THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

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Dear Simon,

The RCM would like to thank you for the opportunity to take part in the planning of the Long Term Plan for the NHS. The funding announcement from the government for the NHS gives us an opportunity to continue and build upon the Maternity Transformation Programme in England, which the RCM fully supports. We have replied to the overall call for evidence through the Social Partnership Forum, and would like to use this letter to expand on our thoughts regarding the early years in more detail.

We believe the maternal and child working group of the Long Term Plan needs to think bigger about the key drivers of health. It is simply not enough to focus on women's health only when they become pregnant. Women's overall health is going to determine how their pregnancies progress, their lives as mothers, and the lives of their children. We need to acknowledge the importance of women's health to the health of the nation overall. Women are still the predominate caregivers – both paid and non-paid, both of children and the elderly – in our society. We cannot look at their health in isolation from the health of the people around them. We must take a life-course approach and rename the stream, 'Healthy Women and Children', rather than 'Healthy Childhood and Maternal Health'.

We would like to structure our comments on the Long Term Plan around the questions put to us as a member of the MTP Stakeholder Council, which have also been circulated to the Maternity Clinical Expert Group and Maternity commissioners forum.

1. What would you prioritise, when considering a life course approach to maternal and child health.

Social determinants have the biggest impact on maternal and child health. Those from the most deprived areas of England are more likely to suffer ill-health, and so are their children. In regards to child health in particular, Black Caribbean, Black African and Pakistani communities have the highest rates of infant mortality amongst ethnic groups. This is largely correlated with these groups living in deprived areas. Smoking is the biggest modifiable risk factor for pregnant women that will reduce infant mortality. Again, young, white mothers living in deprived areas are the most likely to smoke while pregnant and thus increase their risk of preterm birth, still birth and low-birthweight babies. Overweight and obese women have a higher risk of poor birth outcomes and of their children being overweight or obese. These include the risk of impaired glucose tolerance and gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity. Again, maternal deprivation is correlated to obesity. We cannot turn our

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heads away form the fact that the status of women in society determines their maternal health and the health of their babies.

Midwives and maternity support workers build relationships with women to start to change modifiable behaviours. It is estimated a large majority of pregnancies are unplanned or mistimed, and thus many women enter maternity services in poorer-than-optimum health because they live in deprived areas. Their lives are a huge marker of their health from this point on, and therefore it is crucial that midwives are in place to support and care for women at this time. This is the reason that midwives are entrusted with so much public health advice during the antenatal period – and why they feel so frustrated that they don't have the time to do their work to the standard they need to when we are 3,500 midwives short. Midwives need the time to build trust, and the other services that wrap-around women to ensure wellbeing – everything from smoking cessation, to housing, debt advice, mental health, fetal medicine – must be seamlessly in place.

2. What are the specific elements of the maternity pathway which you feel have a particular impact upon child outcomes (do you have robust evidence they can share)

The RCM fully supports the efforts to introduce continuity of carer into English (and Scottish) maternity systems on the basis of robust evidence from the Cochrane Review (Sandall et.al 2016). It's potential to reduce pre-term birth and baby loss means it is imperative that local services are supported in any way possible to make it a reality. Women deserve it.

The 20% target for women beginning a Continuity of Carer pathway has been useful to focus minds, but the RCM is aware that some services are simply relabelling current arrangements to meet the target; a rethinking of the structure of the service hasn't happened. We understand the huge concerns of our members who have seen, and seen fail, continuity schemes of the past. We can't allow those same mistakes happen again, where midwives have been left burn out and disillusioned. NHSE must understand the need to get sate maternity staffing right to give our midwifery leaders the workforce to flex to meet the needs of women across the maternity pathway. Perhaps it is option to make next target measure how maternity teams are structured into providing continuity of carer.

Maternal mental health has a huge impact on overall maternal wellbeing, infant mental health, and even the mental health of babies as they grow, into toddlers and into teenage years. We need specialist maternity health midwives in every trust in England.

3. What are the core elements, from *Better Births*, which would benefit significantly from a longer time period to embed fully into the NHS.

As discussed above, Continuity of Carer is a revolution in the way we approach caring for women across the antenatal, intrapartum and postnatal periods. It is taking time to build trust and capacity across the workface to get this right.

