

# Nursing Studies Elsie Stephenson Memorial Lecture 2018

Transforming Healthcare: are today's nursing and midwifery leaders up to the challenge?

Dame Cathy Warwick RM  
9th October 2018



THE UNIVERSITY *of* EDINBURGH  
School of Health in  
Social Science

## The Elsie Stephenson Memorial Lecture 2018 Introduction

The Elsie Stephenson Memorial Lecture celebrates the work of Elsie Stephenson, the first Director of the first academic department of nursing in Europe, established at the University of Edinburgh in 1956. The lecture was founded by Nursing Studies in recognition of Elsie's visionary qualities, dynamism and her significant contribution to the development of the nursing profession on the world stage. The inaugural lecture was given by Professor Helen Carpenter in 1973.

Tonight we are delighted to welcome Dame Cathy Warwick BSc, MSc, RM to give this year's lecture. Following graduation from Nursing Studies here at the University of Edinburgh in 1975, Cathy has had a distinguished career. She has held several leadership roles including Chief Executive of the Royal College of Midwives and is currently Chair of the British Pregnancy Advisory Service and Visiting Professor at King's College London and the Chinese University of Hong Kong.

It gives me great pleasure to now invite Cathy on behalf of Nursing Studies to give the 13th Elsie Stephenson Memorial Lecture.

Pam Smith  
Professorial Fellow  
Nursing Studies  
9th October 2018

## **Elsie Stephenson Memorial Lecture**

**Transforming Healthcare: are today's  
nursing and midwifery leaders up to the  
challenge?**

**Dame Cathy Warwick RM**

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"It is a pleasure to be here and to have been invited to give the Elsie Stephenson Memorial lecture. This evening rather than giving a talk based on research or academic work my plan is to base this lecture on my own knowledge of the health services we provide today. This knowledge is based on my observations as I have undertaken roles both in the NHS and in organisations linked to the NHS. I hope I leave you with food for thought."

## Elsie Stephenson 1916 to 1967



"So, Elsie Stephenson, who we are here to remember and celebrate, lived from January 1916 to July 1967 and was, in 1956, the founding Director of the Nursing Studies Unit at the University of Edinburgh. This was the first university department of nursing in the UK."



"My father studied medicine here at Edinburgh and then became a general practitioner in Gullane. He was the first member of his own family to go to University and set great store by a university education. He wanted me to apply to study medicine ideally at Edinburgh."

## Gullane Beach



"I hope I am a fitting person to give this lecture. I am an alumni of Edinburgh University and I was born in Edinburgh and brought up in Gullane ... which many of you will know not for that reason but rather as a village with one of the most beautiful beaches and some of the most famous golf courses in the world."

## Early Ambition



"I however had wanted to be a nurse from a young age slide 6 and am eternally grateful to Elsie for setting up the nursing studies unit. This ensured my father fulfilled at least one of his ambitions for his daughter whilst I was still able to become first a nurse and then a midwife. There have been twelve previous Elsie Stephenson memorial lectures and I consider myself fortunate to have been asked to celebrate her legacy in 2018 as it is a year of two important landmarks both of which I am sure would have been of interest to her."

## Nursing Studies Cohort 1970 to 1975



"Elsie Stephenson herself was not Scottish. She was born in County Durham where her father was a farmer. However what we do have in common is that our careers were influenced by our fathers. In Elsie's case it is said that it was the early death of her own father which stimulated her to aim for a career in nursing."



"We have celebrated the 70 year anniversary of the founding of the National Health Service."



## 100 years of woman's suffrage



"And it is 100 years since women achieved the right to vote.

However, whilst these landmarks are a cause for celebration everything, as you are well aware, is not completely rosy for the NHS or for women."

## TODAY'S 5 FACTS PRESSURES ON THE NHS

**Ageing UK population**  
Estimated 18m over-65s by 2037

**A&E demand**  
More than 21m visits in England last year, 32% higher than 10 years ago

**NHS inflation**  
Treatment costs go up by 7.4% on average in the UK every year

**Dementia**  
800,000 cases in the UK now, expected to double by 2040

**Obesity**  
Around a quarter of adults are classified as obese in England

"Expectations around health care are ever rising; resources increasingly strained and while women may have had the vote for 100 years only a very cursory glance at newspapers is enough to raise awareness for example of a gender pay gap, ..."

