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PERMANENT STUDY GROUP XX: Welfare State Governance and Professionalism

What are the barriers to improving public value – the case of maternity services in England?

Benington (2009) identified front-line public service organisations, where public professionals interact with service users, citizens and communities, as one of the main places where public value is created. As a way of exploring some of the challenges in trying to improve public value, this paper will use a case study of the crisis in maternity services in England, as seen through the reports of two enquiries (Morecambe Bay NHS Trust and Shrewsbury and Telford NHS Trust) and the responses to these reports by midwives, managers, politicians, women and their families.

There are several reasons why a study of the crisis in maternity services in England is useful for trying to understand some of the barriers for public professionals in delivering public value. In the last 20 years, there has been a move away from medical interventions to a natural birth approach, due to demands made by women's campaigning groups in the 1980s and 1990s. Health professionals have had to respond to these demands. At the same time, the National Health Service (NHS) adopted public management reforms with the introduction of targets, increased use of evidence-based medicine to determine clinical practice, accompanied by budgetary pressures. These changes have brought politicians, managers and health professionals into uneasy alliances, all working towards slightly different versions of public value. Maternity services are significantly different to other health care services because women are not technically ill, although there are elements of risk involved in giving birth. This generates conflicts about how to deliver the public value of maternity services. The concepts of risk and uncertainty will be used as a theoretical basis for this paper.

Since 2015, there have been two public enquiries into the delivery of maternity services in two NHS hospital Trusts. Further inquiries into two other hospitals are currently underway. The recommendations of the first two enquiries were similar: the importance of safe staffing, training, an organisational culture to reflect on practice, and the importance of listening to women and families. This paper will examine how these recommendations can inform improvements and professionalisation and what political and professional barriers exist.

Benington J. (2009) Creating the Public In Order to Create Public Value *International Journal of Public Administration* 32:232-249

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Benington (2009) identified front-line public service organisations, where public professionals interact with service users, citizens and communities, as one of the main places where public value is created. As a way of exploring some of the challenges in trying to improve public value, this paper will present a case study of the crisis in maternity services in England, which have been pursuing the goal of 'informed choice' since 1991. The crisis is characterised by conflicts over public values as seen through the interests of midwives, obstetricians, managers and women. The 2003 House of Commons Health Committee reported:

> *"The key issues affecting choice in the clinical delivery of care are rooted in two extremely different models of provision. The most highly medicalised pregnancies might involve a series of separate scans and tests, induction of birth, electronic monitoring of the fetus during labour, use of analgaesia such as epidural anaesthetic and then, in almost a quarter of cases, a caesarean section. In contrast, the most 'normal' births would eschew scans and tests, avoid fetal monitoring, make no use of analgesia and favour vaginal birth wherever possible" (House of Commons Health Committee, 2003).*

An analysis of the challenges facing the implementation of '*informed choice*' in maternity services has to include the introduction of the internal market system to the NHS and the marketisation of NHS institutions. These two major challenges provide the context for establishing public value in maternity services. An analysis of maternity service reports and strategies from 1991-2021 and the reports of two inquiries (Morecambe Bay NHS Trust and Shrewsbury and Telford NHS Trust) will form the basis for the case study, also drawing on research that shows the perspectives of women and midwives.

Public value

There is a growing literature that examines different aspects of public value. It is considered a central issue for public administration and public services. However, how to define public value and who creates it remain a subject for debate because it can vary according to different public services and those involved in their delivery. It is much more than the opposite of private value, or shareholder value, which is a driving force for private managers (Bennington and Moore, 2011).

The study of public value is sometimes viewed as a review of output values, for example, effectiveness and efficiency (Moore, 1995). This places the creation of public value as a function of public management, essentially a technocratic process (Bennington, 2009; Van der Wal *et al*, 2014). Alternatively, public values may be process values, for example, encompassing integrity, transparency, participation but also covering efficiency and effectiveness. However, there may be conflicts between governing effectively and efficiently with certain process values (De Graaf and Van der Wal, 2010). None of these values are easy to measure. Agreeing on a definition of public value is key to measuring public values. Faulkner and Kaufman (2018) in a systematic review of studies looking at measurement of public value identified four dimensions: outcome achievement, trust and legitimacy, service delivery quality and efficiency.

Beck Jorgensen and Rutgers (2015) argued that public management and public policy making both require a broad view of public values and so public values should be the starting point, rather than the result. Known as the Public Values Perspective (PVP), this can be presented as a third type of public value research. The definition of public values is still difficult because it is unclear whether public values govern public institutions or whether public values are defined by the public. Rutgers (2015) in a study of the different aspects of public values, managed to bring these two options together. He defined public value as "*ensuring beliefs in the*

organization of and activities in a society regarded as crucial or desirable, for the existence, functioning and sustainability of that society" (Rutgers, 2015:40).

