report on the outputs of

'Birth Tank'

a 'listening event' held on the 23rd July 2015 for the National Independent Review of Maternity Services

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Introduction

The terms of reference for the Independent National Review of Maternity Services make clear that all 'stakeholders' - those who use, provide, commission or otherwise support maternity services in England - should be involved in the assessment of current maternity care provision and in recommending how services should be developed to meet the changing needs of women and babies.

The Review Team, chaired by Baroness Julia Cumberlege, therefore decided that at an early stage in the process they should listen to as a large a group of interests as possible about the issues they thought that the Review Team should address and to their ideas about how the current problems might be resolved.

To that end a large-scale event – called ***BirthTank*** *- pooling ideas for improving maternity services* was held in London on 23rd July. It was designed and facilitated by Laurie McMahon and Sarah Harvey from the Realisation Collaborative and involved around 150 people who represented a wide cross section of interests. They included mothers, advocacy groups, midwives and nurses, obstetricians and doctors from other specialties, GPs, managers, commissioners, educationalists, policy makers, policy analysts and people working in regulatory and professional bodies. It was attended by the majority of Review Team members so was an opportunity for them to listen to the issues that were of concern to participants and to hear the many practical ideas about how to tackle those significant challenges. The engagement work will continue with a series of 'drop in' events around the country over the summer and a final session to test out preliminary conclusions and recommendations with stakeholders in October.

About the event

Following introductory comments from Baroness Cumberlege and Sir Sam Everington (a GP and member of her Review Team), participants worked in two rounds of table discussions.

In the first round, people worked in groups of similar interests or backgrounds. So, for example there were groups of mothers, of midwives, and of obstetricians amongst others. These groups were asked first about the issues that they felt the Review should address and second to talk about what changes and developments they thought would improve services.

The focus of the second this was to hear how the real experts – those directly involved in maternity services represented by the participants – would resolve the critical problems and difficulties that services are experiencing. To stimulate these ideas we created seven imaginary but highly realistic 'stories'. These were derived from conversations with members of the Review Team. For this second round, participants had regrouped so that there was a mix or interests and perspectives at each table, ensuring that each included mothers or people who represented them. Each group considered one of the seven stories and provided suggestions about how the challenges described therein should be resolved. We also asked the groups to highlight any issues that had proved contentious in their discussions.

About this report

This report provides a summary of the two rounds of discussion from the fourteen tables and the plenary discussions that followed. It has three sections: the first summarises the issues that participants felt that the Review needed to address and the second describes the key points made in relation to resolving the 'real life' challenges written into the stories. In the final section, we offer some concluding comments. The names of the participants can be found in an Appendix to the report.

BirthTank Round 1: Issues to be addressed

We hoped that by grouping participants by professional backgrounds and roles it would provide insights about any differences in the concerns of the various interests. In practice, there was a great deal of overlap and consistency in the issues highlighted by different groups. Where there were differences we have noted them in the more detailed discussion below.

The outputs from the table discussions clustered readily into five themes for the Review Team to address.

1. Service availability and choice

- **The lack of personalised care** that takes into account the woman's needs and preferences. Some groups highlighted the particular needs of vulnerable and disadvantaged people. Others emphasised the limitations of the medical (as opposed to a social) model of maternity care being considered the 'default' mode across the system.
- **Inconsistent availability of choice for women -** there was a consistent call for health systems to offer women choice. There were many explanations offered about why some women are denied choice in pregnancy and childbirth. For some it was the product of commissioner and provider decisions about how they plan services and allocate resources. This included the point that some choices can be harder to offer in the more sparsely populated parts of the country. It was noted that trends in centralising obstetric units was effectively limiting choice about the place and /or the style of birth. One group suggested that variations were due to inconsistent application of accepted evidence of best practice. The way in which women are given information on pregnancy and childbirth at the outset may inhibits informed choices about the type of care that they can have. A more controversial interpretation was that professional cultures and ways of working can inadvertently limit women's choices by discouraging certain options.
- **Continuity of care and of carers.** Continuity of midwife during pregnancy and childbirth is something that women value highly. Several groups noted the difficulties of putting this principle into practice, particularly where midwives are required to work shifts as opposed to holding a caseload. Rotations of midwives between hospital and community (e.g. supporting home births) may be an effective way of maintaining skills but can also make it harder to ensure continuity.
- ***Consistency* of care** was essential to safeguard even if complete *continuity* of the carer was difficult to achieve. If women felt that their needs and preferences were taken into account and shared across the team of professionals responsible for their care, this may go some way to offering them the quality of pregnancy and birth experience that they value. Most thought that health professionals involved in early pregnancy, childbirth and aftercare do not always work to a common set of standards and protocols with an understanding of each contributor's role and with well-managed handovers and effective sharing of information and records, which are essential for effective teamwork. A group that comprised mainly obstetricians noted that there could be a lack of continuity by doctors as well as midwives, particularly for women having higher risk pregnancies.
- **Over-use of obstetric units.** The groups representing midwives and one largely comprising people from Strategic Clinical Networks wanted the Review Team to tackle the over-use of obstetric units as the place for the delivery of low risk births. The suggestion here was that too often this had become an almost unthinking 'default option' rather than an informed choice by women based on expert professional advice.