## Women's Inequality



"...sexual harassment, forced marriage and domestic violence. Women may have the vote but there is still much to be done to ensure they are treated with equality and respect. I thought therefore it would be appropriate to think about Elsie in this context."

## Elsie Stephenson 'Britain's Nursing Messiah of the 20<sup>th</sup> c'



"Elsie was clearly an inspirational woman. She was described in the Journal of Advanced Nursing as Britain's nursing messiah of the 20th century. She was someone who had the foresight to deliver a radically different training scheme for nurses from the UK and from overseas. She saw a need to transform the way in which nursing was viewed and was not afraid to take action to achieve that. What transformation would Elsie, a woman of vision and courage, expect to see happening today?"

What issues would she advise nursing and midwifery leaders to focus on if we are to ensure healthcare meets the needs of society today and makes a contribution to ensuring women are less marginalised in that society?"

## Nursing Studies at Edinburgh: underpinning principles

- person centred care
- evidence based care
- informed choice
- high quality leadership
- courage, inquiry, innovation
- advocacy

"I think top of her list would be those very issues that she thought were important when she set up the Nursing Studies Department and which have been underpinning principles in the education of cohorts of nursing students at Edinburgh ever since. I think she would suggest we focus firmly on person centred care including evidence based care and informed choice and she would argue that to deliver such services she would want to see nurses and midwives demonstrating high quality

leadership based on confidence/courage and a spirit of inquiry and innovation with such leadership encouraging nurses and midwives to act as advocates for patients and women and to take part as equal players in the multidisciplinary team."



"With examples mainly from the area of women's health services and maternity services especially let me now go on to explain why I think Elsie Stephenson would be right if she said these issues need focus today.

Lets look first at person centred care, also referred to as patient centred care. This is a model of care that respects the patient's experience, values, needs and preferences in the coordination and delivery of care."

### Definition of patient centred care: the Institute of Medicine

Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions



"The Institute of Medicine defines person centred care as providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions."

### Health Foundation: what everyone should know about patient centred care 2016

'What is important to one person in their healthcare may be unnecessary, or even undesirable to another'



"Person centred care matters because as the Health Foundation says in their 2016 slide 15 publication What Everyone Should Know about Patient Centred Care 'what is important to one person in their healthcare may be unnecessary, or even undesirable, to another'. It is arguably unethical not to provide person centred care as it has been shown to improve clinical outcomes and increase patient satisfaction but in addition it makes better use of resources."

### Health Foundation: what everyone should know about patient centred care 2016

'When care is tailored to individuals they are more likely to stick to treatment plans, take their medicines correctly and interestingly choose less invasive and costly treatment'.

"As the Health Foundation reports 'When care is tailored to individuals they are more likely to stick to treatment plans, take their medicines correctly and interestingly choose less invasive and less costly treatment'. I think this last point is extremely important. There are some who would say that care based on personalisation and choice is an expensive luxury we can no longer afford. This is not borne out by the evidence and the link between personalised healthcare and the improvement of the status of women

is clear. Through the provision of health services we can help to empower women to be confident, to strive for their rightful place in society but this cannot happen unless we respect them as individuals and value their right to make choices and decisions."

### Empowering women

- The World Bank states '*Empowerment is the process of increasing the capacity of individuals or groups to make choices and transform those choices into desired actions and outcomes.*'
- Barack Obama said '*When women succeed, nations are more secure, safe, and prosperous*'
- Kofi Annan 7<sup>th</sup> UN Secretary General emphasised '*There is no tool for development more effective than the empowerment of women.*'

"These quotes highlight the importance of women's empowerment which is closely linked to person centred care. "In policy terms person centred care is now seen as critical: The Health and Social Care Act 2012 imposes a legal duty for NHS England and clinical commissioning groups to involve patients in their care. Vision for Scotland 2020 has a focus on supported self management and similar policy threads can be seen in Northern Ireland and Wales. However whether policy has any impact and whether or

not person centred care is delivered on the ground is often up to clinicians and I would argue that too often services are not person centred. In my own area maternity; women are often made to feel guilty for example because they did not breast feed or they are told they choices are not available to them. They can be labelled difficult if they don't follow the rules. They ask if they are 'allowed to do things.'"





"Too often services are modelled to meet the needs of the system or the population in general not the individual and too often the individual gets either institution centred care or care based on the professional knowing best."