Some of the wider definitions of public value often bring together types of public value which may be in conflict. De Graaf *et al* (2016) approaches this through the lens of governance, defined as "the process of agenda setting and rule enforcement" (p.1103) by public actors. Three types of good governance are identified, often sites of public value conflict:

- Performance governance – efficiency and effectiveness;
- Proper governance – integrity, lawfulness and equality;
- Responsive governance – transparency, participation, legitimacy and accountability.

For example, integrity, lawfulness and equality cover several systems of justice. They might conflict with goals of efficiency and effectiveness. Transparency and participation may be widely held goals in public administration but can conflict with professional practices. Transparency, participation, legitimacy and accountability are public service goals although the extent to which they can be achieved in different contexts varies. It is proposed to use these three types of governance to identify some of the barriers to improving public value in maternity services in England.

As the definition of public value is a complex process, so the process of researching public value presents difficulties in terms of identification and measurement. Beck Jorgensen and Bozeman (2007) provide a useful overview of problems in researching public values but conclude that public values are '*an ambiguous but potentially viable set of criteria for action and accountability*' (377). More specifically, Fukomoto & Bozeman (2019) argue for the use of historical and longitudinal approaches to understand the development of public values and how they change over time.

This paper argues that the concept of '*informed choice*' in maternity services is a public value because it aims to meet the needs of women giving birth but has to achieve this in a system where there are two different models of maternity care. The crisis in maternity services in England can be characterised as a result of conflicting values. There is a fundamental tension between the medical, more technological type of birth, using a high level of interventions and a 'natural birth', where there are no technological interventions, and the birth takes place as a natural process. Although the existence of two models could be considered to provide more choice, health professionals, such as midwives and obstetricians, view these two alternatives in very different ways. This often results in less choice for women.

In addition, the period being studied 1991-2021, covers the introduction and consolidation of the internal market and marketisation of NHS institutions. These processes have introduced a different set of public values into the NHS, which often sit uneasily with conventional healthcare values. Choice in the context of marketisation is often limited to a consumer perspective, in terms of choice of appointment, place where birth will take place and type of ante-natal care. It does not cover the more complex issues of whether to have a type of scan or test or help in the process of assessing risk. By analysing the period from 1991-2021, this case study acknowledges the importance of taking an historical approach, especially during a period of rapid institutional change and the introduction of new values. There is one research question: What were the barriers to creating public values in maternity services during the period 1991-2021?

Methodology

As a way of exploring some of the challenges in trying to improve public value, this paper has developed a case study of the crisis in maternity services in England. It has drawn on an analysis of reports and strategies into maternity services and 'informed choice' between 1991 and 2021. The views of women and midwives are examined by drawing on academic research and research commissioned by organisations involved in maternity campaigning.

The analysis of public values and public value conflicts will use a framework developed by de Graaf *et al* (2016) focusing on three types of governance:

1. Responsive governance is defined as a system where transparency, participation, legitimacy and accountability are key values but these values may be challenged by professionals who have different ways of assessing risk and uncertainty.

2. Performing governance is associated with the marketisation of the NHS and operates on the basis of effectiveness and efficiency goals, driven by financial management and targets.

3. Proper governance is defined as encompassing integrity, lawfulness and equality. In the context of maternity services, this has been interpreted as creating an organisational culture where mistakes can be admitted and analysed.

Structure of case study:

1. Development of maternity services in the NHS and the rise of 'informed choice'
2. Responsive governance – the evolution of 'informed choice'
3. Performing governance – 'informed choice' with limited resources
4. Proper governance – the barriers to learning from mistakes
5. Conclusion – the barriers to achieving public value in maternity services.

1. Development of maternity services in the NHS

After the formation of the NHS in 1948, maternity services were the responsibility of General Practitioners, hospital services and local authority health services, which ran maternity clinics. The 1959 Cranbrook Report on Maternity Services recommended that 70% of births should take place in hospital with 30% at home. However, with increasing obstetric knowledge and methods resulting in more births being classified as high risk, doctors were demanding more hospital births. By 1967, the Maternity and Midwifery Advisory Committee recommended 100% hospital births. From 1963 to 1972 the rate of hospital births rose from 68.2% to 91.4% and after 1975, it never fell below 95 % (Davis, 2013).

