

Leadership in Maternity Services

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Introduction

There is no doubt amongst opinion formers and policy makers that leadership plays a significant part in the delivery of high quality health care.^{1,2} A lack of leadership has been noted in recent reports into health service failures including maternity services^{3,4} and the evidence is mounting that organisations with effective leadership deliver better outcomes.⁵

It is also clear that in today's demanding world the style of leadership matters. Leadership needs to be adaptive and responsive in the face of unknown and complex challenges. It needs to create a vision, ensure people are signed up to a common goal and to motivate and inspire. Leaders need to have emotional intelligence, be interactive and at the end of the day create more leaders.⁶

Background

In 2013 the King's Fund Leadership Survey concluded that NHS organisations must abandon a traditional individualistic model of leadership and embrace a style which is shared, non hierarchical and can adapt quickly in the face of change. It noted the importance of organisations doing more to listen to the views of staff and service user.⁷

So it is of concern that, in 2006, researchers found that institutionalised bullying in maternity care was a reason for midwives leaving the profession,⁸ that bullying is a continuing problem in maternity services and that, as recently as 2008, a Care Quality Commission Survey of all maternity services reported that poor morale and ineffective leadership are commonly linked.⁹ As the Chief Executive of the Royal College of Midwives, I visit maternity services across the UK and see examples of excellent leadership. Sadly

though in some services comments from midwives suggest there has been little significant change in leadership styles in maternity services in recent years. Dr Bill Kirkup's recent report into the failings of maternity services at the University Hospitals of Morecambe Bay NHS Foundation Trust point to the devastating consequences when there is a failure of leadership at every level.⁴

A call for change

And this is a problem because the way in which we deliver maternity services needs to change. Although maternity services in the UK are generally of a good standard and safe there remains room for significant improvement.

In particular, in two areas of service delivery, high quality evidence tells us we should do better. The first pertains to choice of place of birth. Women at low risk of complications expecting their first baby experience better outcomes for themselves and no worse outcomes for their baby if they choose to give birth in free standing or alongside midwifery units and for women expecting their second or subsequent baby the same can be said with the addition of the choice of homebirth.¹⁰

The evidence for change

Despite this high quality evidence and despite a conservative estimate by the Royal College of Obstetricians and Gynaecologists that at least 30% of women fall into the category of 'without complications' only 13% of UK women currently give birth outside of obstetric units and the homebirth rate is falling.¹¹ The provision of services to allow women to choose out of obstetric unit birth remains patchy. The truth is we need to turn maternity services provision on its head.

In addition evidence accumulates telling us that for all women in whatever birth setting midwifery led models of continuity of care ensure better outcomes.^{12,13} It is not clear why this is the case. However it is possible that the critical difference is that in such models, which are based on care by small teams of midwives (4 to 6), continuity of carer is vastly improved and the woman gets to know and trust her caregiver. A relationship between mother and midwife is developed. Care is delivered in partnership.

Despite this evidence most women do not receive continuity of midwifery led care. A survey by the National Society for Prevention of Cruelty to Children found that in the antenatal period, whilst nearly all women see a midwife, 40% of these women saw a different midwife at every appointment.¹⁴ In another survey of 5,500 women by the National Federation of Women's Institutes and the National Childbirth Trust 88% of women said that they had not met any of the midwives who looked after them during the labour and birth before they went into labour.¹⁵

A vision for the future

We have to do better and if we are to see a radical change in the way in which we provide maternity services and hence improve outcomes I believe that we will need to have leadership of the highest quality in maternity services.

We need leaders who are courageous, who are not content with the status quo and who will work with others to create the necessary changes. Major service change is not easy particularly in cash strapped times. Our leaders will need to present a compelling medium to long-term vision, have the tenacity to work towards that vision and the patience and flexibility to make step changes towards their goal. We

need leaders who ensure women centred care trumps taking into account other considerations but not being dominated by them.

We need leaders who foster collaboration and multidisciplinary working. Major change requires collaborative leadership (16). Maternity care will only change if the vision is shared. Doctors, midwives, users and managers all need to be on board. The drive is for continuity of midwifery led care and for more out of hospital birth but this still requires quality communication between midwives and medical staff including GPs. Continuity of care along the midwifery pathway is critical if women are to be safe.¹⁷ A significant number of women who start their pregnancy or their labour without complications will need to transfer into hospital and although women at higher risk of complications need care from a midwife they need care from doctors too. The MBRRACE report into why mothers die demonstrates the consequences of poor communication between GPs and maternity services,¹⁸ and the Kirkup report highlights the critical importance of multidisciplinary team working if women and their babies are to be safe.⁴

We need midwifery leaders who are flexible and adaptive and work with staff rather than imposing their will on them. Our leaders need to have a genuine and current understanding of maternity care and what needs to change but also to understand the pressures faced by the midwives. A midwife is also a mother, a carer and a partner. Any transformation of maternity services must recognise this. It may appear easiest to run services with very clearly defined policies and rules with little room for variability. This may mean the needs of the institution are met but it won't mean the needs of women and midwives are met.

Conclusion

Our leaders need to be innovative enabling different midwives to work in different ways throughout their careers. They need to abandon traditional hierarchies and give opportunities to all midwives playing to their enthusiasms and strengths. Flexibility, an individualised approach to the precious workforce, a commitment to openness, honesty and an ability to listen to and act on what service users and staff are saying will ensure safe care whilst opening up more possibilities for women to receive care that aligns with the evidence and with their choices.

My argument is fundamentally, if we are to transform the future of maternity services we need to transform midwifery leadership.

References

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