- **Availability of perinatal care.** There were strong views expressed across all groups that there is insufficient availability of prenatal care, particularly mental health support, with consequences for the health and wellbeing of babies and children as well as mothers. One group went as far as to suggest that the review should give parity to the physical and mental health of women in its report.
- **Availability of well women support/early pregnancy care.** While the scope of the maternity review does not include pre-conception care, several groups noted the importance of health promotion and prevention in the early stages of pregnancy as a key contributor to good outcomes for mothers and babies. Participants felt that the availability of this support to women was either patchy or poorly coordinated.
- **Lack of end-to-end pathways of care.** This builds on the previous two points about service availability. The fragmentation of commissioning responsibilities across CCGs, NHS England and local authorities were noted as a barrier to the commissioning of comprehensive care pathways for maternity care. The issue was not a shortage of evidence about what works but in translating that evidence into well understood, consistently followed, end to end pathways for maternity services.
- **There never can be a *single* pathway**. The use of the term 'pathway' gives the impression that commissioners and providers could determine a single pathway for women. It was important that the way services and providers are linked together is always described in the plural. This is because taking account of each ach woman's condition and preferences requires multiple pathways. This does not remove the need for clarity about how services fit together or the need for an agreed and accepted understanding of to handle the woman's transition between elements of the services.
- **Conflicting Standards –** Related to this was the fact that different professionals in the same system can often use conflicting standards of care - such as the time after due date to induce birth. Such variations can cause great disquiet for women and their families.

2. Funding and incentives

- **The funding regime for maternity services.** Given the financial challenges facing the NHS, it was not surprising that most groups highlighted the funding of maternity services and post birth support as an issue. Those representing the providers of maternity services argued that the tariffs were set too low and were not a true reflection of the costs of providing good care. Groups also highlighted the perverse incentives that NHS maternity tariffs present to the delivery of good care. There was no culture of 'tariff sharing' so that different providers were able to play their own expert part in the delivery pathway. It was suggested that tariffs inhibited provider collaboration, as institutions were more interested in holding on to tariff income than finding ways to involve others in providing better quality care. A further risk highlighted was cuts in local authority funding of health visiting services.
- **Disincentives for Innovation -** One group noted that funding was only available for 'face to face' contacts, discouraging more innovative ways of delivering antenatal care e.g. via Skype. Commissioners seemed only to be willing to contract for highly traditional services offering providers no incentive to innovate. It was also recognised that providers were not always sufficiently assertive in bringing more innovative ideas about integrated care to commissioners.

3. **Inter-professional working and culture**
   - **Professional tensions.** Both midwives and obstetricians highlighted the need to improve working relationships between their two professions and with other groups such as GPs, neonatologists, paediatricians and anaesthetists. The problems identified included issues of communication, handovers and disagreements about how to handle specific situations such as the transition from low risk to higher risk care.
   - **The wider team.** One group noted the importance of including neonatologists and anaesthetists in the maternity team. The lack of congruity between neonatal and maternity networks was noted as a potential barrier to good planning and communication in some parts of the country.
   - **The GPs' role** - especially in the early phases of pregnancy when the woman decided on how she wanted to give birth - was unclear.
   - **The threat of litigation.** There is potential for the soaring costs of litigation to encourage clinicians to practice in a risk averse way, inhibiting their ability to support some of the choices that women may want to make. This results in overly medicalised care and greater use of obstetric units. The group representing obstetricians, one of the groups representing women and by one of the midwives groups mentioned this point although some participants also disputed it.
4. **Workforce supply and development**
   - **The availability of obstetricians and midwives** is a significant issue for some units, presenting risks of 'burnout' for those who work in services where there are significant shortages and quality and choice implications for women. The scope for more imaginative workforce re-profiling (e.g. with more use of administrative support, maternity support staff and doulas) and more integrated workforce planning were highlighted.
   - **Education and training.** Many groups raised points about the need for better investment in education and training. These included the importance of inter-disciplinary education and training at all stages of pre and post registration careers, training to address some of the 'cultural tensions' noted above and training midwives to improve skills such as perinatal care of both mothers and babies. Midwives highlighted the issue of supervision, which they felt had deteriorated since the abolition of Strategic Health Authorities.
   - One group raised a more fundamental question about whether the whole education of midwives was fit for purpose - from the criteria used to select students to the content and length of the training.
   - There was disquiet about the competencies of midwives immediately after training.

5. **Operational matters**
   - **Data capture.** The comments concerning data covered the time taken to enter data (which competes with time spent on clinical duties), duplication of information and data quality. One group highlighted the challenge of turning data into meaningful information to inform performance and quality improvement.
   - **Integration of information systems.** Providing holistic care for women during pregnancy, childbirth and afterwards requires far better connections between different data sets, particularly between those held in primary care and those by maternity service providers.
   - **Improving services.** Several groups pointed to the difficulty in having the time and energy to make service improvements, particularly given the challenges presented by workforce capacity and demands on and expectations of maternity services. They argued that the review should provide insights about how to make changes happen as well as commenting on what maternity services should look like and how they should be organised.