The introduction of technological interventions in the 1970s, for example, the use of ultrasound to identify foetal abnormalities, as well as increased use of induction, caesarean sections and episiotomies led to extensive public debate about childbirth. The formation of the National Childbirth Trust in 1961, formerly the Natural Childbirth Association, and the Association for Improvements in Maternity Services in 1960, originally the Society for the Prevention of Cruelty to Pregnant Women, campaigned for improvements in hospital maternity services, and have been involved in campaigns for new and improved approaches to maternity care ever since (McIntosh, 2021).

The response by government to demands for greater choice in maternity care was slow. In 1982, the Department of Health formed the Maternity Services Advisory Committee to the Secretary of State for Social Services, which maintained that hospital was still the safest place to give birth (Short Report, 1982). The rate of home births recorded in the mid-1980s was the lowest ever recorded.

In 1985, the case of Wendy Savage, a senior obstetrician with strong views about the need for less medical intervention in childbirth, was suspended because of '*alleged incompetence'* in five cases, where two babies died. After a public inquiry, she was '*exonerated and reinstated*'. This case had a huge impact on obstetrics, the medical profession and women as users of maternity services, introducing a greater awareness of the need for choice in childbirth (Davis, 2013; Savage, 2007).

Savage (2007) provided an account of how the Short Report (1982) had misinterpreted data about home and hospitals births because unplanned and un-booked births were included. Unplanned births had not received any antenatal care. Un-booked births were scheduled to have a hospital delivery but, as a result of an emergency, took place at home. The perinatal mortality rate was high (196/1000 birth) for both unplanned and un-booked births, whereas hospital births had a rate of 67.5/1000 births. However, home births, excluding unplanned and unbooked births, had a perinatal mortality rate of 4.1/1000 (Savage, 2007).

In the 1990s, there was a fundamental change in policy at national level towards maternity services, indicating a greater recognition of the importance of choice for women. Several maternity reports which have informed policy/ strategies over the period 1991-2021, reflect the importance of choice, starting with the *Changing Childbirth* (1992) report. Over ten years later, the 2007 *Maternity Matters* strategy aimed to provide women with choice about where to have a baby. In 2012/3, *Framework – choice in maternity services* was launched. *Better Births* (2017) was informed by the National Maternity Review, the government response to the inquiry into maternity services at Morecambe Bay NHS Foundation Trust. By 2021, 41 Local Maternity Systems were being supported by the *Maternity Programme,* to improve choice and deliver personalised care for pregnant women.

Maternity statistics for the period 2011-2021 show that there were several significant changes over this decade. There were 559,728 deliveries in NHS hospitals during 2020-21, a decrease of 5.4 per cent from 2019-20. The figure for 2021 is the lowest for the period 2011-2021.

Table 1: Types of delivery 2010/11 – 2020/21

Type of delivery	**2010/11**	**2020/21**
Spontaneous	67%	47%
Caesarean section	12%	18%
Induced birth	21%	34%

Source: Office for National Statistics (ONS) Maternity Statistics 2010/11-2020/21

Although the majority of deliveries were spontaneous, the percentage had fallen from 67% in 2010-11 to 47% in 2020-21. Caesarean sections increased from 12% to 18%. Induced births increased from 21% to 34% in same period. The decrease in spontaneous births and increase in caesarean and induced births showed an increase in obstetric interventions, away from 'natural' births. This had implications for how women experience 'choice' although providing women with 'choice' has been central to maternity strategies since 1991.

What do women want?

Research into what women want from maternity services during the second half of the twentieth century shows some consistent demands. Davis (2013) found that *"women's criticisms of their care centred on the quality of their inter-personal relationships with health professionals (doctors, nurses and midwives), rather than the precise nature of their medical care"* (Davis, 2013: 5). They felt that there was a lack of emotional care.

A survey by the National Federation of Women's Institutes (NFWI) looked at women's experiences of giving birth between 1955 and 2005. Women recorded many improvements during this period although the one element that had changed little in the period was that women felt that they were left alone for too long during labour. There was more criticism about the access and use of information. Many respondents felt that "*to be truly effective it must be tailored to their individual needs and communicated to them in real-time. Some women shared*

stories of times when information was useful and empowering to them, while others told of how lack of information left them frightened, and sometimes, feeling violated" (NFWI, 2015: 17).

In 2003, the Maternity and Neonatal Workforce Group commissioned a survey on the views of women and midwives about the range of options available for antenatal care and birth and experienced during the ante-natal period (Lavender, 2003). There was little understanding of home births and 50% of respondents were not offered a choice. Only 8% had considered it. 72% wanted local antenatal care. About 64% said they would feel unsafe if there was not a doctor available during labour but after the birth, this figure had dropped to 45%. 51% wanted 24 hour access to epidural anaesthetic and even after the birth, the percentage had only dropped to 50%. 51% felt it was important for them to have a midwife who can provide support at birth without medical intervention. Women felt that consultant-led maternity units were busy and impersonal but were reassured about the availability of appropriate medical staff. They felt that a midwife-led unit on the same site would offer a more sensitive, safe environment. These results show some of the conflicting views of women who wanted a sensitive, homely environment but also wanted safe, medical care (Select Committee, 2003:6)/ Lavender.