"I love the cartoonist Ros Asquith and her commentary on healthcare. Here is one of her jokes just to remind you who I am talking about and to help you visualise another cartoon that unfortunately I can't find. So imagine a woman receiving maternity care is lying on the couch. The professional standing over her and looking at her notes says 'Ah Mrs Smith I see you have a boy and a girl' She corrects him saying 'no I have two boys'. No no says the professional pointing at the notes 'a boy and a girl'. A lovely

illustration of the professional knows best. Now this is not to say that there has not been progress in delivering a person centred model of healthcare. I am Chair of the British Pregnancy Advisory Service (BPAS), a charity which provides counselling in relation to reproductive choice and services in relation to abortion. I have found that at BPAS staff don't focus on the rights and wrongs of abortion, on who should have one and who should not. They don't comment or make judgement on the issues driving a woman's choice to end her pregnancy.



The focus is instead on the women and indeed BPAS's advocacy slogan is, 'we trust women' trust them to make their choice about the life they not the BPAS staff will have to go on to live. The aim is to provide flexible, responsive, caring services which, as far as is possible within the current law, enable women to make the choices that are right for them. Of course the law relating to abortion services still ensures some restrictions on person centred care and choice but my point is that it is not the nurses, midwives and

doctors restricting what women can do. To the contrary they do everything they possibly can to ensure that the restrictions of the law only have a limited impact."



"It is worth noting that BPAS does a huge amount of advocacy trying to change the law so that women's choices are not restricted in the way they are now and policy makers and the public seem increasingly to be convinced of the importance of trusting women. The recent landmark decision to provide abortion services in Ireland and decisions in Scotland, Wales and now England to allow home use of misoprostol are very significant steps forward. In my view the

area of abortion is an example of how services change as much through grassroots front line advocacy as from top down policy direction. There are other areas of healthcare where I have witnessed first hand the work being done to personalise care by committed professionals one of which is not specifically about women."

Outstanding



"I am a non executive Director on the Board of Kingston Hospital an acute hospital in SW London. Kingston just received an outstanding rating from the Care Quality Commission and one of the areas they highlighted for specific praise was services for patients living with dementia."

### The NHSI Guide to Reducing Hospital Stays 2018



35% of 70 year old patients experience functional decline during hospital admission in comparison with their pre illness baseline; for people over 90 this increases to 65%.

"This is critical because as The NHS Improvement Guide to Reducing Hospital Stays 2018 states 35% of 70 year old patients experience functional decline during hospital admission in comparison with their pre illness baseline; for people over 90 this increases to 65%.

This is terrible for the patient and costly for the NHS and is a clear failure to provide effective and efficient care. I think the changes that the Care Quality

Commission (CQC) noted at Kingston are attributable to high quality leadership and enthusiastic committed healthcare professionals as much as to overarching policy directive. I could also give examples of exceptional care in maternity services"

"The report notes:

'All staff were extremely caring and compassionate. People were treated with the utmost kindness, dignity and respect. Care and treatment was delivered as part of a person centred culture.'

The aim at Kingston has been to ensure the hospital environment is personalised to help the patient feel at home thereby minimising the disruption and confusion commonly caused by an alien environment and ultimately the disabling effects of hospital admission..."

### Celebrating innovation and good practice



Pregnancy plus



Labour Line



Whittington midwives

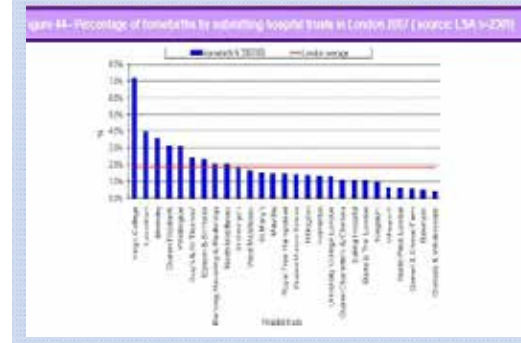
"So change is happening but it is slow and I think more focus is necessary. Still some might accuse me of being a bit harsh in saying nurses and midwives are responsible for a failure to implement policy.

Are other issues at play? Well of course personalising care is not necessarily easy. It can take enormous amounts of energy eg helping the woman to have a homebirth..."

### The homebirth she wanted



### Variation in home birth rates, London



“Helping the woman to have a homebirth who has issues which on the face of it would suggest hospital birth as her better option or supporting the woman who has a completely normal pregnancy but who is desperate to have her baby by caesarean.