BirthTank Round 2: Solutions to the current challenges

In this section we summarise the comments made in relation to the seven stories mentioned above. Two or three groups covered each story. Again, given that there was a good deal of commonality in the responses we have clustered the key points from across the groups.

Story 1 – Sustainable Services

Synopsis

The focus here was on the workforce challenges of maintaining obstetric and maternity services in a Trust with two sites offering obstetric services and a freestanding and under-utilised midwife-led unit. The distance and travel times between these units meant that consolidation would present significant access problems for women and would limit the choices available to them.

Resolving the problems

The key question here was how best to maintain the choices available to women and their families. The resolution themes that were identified included:

- Commissioners should undertake effective modelling of needs and demands such as birth rate trends, population changes, indicators of women's health and preferences and use this to inform the medium and long term planning of maternity services so that demand and capacity can be properly aligned;
- In areas where access is a potential problem and in areas where birth numbers may be relatively low, commissioners and providers should look seriously at the various staffing and service models developed elsewhere in the UK and internationally to identify alternative solutions to sustaining care.
- Look at opportunities to forge formal collaborative networks between NHS trusts and other providers providing scope for using the combined clinical workforce in alternative ways (some further details on this point are included in the discussion about networks in story five);
- Consolidation of obstetric services on one of the hospital sites may need to happen but access to services can be promoted by developing midwife led services on both hospital sites and maintaining the community unit;
- If obstetric services do need to be consolidated, there should be investment in transport so that women can be properly supported. There would also need to be a proactive campaign to keep local people and politicians informed of - and involved in - the difficult decisions the Trust may need to take, explaining the rationale for any changes in terms of clinical risk and what services women can expect. Without this, any attempt to change services – even though commissioners and providers are genuinely trying to develop a sustainable service that makes the most of available resources - will be slowed or prevented by public outcry.
- Staff morale problems need to be addressed with some priority. This which would help to improve difficulties with recruitment and retention e.g. through providing support and engagement opportunities. Commissioners and providers also need to ensure that they do not delay decisions – a system that is recognised as sustainable is a powerful attractor for staff.
- The whole spectrum of care required for women in pregnancy, birth and the perinatal period needs to be considered as part of maternity pathways. Trusts need to think carefully about

how available resources are utilised for the whole pathway not just the actual delivery of the baby.

- It was also suggested that a new national workforce planning tool would be helpful – an alternative to Birthrate Plus and one which looks at the whole clinical and support workforce for maternity services

Areas of contention

- The most contentious suggestion was that midwives could be trained to provide epidurals, so they could offer women a wider range of choice of pain relief in freestanding midwife led units. The issue was less about achievability or the defence of professional boundaries and more about the whole philosophy of midwife led care. A related question was how to handle the associated clinical governance responsibilities.
- Although there was a good deal of support for 'networks' of maternity services some felt that the willingness of doctors to work shifts and rotas on different sites could affect the viability of this solution in practice.
- It was suggested that more could be done to encourage women with low risk pregnancies to utilise midwife led services e.g. through the development of rigorous pathways for high and low risk pregnancies and birth, albeit with flexibility in how these pathways are applied to individual cases. The language used by some was interesting with one group referring to 'wasting resources on complex care that may not be needed'. It was unclear how this would sit with the woman's right to choose the style and place of delivery.
- As noted earlier the way that maternity tariffs are structured was highlighted as an inhibitor to developing operational networks of maternity care.

Story 2- A Fresh Start

Synopsis

This story revolved around issues of inter-professional culture and the challenges of overcoming long standing tensions within and between groups of midwives and obstetricians. Factors contributing to poor staff morale included disputes about how to handle the transitional care of women whose pregnancies shift from low to high risk and concerns about whether professional skills were being used to best effect.

Resolving the problems

- There was agreement that changing the culture of a department requires an understanding of the root causes of the problems, rather than assumptions or jumping to quick conclusions. Behaviours can be heavily influenced by the circumstances in which staff operate – the staff satisfaction survey and feedback from women and families can provide helpful insights about the problems to be addressed.
- It is essential to involve all staff groups – managers, obstetricians, paediatricians and anaesthetists, midwives and administrators - in discussions about the issues and potential solutions. Areas highlighted for specific attention included:
    - Direct involvement of women in designing services and in providing feedback on their maternity experiences.
    - Understanding each other's' roles and skills;

    - Agreeing a set of 'good outcome' measures to guide the way the department works. These should build on feedback from mothers about the things that are important to them;
    - Multi-disciplinary team meetings to review things that have gone well/not so well and to learn from these instances
    - Opportunities for joint training both on clinical and behavioural issues
    - Redesign and training in the use of the transition pathway from low to high risk
- Consideration of the use of mediation or external facilitation to assist with the change effort
- Support from the top of the organisation e.g. by CEO open forums, 'back to the floor' sessions and a review of how issues might be overseen by the Board.