In 2015, research to support the National Maternity Review found that choice about where to have a birth was not available to all women and the offer of choice varied from unit to unit. Women view the midwife as the most important source of information about choice. Even written information should be discussed with a midwife. Only a minority of women (<10%) considered a home birth (Hollowell *et al*, 2015).

Some groups of women have particularly poor experiences of maternity services, with women from Black and Minority Ethnic communities having the worst experiences. The Maternal, Newborn and Infant Clinical Outcome Review Programme published by the Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries in the UK (MBRRACE) in 2017 reported that there was a more "*than four-fold difference in maternal mortality rates amongst women from Black Ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women*"(MBRRACE, 2017).

During the last decade, in response to a growing demand from parents and campaigning groups, two inquiries into the delivery of maternity services in two district general hospitals were commissioned by the Department of Health. The first inquiry examined the '*management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013*' (Kirkup Report, 2015). The inquiry report was published in 2015. It found that the 'dysfunctional nature' of the maternity services in Furness General Hospital (part of the Trust) were the result of poor working relationships, inadequate skills and knowledge of staff, inappropriate pursuit of 'normal childbirth', unsafe care and inadequate investigation processes.

The second inquiry looked at the delivery of maternity services at the Shrewsbury and Telford NHS Trust between 2000 and 2019. The Ockenden Report was published in February 2022. It found that there had been an extensive failure of maternity services to provide adequate care due, a failure of governance and leadership and a failure to listen to women and families. A major recommendation was the development of a maternity workforce plan for England.

In addition to these two published reports, there are two inquiries into maternity services still in progress, at the East Kent University NHS Foundation Trust (report to be published 21 September 2022) and at the Nottingham University Hospitals NHS Trust.

Conflicting public values

The main maternity service reports and strategies between 1991 and 2022 are set out in Table 1 (Maternity Services reports and strategies 1991-2022). This period can be divided into two sections: 1991-2015 and 2015-2022. In 2015, the Kirkup Report was published, which detailed major criticisms of how maternity services had been delivered in Morecambe Bay NHS Foundation Trust. The response of the Department of Health was to launch a National Maternity Review, which informed maternity strategies between 2015 and 2022. This second period ended with the publication of the Ockenden Report into maternity services at the Shrewsbury and Telford NHS Trust and the launch of a new inquiry into maternity services at Nottingham University Hospitals NHS Trust.

Also significant, was the incorporation of choice into the mainstream NHS and wider public service goals in 2012. The Choice Framework (2012/13) was part of the Cabinet Open Services agenda and introduced choice of General Practitioner, where to go for first out-patient appointment, choice of consultant, choice of community health services as well as maternity services. It provided a basic form of choice about access to health services but not more fundamental questions about a choice of care. By 2021, choice in maternity services had become part of the 'Personalised Care and Support Planning Advice'. The Maternity Programme supports Local Maternity Systems (LMS) to improve choice and deliver personalised care for women and their families.

Table 2: Maternity Services reports and strategies 1991-2022

Year	Policy/Strategy	Comments
1992	House of Commons Health Committee (Winterton) Report	Resulted in setting up of Expert Maternity Group for Secretary of State for Health in 1993
1993	Department of Health. *Changing Childbirth*, Part 1: Report of the Expert Maternity Group. Chaired by Julia Cumberlege	Made extensive recommendations for improving maternity services but had to be cost neutral (Savage 2007)
2003	House of Commons Health Committee. *Choice in Maternity Services*, Ninth Report of Session 2002-03.	A 10-year review of choice in maternity services – Extensive recommendations for improvements
2007	*Maternity Matters* aimed to provide women with choice in type of care and place of delivery (at home, in a birth centre or in an obstetric unit)	By 2009, research by the National Childbirth Trust (NCT) found that only 4% of women were given a choice of these options (Davis, 2013)
2012/13	*Choice 2012/2013* Framework for all patients with a section *Choice in Maternity Services*	Choices for maternity services is qualified by the statement '*You can expect a range of choices over maternity services, although these depend on what is best for you and your baby, and what is available locally*'. This does not include '*informed choice*' of interventions.
2015	***Publication of Inquiry Report into the University Hospital Morecambe Bay NHS Foundation Trust (Kirkup Report)***	***Extensive analysis of maternity services from 2004 to 2013 with a highly critical account of how maternity services were delivered and managed.***
2016?	*National Maternity Review* Chaired by Julia Cumberlege, a Conservative politician	Response to Morecambe Bay report – recommended the importance of safe staffing, training, an organisational culture to reflect on practice, and the importance of listening to women and families