We are disappointed that again, postnatal care seems to have fallen from focus in the implementation of *Better Births*. Almost all maternal deaths take place in the postnatal period, the stakes cannot be higher to get postnatal care right. We would like to see some clearer direction from

NHSE to Local Maternity Systems to improve the support to women in this time, in particular on the GP 6 week check which is not commissioned and yet vitally important, and the transition to health visitors. Breastfeeding rates in England fall well below our peers. Despite many women initiating breastfeeding, they struggle to continue in workplaces and public spaces where stigma reigns, and in the middle of the night where there is no support from trusted advisors at the end of the phone. The benefits of breastfeeding don't have to be restated, so we must do everything we can to help the women who want to feed, to continue.

We also would like to see more focus on the elements of *Better Births* which touch on culture, 'the way we do things around here'. We would like to see staff more involved in decisions, having the space and trust to think innovatively. Midwives have some of the lowest satisfaction scores of any professional in the NHS Staff Survey. They are a female-dominated profession juggling family commitments with paid work. They are at high risk of bullying, burnout and only recently, has their pay award begun to claw back what we believe, as their trade union, what they are owed. The MTP programme will only succeed if midwives are doing well.

Similarly, we need to think about the second part of the vision statement in *Better Births* which talks about staff working in high performing teams, who learn together, and support each other. As a Royal College, we model this behaviour in our partnerships with other Royal Colleges who represent the professions that our members work with every day. We would like to see some development of the idea that different professionals train together, not only for continuing professional development, but in the early parts of their careers. We hear from student midwives and junior doctors that toxic behaviours begin early. This is disastrous for keeping motivated people working in our NHS, and it certainly distorts care for women who need a high-performing team supporting them. With the number of women with pre-existing medical conditions rising, the importance of getting the multiprofessional team right has never been greater.

We also understand from the work of the Pioneer programme how difficult the structures around maternity have made the spirit of *Better Births* – choice and partnership – more difficult. Heads of Midwifery have met off-site to avoid the glare of finance directors who can't see the benefits of collaboration on the bottom line. Creating a menu of local choices for women on place of birth has been held back by parochial– and understandable – Trust interests. Blood tests are repeated when women pitch up to a new service, her records don't follow her. Local Maternity Services are struggling to change these behaviours with the architecture we are working in. No one is wanting a wholesale reorganisation of the NHS again. But we need to acknowledge that architecture's power and how much time it is going to take to change it.

We will never 'finish' the safety stream of the MTP programme. But what we can do is refine it. Maternity services are on board with the various programmes, but the duplication of paperwork – one incident reported into ten different portals – doesn't make mothers and babies safer. We hope that the work of HSIB, and the introduction of Rapid Resolution and Redress will help clarify the places where we can make changes to make quality improvement more simple. We owe it to mothers and babies to make all the interconnected safety programmes as seamless and easy as possible for our members who are working in them.

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4. What are the realistic digital expectations we can have on maternity services (or are there significant digital and data activities out there we should know about and build upon)

There are great examples of apps for women that help them get advice, log their own care and enable them to feel more in control. BabyBuddy and MyBirthplace are two such examples. We hope that other local maternity systems can be supported to learn from these examples at so all women across England can access them and reap the benefits.

The Maternity Services Dataset is making great strides in collecting the information that will make services safer and more personal. It's been a challenge for some services to get on board with outdated IT and we would like NHS England to better support services with funding to make sure IT doesn't hold digital innovation back.

5. What are the core 'prevention' elements we can bring into maternity services.

Midwives and maternity support workers public health role is huge, as we have discussed above. What needs to be brought in is the structures that allow women to seamlessly be cared for from different professionals with the right expertise.

The concept of Community Hubs features in both England's and Scotland's maternity reviews but progress in creating these physical spaces has been slow. GP practices need to charge for their space, NHS estates haven't been able to make it work. Many Sure Start centres have shut recently and this shows how hard it has been to keep these useful spaces viable, in a model still based on 'competing' and separating public providers. But the idea that women would see midwives, debt and housing advisors, even their obstetricians or a nurse, in the same place makes perfect sense in regards to the social determinants of health we mentioned earlier. *Better Births* was right to push the concept and we need NHSE to make it happen.

Regards,

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