Areas of contention

There was a good deal of agreement about how to tackle the challenges in this story. The areas of contention were a) the availability of resources to support the remedial work at a time when there is tight control of costs and b) the handling of 'grey areas' such as the potential disagreements that can arise when professional judgements are applied which over-ride agreed protocols and guidelines. Some participants felt that given the risks of local disagreements that national standards, jointly developed by the RCM and RCOG might be the way forward.

Story 3 - Mind the Gap

Synopsis

This story centred on a CCG looking after a relatively young and deprived population. Determined to improve maternity care the CCG had proposed letting a contract with financial incentives based on the achievement of specified outcomes. The main provider of maternity services, whilst sympathetic to the approach, was reluctant to agree to a contract where it was not in complete control of the pathway, bringing into question the balance of responsibilities between different providers and commissioners.

Resolving the problems

- Commissioners should specify the outcomes that they expect to be delivered and how these are measured but must also take into account the costs (and opportunity costs) of data collection and analysis. Commissioners and providers need to agree the trajectory of outcome improvements so that contracts are not based on unachievable standards.
- Before entering into an outcome-based contract commissioners and providers need to agree an explicit 'end-to-end' pathway for maternity care with appropriate quality standards for each element. They also need to agree a common approach to the assessment of risks. This should include statements about how other services such as dietetics and mental health are expected to support women in pregnancy, childbirth and afterwards.
- This work needs to be informed by proper analysis of the community's wider needs
- NHS England, CCGs and the commissioners of public health services need to consider what they can each do to promote positive and culturally appropriate pre-conception care, including mobilisation of support from the third sector and faith communities;
- Opportunities for strengthening the links between GPs, midwives, health visitors and other social services should be considered. These might include one stop clinics and co-located maternity and child health services.

- There may be opportunities to redesign maternity tariffs so that they reward outcome improvements and support integrated care across providers offering different parts of the care pathway.

Areas of contention

- Participants highlighted the problem of variation in the degree to which GPs are involved in or have the skills to provide appropriate support to women in understanding risk and in deciding the type of care they desired. The role of GPs in maternity services needs to be reconsidered.
- There was support for the development of a national set of outcome indicators that include user ratings. One group referred to the work that has been started on a national maternity data set and requested an early decision for it to be either finished or abandoned;

Story Four - The Quality Cluster

Synopsis

This story revolved around a 'cluster' of complaints and negative feedback from women and families unhappy about the quality of maternity and perinatal care offered by the Trust. The CEO had brought in an independent review panel to provide recommendations on how to improve the Department's systems, processes and behaviours, including arrangements that could help address the growing number of litigation claims.

Resolving the problems

- Systematic processes for seeking and capturing feedback from mothers and families were identified as a first priority for the Trust in this story, together with a wider review about how quality data is collected, analysed and utilised. Patient records could be adjusted to include space for feedback data.
- Linked to this point, the Trust should invest in experience based co-design of their maternity services ensuring that women's views are placed at the centre of how services operate. A potential for focus for this work is how choices are explained and communicated, including any constraints needs to be undertaken. Health professionals would then need to agree how they explained the benefits and risks that different choices may entail for individuals and how they would support the management of those risks. Any lack of consistency amongst the professionals about the facts or the manner in which they are discussed reduces quality and brings the system into disrepute. It is important that the first point of contact that the woman has in discussing her pregnancy and birth options and choices can explain all options available clearly and simply and in a neutral way.
- It was also suggested that units should be more 'honest' with women about capacity challenges in discussions about labour and what might happen at each stage. This was particularly important for women with higher risk pregnancies where neonatal care might be required.
- Intelligence drawn from the feedback of women needs to be built into team processes for learning and development, with structured opportunities for debriefing where things do not go to plan. (Many of the blockages to change the culture of professional working, highlighted in the previous story were also mentioned for this case).
- Trusts facing challenges in service quality could consider 'buddying' - organising reciprocal peer reviews - rather than setting up a one-off external panel. A buddying system has the advantage of enabling local staff to see good or interesting practice in other units

- Reviewing and investing in team midwifery structures and midwifery supervision may be considered as a further strand to safeguarding quality and morale
- Training on personalisation and communication, specifically applied to maternity care may also be relevant
- Commissioners should be involved in these types of reviews and could consider identifying specific CQUINs for maternity services. There was also the suggestion that commissioners consider buying a dedicated home birth service separately from mainstream providers in order to guarantee women the choice of delivering at home, provided this is safe.
- The Trust might also need to look whether quality issues are a reflection of staffing shortages or working practices and behaviours. To this end alternative ways of profiling the workforce might be considered. Trust Boards should also be made aware of staffing shortages and risks.
- Commissioners of mental health services should ensure that there within local community mental health teams there is appropriate provision for and skills in dealing with perinatal mental health problems;
- Pharmacies could be utilised for some aspects of post natal care education

Areas of contention

- Participants noted that from their experience it is rare that home births will not be safe because of staffing issues. More typically, it is the way that risks are explained to and discussed with women that determine whether a woman chooses to have a home birth.
- The second area of contention noted was the perception that in some Trusts finances can be somewhat opaque making it difficult to determine the true connection between service income, expenditure and the scope for investing in improvements. This is also a commissioner problem if they are not clear about what their money is paying for.
- Finally, there were concerns about individual and staff accountability where there are mismatches between demand/expectations and the capacity to respond.