2017	*Better Births* following the *National Maternity Review* - set up 44 local maternity systems	Set out 7 points for action and suggestions for resources and payment reforms - pilot **Personal maternity care budget** – continuity of carer model – access to personal care budgets
2021	March 2021, the NHS published Personalised Care and Support Planning Guidance. The Maternity Programme supports Local Maternity Systems (LMS) to improve choice and deliver personalised care for women and their families.	The guidance helps Local Maternity Systems ensure that every pregnant woman in England is offered a Personalised Care and Support Plan by March 2022.
2022	***Publication of the Inquiry Report into the Shrewsbury and Telford NHS Trust (Ockenden Review)***	***Extensive analysis of maternity services between 2000 and 2019 in Shrewsbury & Telford NHS Trust – highly critical of how services were delivered. Similar recommendations to 2015 report – safe staffing, training, reflective organisational culture and listening to women***

Table 3: NHS reforms and plans 1991-2021

Year	Reforms/ changes	Comments
1991	NHS and Community Care Act	Introduction of internal market – district general hospitals become NHS Trusts. Commissioning and provider roles created.
2003	NHS and Social Care (Community Care and Standards) Act	Foundation Trusts set up – semi-autonomous entity with some financial independence from Department of Health
2012	NHS and Social Care Act	Reduced cap on NHS Foundation Trust income and encouraged greater competition
2012/13	*Choice Framework* for all patients	NHS *Choice framework* is part of the Cabinet Office's Open Public Services agenda. Designed to raise awareness of the choices available in a number of individual public services.
2013	*Francis Inquiry* (2013) into '*failure of care*' at Mid-Staffordshire NHS Foundation Trust before 2009	Major inquiry into deaths in Mid-Staffordshire NHS Foundation Trust before 2009 - managers obsessed with Foundation Trust status and targets, staff shortages
2019	NHS Long Term Plan	To improve care for patients, including maternity services through 'Personalised Care and Support Planning Guidance'

Table 3 outlines key NHS reforms and plans during the period 1991-2021. The introduction of the internal market in 1991 (NHS and Community Care Act) was one of the most significant changes in NHS management and systems since the foundation of the NHS in 1948. NHS hospitals were encouraged, initially, to become Trusts with increased control over their own budgets and then after 2003, to become Foundation Trusts with even greater control over their management and finances. The gradual corporatisation of NHS institutions took place during this period with implications for transparency and accountability. The Francis Inquiry into unexplained deaths in the Mid-Staffordshire NHS Foundation Trust had an impact on the NHS with reviews of existing practice and supporting training.

Representative governance - the introduction of 'informed choice'

Choice can be seen as a public value although its use in different parts of the public sector varies. It is sometimes an opportunity to provide people with different options for care or public services. A narrower view is that people are given a choice of time of appointment or place of appointment but are not given a choice about their care or type of service. The case of maternity services illustrates the complexity of implementing choice as a public value. This section discusses how 'informed choice' was chosen as a strategy for maternity services and some of the immediate problems of involving women in making choices.

'Informed choice'
The 1990s show some of the first positive examples of representative governance in maternity services, where the views of women, midwives and campaigning organisations were actively collected and used to inform reports. The Winterton Report (1991) was the first inquiry into maternity services that took evidence from women, midwives and campaigning groups directly.

> *"We allowed virtually any interested body or individual to give evidence... we were able to interview individual women who had actually given birth at home... allowing a mother who had recently given birth actually to breastfeed while giving evidence" (McIntosh, 2016).*

Previous inquiries, the Cranbrook Report (1959), the Peel Report (1967) and the Short Report (1982), which all recommended an increase in hospital births, had drawn from 'experts', specifically obstetricians and medical practitioners, but not women who had given birth.

As a result of the Winterton Report, an Expert Maternity Group (chaired by Lady Cumberlege, a Conservative politician) was set up in 1992 to investigate maternity services for the Secretary of State for Health. It had a wide membership of medical professionals, service users, a representative from NCT, a journalist and management consultant. *Changing Childbirth* was published the following year with this definition of choice in maternity care.

> *"The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved"* (House of Commons Health Committee, 2003)

Changing Childbirth (Expert Maternity Group, 1993) identified 10 indicators of success for a service where women were given choice. Only three indicators (in bold) were implemented by 2003 (Select Committee, 2003).

