this as CoC was introduced without additional funding. A change of this magnitude must come with the staffing resources to facilitate it and the ears to hear when safety concerns are raised. Safe staffing levels are critical to this discussion. Modelling, planning and implementing changes that deplete a system already experiencing staff shortages and therefore inappropriately staffed maternity services in order to meet national guidance, are detrimental to the entire workforce.

5. In order to meet the ‘targets’ CoC for many Trusts has evolved into a tick box exercise with examples of inequalities in the care given to women. When this has been raised as a safety concern by those responsible for leading maternity services they have been described as being obstructive to change.

6. Although it is recognised that an availability model (one that works around and is responsive 24 hours a day to the needs of women) is the truest form of CoC to achieve the desired outcomes, from a workforce perspective, this model is not achievable or sustainable. In trying to achieve it, we have seen a detrimental impact upon workforce numbers. Many midwives, (predominantly women) and therefore, in many circumstances, main carers (be it to children or extended family members) have had to decrease their contractual hours in order to manage the shift hour changes or on call requirements. This in itself has led to real examples of financial hardship.

7. With the attempt to try to implement CoC during labour we have all observed a detrimental impact on postnatal care provision, with maternity support workers now delivering the majority of postnatal care. Much of the workforce in some of our units can consist of up to 70% part time midwives making CoC across all areas impossible to achieve. With more & more women presenting with care complexities, we need ensure that the maternity system supports confident & skilled midwives to ensure the safety & wellbeing of women.

8. There is a notable decrease in both staff morale and retention of midwives. Many midwives, trained by the NHS have moved into alternative careers such as health visiting/family nurse partnership. Moreover, staff are at work tired after working unmanageable shift patterns including night shifts straight into day shifts, on many an occasional without a meal break, due to inadequate staffing. As we all know, fatigued and unhappy staff are far less likely to be in a position where they are confident in their ability to be able to provide high quality and safe care. We cannot of course, fail to recognise the additional impact of the Covid pandemic on maternity services tasked with trying to implement this care model.

9. The Maternity review team is very clear and holds the unanimous view that we need to refocus on the maternity system’s national ambition of aiming to achieve a year on year reduction in both maternal & neonatal morbidity which means providing safe maternity care across the continuum. Safety includes ensuring an appropriately resourced workforce comprising highly skilled staff across the multidisciplinary team who have access to high

quality training which includes learning from both clinical incident investigation outcomes and from examples of excellence across the services.

10. From conversations and observations with multiple hundreds of women as part of the maternity review and in the 'home' Trusts of the members of the maternity review team we note that time and again women choose to have safe care from the most appropriately skilled professionals. This is particularly when women have complex needs and that CoC during the antenatal and postnatal period is deemed sufficient by most women we have contact with.

11. Every single day we are aware of labour wards that are insufficiently staffed. This is now often accepted as the norm and this lends itself to increasing numbers of patient safety incidents. An aircraft would not take off without the correct crew but maternity services do this every day. Why should women have to attend hospital without safe staffing levels and why should this vary depending on what day/time they come in during the week? On top of this, the Maternity review team are aware of the pressure on clinical staff 'on the ground' pressed to enforce an ideology and raising women's expectations on an already stressed, depleted and overworked workforce.

12. As a result of implementing CoC, midwives consistently work above their hours which has resulted in midwives reducing their hours or experiencing burnout. Under resourced services are focusing on CoC during labour care leading to missed opportunities during the critical postnatal period to support women & their partners with for example, breastfeeding for which it is well known improves then health of both women and their babies.

13. During the national roadshows leading to the publication of Better Births, when women were asked if they wanted CoC, of course the majority said yes. They would not have (and why indeed should they?) understood the impact of introducing CoC without additional funding and what this may have meant for the workforce tasked with trying to achieve this.

14. Whilst there remains a national shortage of midwives, continuing with the promotion of the CoC model, will only see increasing numbers of midwives leave the profession. We need to prioritise **continuity of care** in the antenatal & postnatal periods. Maternity review team members are aware that senior midwives in Trusts across England have tried to escalate their concerns to the Regional Chief Midwives and LMS leads and they have been labelled as obstructive of the National Maternity vision. Midwives were "sold

the dream" of caseload midwifery by well-meaning and optimistic CoC Champions and are now disillusioned and choose to seek different careers or reduce further their hours so that they achieve work-life balance.

15. At the same time, there is an expectation that the clinical leadership teams and with no further investment by the Trusts and CCGs, are held accountable for delivering the impossible task of the full CoC ideology in an environment of high sickness absence and low morale. The new investment of £95m in response to our first report is not enough to implement CoC. Our review has highlighted to all that what women need is safe care, to be cared for by a competent fully resourced workforce and for they and their baby to leave that environment safe and well.

16. CoC is a postcode lottery exposing care inequalities. Many Trusts set up 'pilots' for CoC which excluded swathes of women, resulting in 2-tiered services: women in CoC teams and those receiving more traditional care. Those in CoC teams are prioritised on the Labour Ward meaning their midwife who may have been working elsewhere, is moved from the area she is working in to look after the woman in labour but she is not replaced, leaving the area she was working in short-staffed. That midwife may never have met the woman before but she is in the woman's team of carers. Thus, another box ticked, as the woman has been cared for by her CoC team.

17. The attrition and retention of midwives has been thematic for many years now and the implementation of CoC is adding to this. The pressure is to provide CoC throughout the pregnancy pathway but it has never been really clear whether the expectation is for labour care as well and how this is measured. So many Trusts are experiencing difficulties. They are not achieving the % targets and for those who are the concern is how long will the models be sustained owing to concerns about staff wellbeing and the resultant safety and quality of care.

Conclusion

The Maternity review team is a multi- professional team made up of expert clinical colleagues on the ground in 25 Trusts across England. We hope that you find our observations a useful contribution to the panel of experts' conversation. As a team we recognise the current challenges within the wider maternity system and from our first report published in December 2020 you will note that we are committed to ensuring that maternity services remain safe for all, with the woman and her family at the centre of care delivery. However, our observations on the rollout and attempts to interpret what is being asked in relation to CoC and its implementation has led us to

question whether this is the right framework in which to develop our services for the future.

It is the belief that going forward we need to be completely focused on providing safe maternity care within a framework which recognises that the workforce is critical to achieving this. We do not doubt for one moment the positive impact that CoC has on some women's overall satisfaction and pregnancy outcomes. Our concerns are focussed on an ambition which has been rolled out with the expectation to implement with what appears to be limited thought given to the impact on the workforce providing the service.

With all good wishes

Donna Ockenden Chair

On behalf of The Independent Maternity Review Team

Authors of:

Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Hospital NHS Trust (December 2020)

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