Story Five – Needing Networks

Synopsis

This Story and Story Seven which follows both focused on the challenges of sustaining services across a county. In Story Five the senior clinical leaders were considering the relative merits of organising obstetric care in a network that included several providers and whether the existing Strategic Clinical Network for Paediatric and Maternity Services might be the appropriate vehicle to drive these changes forward.

Resolving the problems

- There was some support for the use of Strategic Clinical Networks to improve the sustainability and safety of maternity services.
- In this story (and also in story one) it was suggested that the potential solution to configuration challenges might be a different form of provider network. These would go beyond professional groupings to become explicit operational networks responsible for delivering maternity care across a larger geographical area than that typically served by one trust. These maternity networks would be developed through 'bottom up' agreements between providers who were interested in working together. There would need to be clear arrangements for governance and accountability – both clinically and managerially. It was

important that the networks operated in a way that promoted and safeguarded choice in maternity services, rather than promoting professional self-interest.

- All providers across the network need to be involved from the outset and work together to agree a shared dashboard of quality indicators.
- Commissioner input is specifically required to ensure that there are proper connections between plans for maternity care and other associated services such as neonatal and paediatric care.
- Commissioners have a key role in conducting and paying for appropriate levels of public, patient and political involvement and communication – so that future plans take account of their views and so that proposals for change can be explained and communicated effectively.
- Where some consolidation of obstetric services is required/inevitable, it is important to be explicit about assumptions of the cost/quality implications so that the benefits can be tracked and demonstrated.

Areas of contention

- Participants warned that it is easy to see the attraction of maternity networks at a strategic or theoretical level but far more challenging to make them work on the ground where unified processes might cut across established ways of working within individual Trusts.
- There are also governance issues to consider around the status of networks. If networks are to be accountable as service providers, it is likely that they would need to be registered with the Care Quality Commission and licensed by Monitor. This means that networks have to go beyond loose collaborations and be more formally structured. (It was mentioned that there might be parallels here with GP Federations that have had to undergo registration in order to provide services across practices.)
- A further issue is that in some places maternity and neonatal networks cover different geographical areas with detrimental consequences for planning joined up care.

Story Six – Commissioner Led Change

Synopsis

With similar configuration challenges to those in Story 5, the focus in this Story was on the commissioner's role in leading change in a situation where Trusts find it difficult to contemplate collaboration.

Resolving the problem

- Participants emphasised the important role of commissioners in coordinating plans for maternity care with those for other services such as paediatrics, surgery and emergency care
- Whilst there was a recognition that a more formal networked approach could offer a potential solution there was a strong view that network arrangements could not be imposed top down. They must be developed to suit local circumstances. Building networks can only work if there is active trust and mutual respect between the negotiants, it is not simply a matter of convenient geography.
- Commissioners can facilitate connections between service providers - they can provide mediation, engage independent facilitators or act as a 'dating agency' as one group aptly described it - but they should resist trying to force collaboration as a solution. Networks building is a provider-side activity.

- To make any collaborative arrangements work requires some form of partnership board to oversee it and to provide the necessary governance. This should include/ be led by women and clinicians.
- The proposal that the commissioners could let a contract to a lead provider that would then be responsible for making any subcontracting arrangements with other services was attractive, but with little experience of this in maternity services, there were many questions about how it would work in practice.

Areas of contention

- The operation of lead provider arrangements in maternity services needs further clarification and discussion before units can assess whether there is merit in this solution. The specific role of the lead provider, the qualities or characteristics needed to perform this role and the funding arrangements between the lead and subcontractors all need consideration. These types of arrangements are starting to be developed for other services and conditions such as cancer, older people and long term conditions so there would be some value in looking at the lessons from these experiences for maternity services.

Story 7 – Spoilt for Choice

Synopsis

This final story focused on the experiences of an older, second-time mother who had hoped to give birth at home but who was assessed as 'high risk'. Many aspects of her care were not in line with her preferences about the pregnancy, birth and aftercare.