1. **All women should be entitled to carry their own notes; partial success**
2. Every woman should know one midwife who ensures continuity of her midwifery care— the named midwife;
3. At least 30% of women should have the midwife as the lead professional;
4. Every woman should know the lead professional who has a key role in the planning and provision of her care;
5. At least 75% of women delivered in a maternity unit should know the person who cares for them during their delivery;
6. Midwives should have direct access to some beds in all maternity units;
7. **At least 30% of women delivered in a maternity unit should be admitted under the management of a midwife;**
8. **The total number of antenatal visits for women with uncomplicated pregnancies should have been reviewed in the light of the available evidence and the RCOG guidelines;**
9. All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency;
10. All women should have access to information about the services available in their locality (Maternity and Neonatal Workforce Group, 2003).

Although choice and 'informed choice' became a goal of maternity services, the evaluation of *Changing Childbirth* (2003) and the reiteration of the importance of choice in *Maternity Matters* (2007), which was to provide women with a choice of type of care and place of delivery, show that effective implementation was difficult. There was a lack of understanding of how choices are made and what support was needed for women to make choices and for midwives to facilitate them through this process.

Women are not ill when they give birth, and this makes the nature of maternity services different to other forms of healthcare. The 2003 *Changing Childbirth* report was critical of the use of clinical outcomes to measure the effectiveness of the service. It was also critical of the lack of data available, even though half a million births are recorded by the NHS every year. It recommended that research was commissioned into women's concerns and what they wanted and needed, thus gaining a picture of how women view maternity care (House of Commons Health Committee, 2003: 7).

Midwives and choice

Studies which examined how midwives worked with women to establish an 'informed choice' in relation to specific tests and interventions showed that the creation of 'informed choice' depended on several factors, including the provision of information and professional discretion, which were not easily reconciled. How women make choices depends on the information available, their own knowledge about their bodies and how they assess risk and uncertainty. There had been no provision to help prepare women to use the information to make decisions about their care pathways.

Hindley *et al* (2005) explored 'informed choice' through a study of how midwives prepared and provided information for women about intrapartum foetal heart monitoring in two hospitals in the north of England. The term informed choice is defined as "*having had enough information and detailed discussion from a midwife for the women and the midwife to make a choice together*" (Hindley *et al,* 2005: 306-7). Foetal monitoring was taken as an example of midwifery practice which illustrates some of the problems of ensuring informed choice. There was evidence that women were not always provided with all relevant information to make an informed choice for foetal monitoring.

Ahmed *et al,* (2013) examined how midwives perceived their role as facilitators of informed choice in antenatal screening. Midwives were reluctant to give advice directly to women because they felt the decision was the responsibility of the woman. Although they recognised the importance of facilitating a decision, they had mixed views about how to present and discuss information. Midwives suggested that clinical guidelines for health professionals explaining how to discuss information and make decisions would make the process more standardised. They felt the decision should be recorded and a system of record keeping established which recorded both acceptance and rejection of ante-natal screening.

Kloester et al (2022) found that the experience of midwives facilitating informed decision-making reflected the findings of Ahmed *et al* (2005). Although midwives were committed to facilitating informed decision making, they identified several barriers: lack of education and training, fear of litigation, lack of time and fragmented models of midwifery care. More education, research and policy/ practice solutions were needed.

In the early 1990s the voices of women were heard in two key reports on maternity services. The recommendations emphasized the importance of 'informed choice' for women using maternity services. This contrasted with previous decades where choice was not considered. However, identifying the need for choice and implementing it within maternity services proved more challenging because of a lack of understanding of how women make choices. There was no provision of resources to support women in making choices and to train midwives in facilitating choices. This limited the scope of the reports and strategies to implement choice as a public value.

Performing governance – the case of 'informed choice' with limited resources

Although a series of reports and maternity strategies continued to focus on choice there was growing evidence that this was not systematically delivered across the NHS. By 2021, the commitment to providing women with choice had become part of the NHS Long Term Plan, which aimed to '*make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment*'. The goals of efficiency and effectiveness had been integrated into all health care strategies.

This section on performing governance will provide an analysis of how the efficiency and effectiveness agenda affected the pursuit of 'informed choice'. It will examine whether maternity services were adequately resourced, as seen through numbers of midwives and whether resources were available for organisational developments necessary to deliver 'informed choice'.

Adequate resources
Although the number of midwives has increased over the period 2010/11 to 2020/21, there has been an annual short fall recorded during the period 1991-2021. The level of staffing was one of the most important issues that emerged during this period but was not resolved. Some regions of England were affected more than others. The findings of the two major inquiries into maternity services both concluded that staff shortages were one of the causes of the dysfunctional delivery of maternity services. A shortage of midwives as well as other healthcare professionals contributed to poor quality teamwork, training issues and unwillingness to reflect on critical incidents and complaints.