Resolving the problems

- One suggestion given was that the continued use of the term '*choice*' in maternity services should be changed – a better alternative that suggests a more empowered position for women would be to talk about the woman's *decisions* about her care. (This shift in language was widely endorsed during the feedback session.)
- Many participants felt it was unfair to present 'choice' and 'safety' as polar opposites. Most women want and expect safe care and good outcomes for their babies in the short and long term– they expect health professionals to support them by observing their preferences/decisions as far as possible by managing and mitigating risks.
- Commissioners and providers of maternity care need to agree a local menu of the choices across the whole care pathway that women can be offered. Here it is important to consider perinatal care and as well as support during pregnancy and childbirth.
- It was also suggested that the NHS Constitution be amended to include a more explicit reference to choices in maternity care.
- A clear and simple tool for explaining risks using both numbers and graphics would be helpful to women in making decisions about their pregnancy and the birth. This would help to ensure that women understand the nature of the risks they are facing and provide the basis for informed discussion about the choices available and how any down sides should be managed
- Health systems need to ensure that they offer appropriate pre and post-natal support for women having second or subsequent births, particularly if there is a large gap between pregnancies.

- While individual choices in maternity care are essential, they need to be informed by evidence-based guidelines that are agreed between professionals about how care at different stages should be managed.
- The groups noted that once the options and risks have been explained all women should be encouraged to put together a written birth plan. It would be helpful for local systems to have a tool to support the preparation of these plans.

Areas of contention

One of the key issues in the story concerned continuity of care. There was a suggestion that a caseload system for midwifery teams might be more effective in facilitating continuity than shift systems. There was no consensus about this. One group argued that commissioners need to build in some measure of continuity of care built into maternity service specifications so that provider performance in this 'softer' area could be assessed.

There were different views about whether guidelines and protocols should be developed nationally or bottom up. This is an area where the independent national review might shed some light.

BirthTank: Commentary

During the event there appeared to be two schools of thought about how the problems of the maternity service might be resolved. On the one hand there were those who felt that the issues facing maternity services could be improved by 'tweaking' the existing system. They suggested incremental changes such as expanding the midwifery workforce or increasing the level of general funding. On the other hand – perhaps the majority of participants were of a more radical school which felt that the seat of the problem lay in the way that many maternity services were designed and delivered: improving their responsiveness, safety and sustainability would require more fundamental change.

At the heart of their concerns was that maternity services still do not always put the views and preferences of women and families first. There was a mix of embarrassment and incredulity that this situation – though long recognised - had been allowed to continue. If a fundamental issue facing maternity services is one of principle – that of respecting the needs and preferences of women and families – then any change, no matter what its effect on safety or sustainability, needs to be judged on its ability to achieve that outcome for all women, no matter where they live. Participants said this problem was exacerbated by continued tensions in the inter-professional relations between midwives, obstetricians, paediatricians and GPs.

There was a reassuring level of consensus about many of the changes proposed by participants. These ranged from *commissioner-led* changes (such as new ways of funding maternity services to increase the level of personal choice or to incentivise healthier outcomes for mother and baby) through *provider-side* changes that focussed on organising the provision of care based on sustainable, operationally accountable networks of maternity providers, to *educational sector* improvements in the education and training of clinicians and supervision of midwives.

Changes in the technicalities of funding or the organisation of providers may be necessary but they will not be sufficient to produce the improvements the participants described. What is required are shifts in culture, relationships, attitudes and behaviour between the professionals and the organisations that support women in pregnancy, childbirth and aftercare.

Much of this change has to happen locally. The general public and their representatives should expect there to be transparency about ways in which local issues might best be resolved but it is those on the inside of the services who will bring about the changes required.

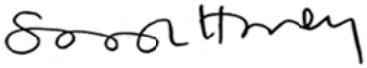
Reviewing the suggestions made by participants in the discussion groups and in the open plenary discussions there seem to us to be seven types of interventions - which together have the greatest potential to make maternity services sensitive and responsive to women's preferences as well as safe and sustainable.

1. **A change in the language -** replacing the weak rhetoric of 'women's choice' with the much more empowering '*the* woman's *decision'* about the care she wanted during her pregnancy and birth and the aftercare she expected for her and her baby. This would fundamentally change the status of the birth plan in the minds of women and professionals alike.
2. **Redesigning the 'first point of contact'-** to help women make much better decisions in the light of accepted evidence about the benefits and risks of different options. This may be a service better provided by midwives in community settings. Women and their families need information about all the options available locally and about the approach of different providers presented in a neutral way. This information cannot be framed to reflect the preferences and interests of professional groups or particular provider organizations. There may be a need for some supportive national work to provide background evidence for this essential function but it is crucial that local systems are able to decide how best local circumstances can be accommodated. Women and their partners should be actively involved in designing any local arrangements.
3. **Creating 'operational maternity networks'** - many of the participants saw the development of 'networks' as part of their solution. The notion of 'networks' is used so often in the NHS that the meaning is not always obvious. However participants were quite clear that they were talking about proper collaboration between NHS and independent providers along the *whole* service pathway. To be commissioned, these operational maternity networks would require clear governance, accountability and financial arrangements and explicit agreements about how the providers worked together. They would need to agree their relationships between 'primary' network members and 'secondary' providers such as social care organisations and ambulance services. The operational networks would be required to be clear about how they would be flexible and responsive to the woman's decisions about her care and how they would engage women and staff in continuous quality improvement. These networks would include providers along the whole service pathway – those in primary care, groups of independent midwives where appropriate (as suggested in the Five Year Forward Review) as well as NHS Trusts. They could be led by any of the providers in the networks that were judged capable. To work effectively these operational maternity networks would have to be developed 'bottom up' with agreements being made between local providers who want to work together. They are likely to fail if nationally imposed. There may be a case for supporting a limited number of local systems to work together as pilots to learn about building these operational networks.
4. **Building better assurance** - in parallel, attention will need to be given to building an assurance process for commissioners and regulators so that they can be confident that they 'see' the whole system and that new networked provider arrangements offer not only safe and sustainable care but also they are effective in putting the interests of women and babies at the heart of what they do.
5. **Improving inter-professional relations.** It was said that no matter how well the arrangements for these operational networks are developed they will fail if they are not infused with a culture of trust and respect between the different professionals involved in delivering care. The seeds can be sown in the early stages of professional education and