Several maternity strategies were not provided with adequate resources to implement the proposed changes. *Changing Childbirth* (1992) was a consultative document but not government policy. Although it placed the concept of 'informed choice' in maternity policy, how this could be implemented by bringing different groups and services together, had not been considered (Edwards, 1993). Any implementation was supposed to be cost-neutral (Savage, 2007: 175).

The results of 'informed choice' being considered as cost-neutral was reflected in the 2013 National Audit Office review of maternity services in England. It was critical of the Department of Health because it had not considered the resource implications of its maternity strategy.

> *"The Department has failed to demonstrate that it satisfactorily considered the achievability and affordability of implementing the strategy. There are potential tensions between different elements of the strategy, such as between choice and quality-and-safety considerations. Reconciling these different elements is challenging for NHS bodies" (NAO, 2013:7).*

These comments reflect the views of the 2003 review of *Changing Childbirth* but presents them in relation to achievability and affordability. They show that the tensions between choice and safety were still visible. The NAO highlighted that out of a total maternity budget of £2.6 billion, the cost of maternity negligence cover in 2012-3 was £482 million, almost a fifth of the total maternity budget. Maternity services had become the focus of increased litigation.

The NAO (2013) also observed that it was unclear how local commissioners were monitoring maternity services. 28% of trusts did not have a service specification with their lead commissioner in 2012-13. 31% of trusts did not expect to have a service specification when the new commissioning arrangements were in place. There was also variation between trusts in the costs delivering maternity care.

The process of commissioning and drawing up of service specifications in maternity services had been criticised in 2003. The 2003 Select Committee report observed that Primary Care

Trusts, responsible for commissioning health services rarely had specific maternity expertise. The report saw this as part of general issue about where maternity expertise was located and whether there was enough of it in the management of the NHS in acute hospitals and community services *(*Select Committee 2003:15).

The use of maternity expertise in management was raised in a study of midwives who had become NHS managers. The study aimed to explore how midwifery leaders perceived themselves in relation to a professional identity as midwives, within a specific region in England. Although the leaders felt that they were still midwives, committed to midwifery even though no longer practising but with many years of experience, this was often challenged because they no longer had a clinical role and there was no organisational commitment for them to maintain their clinical skills. Divall (2015) argued that if clinical leadership is to be strengthened within the NHS, then midwives need continued professional support.

During a period when the internal market was putting the management of the NHS under increased scrutiny, the failure of the Department of Health to provide adequate resources for the implementation of the 'informed choice' agenda had a long-term impact on the service. This was reflected in staffing levels – midwives – which recorded a short fall during much of this period. The lack of maternity expertise within NHS management was identified by 2003. This was reflected in the lack of service specifications for maternity services, which made monitoring the service delivery difficult. The failure of the Department of Health and NHS management to provide resources and expertise needed to implement 'informed choice' illustrates some of the barriers to delivering this public value.

Proper governance – the barriers to learning from mistakes

Proper governance covers forms of justice such as integrity, lawfulness and equality. In the context of maternity services, this paper has interpreted this as an organisational culture where mistakes can be admitted, analysed and reflected on. The implications of hospitals being resistant to admitting mistakes are serious in a service which spends almost a fifth of its budget on litigation (NAO, 2013). More generally, it shows the reluctance to develop an evidence-base for 'informed choice'. This section will discuss the barriers faced in creating a form of proper governance that builds on research into choice, using a historical perspective.

Evidence based medicine

Archie Cochrane, the founder of evidence-based medicine, in an account of evidence-based medicine in the NHS, pointed out that the development of maternity services by 1972 had not been informed by evidence (Cochrane, 1971). The trend towards more hospital births and increased medical interventions that intensified after 1960 should be understood in this context. It shows that the debates in the 1970s and 1980s about hospital versus home births were not informed by a rigorous evidence base. Savage (2007) is critical of the way in which statistics were used to justifying maternity services. The presence of a male-dominated obstetrics profession and its power to influence the delivery of maternity services cannot be over-estimated. It exerted power over the overall service, midwives and women giving birth.

The Winterton Report (1991) was innovative because it emphasized the importance of evidence to inform maternity services. It drew evidence about place of birth, types of birth, birth attendant and interventions. One of its most startling findings was that there was no evidence that hospital births were safest and no reason why women could not be given the choice of what to have their baby. The Winterton Report (1991) was the first government report which provided a very different perspective on maternity services, one which reflected what campaigners, women and midwives felt.

Although evidence-based medicine has received recognition within the NHS since then in a wide range of specialities, maternity services have been slower to develop an evidence base. This can

be explained by looking at how foundation trusts have been reluctant to admit mistakes and the limited reviews of research into 'informed choice'.