training but the immediate priority is to help and support those already working in maternity services. Each system needs to ensure that all professionals involved in maternity care - from early pregnancy and childbirth to post-natal care and the care of the baby - take time to work together to agree their respective roles and contributions. There would also need to be explicit agreements about how best to handle transition points both across different strands of care pathways including the implications for professional accountability. They should set in place effective processes for learning from routine feedback about the acceptability of the service and from situations where care has not been as good as it could be (from either the woman's or the clinicians' point of view) and for putting that learning into practice.

6. **Developing new payment systems** – there is a strong case for rethinking the way that maternity care is commissioned and incentivised. This was also highlighted in the Five Year Forward Review. Alternative approaches to the current tariff system need to be explored - such as outcome-based commissioning, population–based contracts or individualised maternity care budgets that promote personalisation. Concerns about major variations in provider costs for similar services need to be addressed.
7. **Reforming the litigation process** – Robust analysis is needed to identify how to address the rising costs of litigation against maternity providers. As well as constituting an increasingly large and unacceptable component of service costs it has the negative effect of reducing the willingness of the system to offer choice. The current process by which courts assess and award damages also causes unwarranted delays in families receiving financial support when they most need it.

There was some scepticism about whether the Review would lead to any significant change if all it did was produce another set of recommendations. It was said that there is already a good deal of knowledge of what 'good' maternity services should look like – but the big challenge is about how to put this knowledge into practice in local areas. Participants wanted the Review to go beyond recommending 'what needs to be done' or 'what lessons must be learned' and offer practical ways of supporting them to develop their local systems and make the changes they desired happen. The planned regional 'listening events' provide an opportunity for the Review Team to gather specific suggestions about the type of support local systems would find most helpful.



Dr. Sarah Harvey

Prof. Laurie McMahon

The Realisation Collaborative. 12th August 2015.

Appendix 1 – BirthTank1 Participants.

First Name	Surname	Organisation
Cheryll	Adams	Institute of Health Visiting
Mary	Ardill	Practice Development Midwife
Sarah	Armstrong	Obstetric Anaesthetists' Association
Carmel	Bagness	Royal College of Nursing
Alison	Bedford-Russell	Birmingham Women's Hospital NFT and West Midlands M&C SCN
Beverley	Beech	Association for Improvements in the Maternity Services
Helen	Beecher-Bryant	Maternity Action
Jeanette	Beer	NHS Litigation Authority
Ruth	Bender Atik	The Miscarriage Association
Sue	Bennion	United Lincolnshire Hospitals NHS Trust
Prof. Debra	Bick	Kings College London
Myriam	Bonduelle	ABMU Swansea
Jane	Brewin	Tommy's
Kate	Brintworth	NHS England
Cath	Broderick	We Consult/RCOG Women's Network
Christine	Carson	Centre for Clinical Practice - NICE
Natalie	Carter	
Mr Felipe	Castro	Member of Midwifery Unit Network
Denise	Chaffer	NHS Litigation Authority
Natalie	Charalambides	West Middlesex University Hospital
Julie	Cheetham	GMLSC SCN
Katie	Chilton	East and North Hertfordshire NHS Trust
Lesley	Choucri	University of Salford
Valerie	Clare	St Mary's
Julie	Clatworthy	Gloucestershire Clinical Commissioning Group
Shona	Cleland	Bliss
Elaine	Cockburn	Scottish Government
Dr Tracey	Cooper	Lancashire Teaching Hospitals Trust
Dee	Davies	LSAMO - North

Sarah	Davies	University of Salford
Jane	Denton CBE	Multiple Births Foundation
Miranda	Dodwell	BirthChoiceUK
Linda	Doherty	NHS England
Jacqueline	Dunkley-Bent	NHS England
Sarah	Dunsdon	NHS England Southside
Prof. Judith	Ellis	Royal College of Paediatrics and Child Health
Dr Carol	Ewing	Royal College of Paediatrics and Child Health
Dr Heidi	Fahy	East Surrey CCG
Dr Nusrat	Fazal	Great Western Hospitals NHS FT
John	Ferguson	
Clare	Fitzpatrick	Liverpool Women's Hospital
Gillian	Fletcher, MBE	The National Childbirth Trust
Dr Jacque	Gerrard	Royal College of Midwives
Sally	Giddings	Perinatal Institute
Charlotte	Goldman	NHS England
Alasdair	Gordon	East Lancs NHS Trust
Adam	Gornall	Royal Shrewsbury Hospital
Juliette	Greenwood	RCN
Dr Alain	Gregoire	Maternal Mental Health Alliance
Teresa	Griffin	NHS England
Kathryn	Gutteridge	Sandwell & West Birmingham Hospitals NHS Trust
Hannah	Hague	NHS England, Cheshire and Merseyside SCN
Jayne	Haley	Maternity, Children & Young People
Richard	Harris	NHS England South Region, South West
Michelle	Hemmington	Campaign for Safer Births
Clare	Hillitt	NHS England, Yorkshire and the Humber SCN
Kim	Hinshaw	City Hospitals Sunderland NHS Foundation Trust
Mr Kim	Hinshaw	City Hospitals Sunderland NHS FT
Eleanor	Hodgson	NHS Cumbria CCG

Jennifer	Hollowell	National Perinatal Epidemiology Unit
Ann	Hoskins	Public Health England
Simon	Jenkinson	Royal Wolverhampton Hospitals NHS Trust
Lisa	Jesson	Birmingham City University
Frances	Jones	Royal College of Nursing
Prof Ian	Jones	Royal College of Psychiatrists
Leigh	Kendall	
Denise	King	Local Supervising Midwifery Forum UK
Dr Deb	Lee	North Cumbria University Hospitals Trust
Nicky	Lyon	Campaign for Safer Births
Lucy	Lyus	
Dr Jayne	Marshall	Kingston and St George's
Elizabeth	Martindale	Labour Ward Leader
Rona	McCandlish	
Catherine	McClennan	Merseyside Maternity Review
Sarah	McGrath	MLU/JEFF
Mek	Miskin	IMUK
Ruth	Moore	Staffordshire, Shropshire & Black Country Newborn & Maternity Network
Vandra	Najran	NHS England
Mary	Newburn	Member of Midwifery Unit Network
Veryan	Nicholls	Horsham & Mid Sussex CCG
Femi	Obileye	
Pip	O'Byrne	Family Nurse Partnership
Dr Lesley	Page	Royal College of Midwives
Alison	Parkes	La Leche League Great Britain
Chloe	Peacock	HealthWatch England
Helen	Pearce	LSAMO - South West
Gill	Phillips	Creator of *Whose Shoes?*
Catherine	Platt	
Lisa	Plotkin	Women's Institute
Elizabeth	Prochaska	Birthrights
Dr Daghni	Rajasingam	Guy's and St Thomas' Foundation Trust

Keith	Reed	Twins & Multiple Births Association (Tamba)
Ann	Remmers	NHS England, South Region
Margaret	Richardson	Maternity Matters
Lucia	Rocca-Ihenacho	Member of Midwifery Unit Network
Jane	Sandall	King's College London
Rebecca	Schiller	Hackney Doula, Birthrights
Sarah	Skelton	Centre for Workforce Intelligence
Heidi	Smoult	Care Quality Commission
Tina	Strack	Healthcare Quality Improvement Partnership
Suzanne	Sweeney	UCL Partners
Liz	Thomas	Action Against Medical Accidents
Cheryl	Titherly	SANDS
Jacqui	Tomkins	IMUK
Clare	Tower	St Mary's Hospital, Manchester
Sue	Turner	Perinatal Institute
Matt	Warman	House of Commons
Amy	Warren	NHS England, South Region
Suzanne	Watts	Royal College of Nursing
Emma	Westcott	Nursing and Midwifery Council
Miss Florence	Wilcock	Kingston Hospital NHS Foundation Trust
Dr Debbie	Wisby	Royal College Nursing / University of Central Lancashire
Fiona	Wise	Monitor
Dr Peter	Yeh	Northwick Park Hospital
Margaret	Jowitt	Association of Radical Midwives
Dr Helen	Schofield	Cheshire and Merseyside Strategic Clinical Networks and Senate
Lucy	Lyus	Lullaby Trust
Gillian	Fletcher, MBE	The National Childbirth Trust
Heidi	Eldridge	MAMA Academy

Maternity Review Panel

Julia	Cumberlege	Maternity Review
Cyril	Chantler	Maternity Review
Alison	Baum	Best Beginnings
Jocelyn	Cornwell	Point of Care Foundation
Rowan	Davies	Mumsnet
Elizabeth	Duff	NCT
Sam	Everington	Tower Hamlets CCG GP, Bromley by Bow Partnership
Alan	Fenton	Newcastle upon Tyne Hospitals
Donna	Kinnair	Royal College of Nursing
Sarah	Noble	Birmingham Women's NHS FT
Melany	Pickup	Warrington and Halton Hospitals NHS Foundation Trust
David	Richmond	Royal College of Obstetricians and Gynaecologists
James	Titcombe	CQC
James	Walker	University of Leeds
Cathy	Warwick	Royal College of Midwives