Resistance to learning from mistakes
In 1991, the NHS and Community Care Act required hospitals to operate with business principles, with an emphasis on effectiveness and efficiency. NHS district hospitals were initially encouraged to become NHS trusts and after 2000, to become Foundation Trusts. The Health and Social Care (Community Health and Standards) Act 2003/4 established NHS foundation trusts as independent public benefit corporations, which 'aim to be responsive and accountable to the populations that they serve' (RCN, 2010). Foundations trust would have greater control over budgets and management, including borrowing money and re-investing surplus money in patient services (RCN, 2010). However, this move towards trust status was accompanied by less transparent decision-making, with Trust boards only meeting in public once a year with no local representatives. This contrasted with previous district general hospitals that had some representation from the local authorities, with community health councils as observers. A study by the Royal College of Nursing in 2010 found that there was a lack of awareness by Trust staff about the decisions made by Trust boards, often on grounds of commercial sensitivity (RCN, 2010).

Commercial sensitivity influenced hospitals when they were applying for Trust status, making them resistant to making any problems in the delivery of healthcare public. The Morecambe Bay University Trust inquiry report documents the resistance of senior hospital management to look at complaints about maternity services during the period when the hospital was applying for Foundation Trust status between 2008-2010. This affected the way in which complaints and serious incidents were investigated with a focus on current practice rather than past incidents. There was evidence of dysfunctional clinical working and inadequate and ineffective clinical governance (Report of the Morecambe Bay Investigation, 2015).

Lack of research on consumerism in maternity services
As part of the submissions to the 2003 Health Committee, the Chair of the Royal College of Obstetricians and Gynaecologists acknowledged that there was a need for more consumer research into what choices women want. This shows that although the term 'choice' had been part of NHS policy since 1992, there were no systematic reviews of choice to support the implementation of 'informed choice'. Even by 2020, there was only one systematic review of choice and decision making in maternity care. This study (Yuill *et al*, 2020) concluded that 'informed choice' is an illusion, very similar to Beech's submission to the 2003 Health Select Committee report *Choice in Maternity Services*.

Yuill *et al* (2020) concluded that decision-making and informed have to be reconceptualised. The 'embodied dimensions of pregnancy, birth and decision making' do not feature in classical models of decision making, which have dominated thinking about 'informed choice'. Decision-making in pregnancy has to be made at several levels. Health systems need to be more flexible and fluid in practice so that new models of maternity care can be developed, for example, midwifery-led care, continuity of carer or group antenatal care. Women are often concerned with uncertainty in pregnancy so effective communication about risk and safety is important. Place more trust and respect in women's knowledge and experience of their own experiences and 'bodily autonomy and integrity' should inform that way that services are restructured (Yuill, et al, 2020: 19).

The failure to establish an evidence base for 'informed choice' contributed to the failure to implement several maternity strategies. Even by 2020, there was only one systematic review of 'informed choice'. This reflects the failure to anticipate how to listen and support women in making choices as well as recognising the support that midwives needed to enable women to make choices. The history of maternity services since the setting up of the NHS in 1948, shows

that the voices of women did not inform the development of these services. The professional power of obstetricians in the delivery of maternity services remains strong even after many decades of campaigning for greater choice.

The creation of foundation trusts was part of a major organisational change taking place in the NHS during this period. The move towards marketisation placed commercial considerations above a transparent and accountable operational culture. Admitting failures of care was difficult when foundations trust applications were in process. The combination of professional power and commercial considerations contributed to the failure to put a proper governance system in place.

Conclusion

This case study into maternity services and 'informed choice' in England from 1991-2021 has shown that there were several barriers to improving public value. They operated at several levels within government, the NHS and professional organisations.

What has contributed to undermining the pursuit of 'informed choice' was the failure by government to allocated adequate resources to the implementation of the strategy. An increased centralisation of services and facilities led to a reduction in the choices that women were able to make about where to give birth.

There was a lack of understanding of what informed choice involved accompanied by an unwillingness to commission research to develop more research informed solutions. This was not just a responsibility of government but of professional groups, especially the Royal College of Obstetricians and Gynaecologists, which did not prioritise consumer focused research into choice. This contributed to a failure to understand how to support women to make informed choices and how to support midwives in this process. This was reflected in a lack of adequate staffing and training for midwives.

The introduction of new organisational structures and ways of operating within the NHS contributed to a failure to develop a transparent and accountable culture, instead the marketisation of the NHS led to a simpler consumer focus, which was not based on research. The use of targets influenced the professional practice of maternity units to the exclusion of listening to what women wanted.

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