But it also takes energy arguing against a persons wishes and the question has to be why are some nursing and midwifery leaders prepared to personalise care and others not.

Let me give you another example of the variation that exists at a clinical level.”

“This slide picks up the issue of whether women are or are not given the choice of homebirth. Its an old slide but the same situation pertains today. The horizontal axis is all London Hospitals, the vertical the homebirth rate. As you can see at this time Chelsea and Westminster had the very lowest rate, Kings College Hospital London the highest. Now many would look at this and say that this is odd and because homebirth is seen as a choice most commonly made by white middle class women and given that Chelsea and Westminster is sited in one of the wealthiest boroughs in London and Kings in one of the most diverse and poorest the graph should be the other way up. I would respond it isn't surprising ...what this reflects is that , at this time, at Kings, midwives were actively offering the choice of homebirth ...the leadership at Kings ensured the service was properly staffed by committed confident midwives and women were informed about it when they booked to have their baby. In other words the active provision of a service which enabled women to make a choice meant more women choose it...



## Better Births

### RECOMENDATIONS

- Personalised care
- Continuity of carer
- Safer care
- Better postnatal and perinatal mental health care
- Multi-professional working
- Working across boundaries
- A fair payment system



“The choice was not actively supported in many other London hospitals at the time. In fact it was not uncommon to hear women either saying they had to fight to get the birth they wanted OR to say that they didn’t think it was allowed. Ironically , unlike in abortion services, any difficulty in providing truly personalised services in maternity is not due to legal or policy restrictions. Indeed key policy documents in both England Better Births and Scotland”

## The Best Start Plan for Maternity and Neonatal Services in Scotland

Scottish Government Policy published January 2017

Signalled changes in the way care is provided, where it is provided and by whom

Key recommendations:

- Continuity of carer central model of care
- Maternity care in ‘community hubs’
- Move from 8 NICUs to 3
- Choice of place of birth in all areas
- Individualised needs assessment



“Best Start talk about the need for personalised care and informed choice. Overarching policy documents in maternity services are in agreement too that women should be able to choose their proposed place of birth from a range of options, obstetric unit, alongside midwifery unit, stand alone midwifery unit and homebirth”

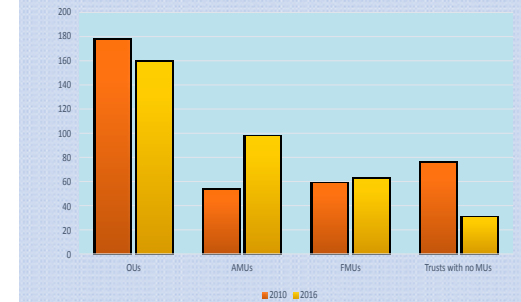
## Birthplace in England

- The evidence supports the policy of offering ‘low risk’ women a choice of birth setting.
- FMUs and AMUs appear to be safe for babies and offer benefits to both the mother and baby
- For multiparous women, home births appear to be safe for babies and offer benefits to both the mother and baby
- The substantially lower incidence of major interventions, including intrapartum caesarean section, in all three non-OU settings has potential future benefits to both the woman and the NHS in terms of avoiding surgical complications and reducing the need for repeat caesarean sections in future births.

Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. Birthplace in England Collaborative Group. BMJ. 2011 Nov 23;343. Summary on NHS Choices web site about the implications of the Birthplace in England Study. <http://www.nhs.uk/news/2011/11/november/pages/hospital-births-home-births-compared.aspx>

“This is based on evidence which demonstrates that for all women without complications in their pregnancy choosing to give birth in midwifery led units leads to improved outcomes for themselves and as good outcomes for their babies as choosing to deliver in obstetric units and for women having their second or subsequent babies the same applies to the choice of homebirth.”

## Numbers of OUs, AMUs, FMUs in England: Change since Birthplace Study



“But here again I can demonstrate variation in provision. There are many areas of the UK where it is hard to access a homebirth and/or there is no stand alone midwifery unit and still some places where the only place a woman can give birth is an obstetric unit. It can be costly to create new services when still maintaining old service models but bear in mind that in the longer term homebirth services and midwifery led units are cheaper than hospital based services. I believe that where there are strong professional voices as there were at Kings around homebirth supporting these developments and basing their arguments on quality outcomes and longer term savings ...they happen.

Now maybe the policy direction is not clear enough.

But the issue of the pendulum in healthcare delivery very much swinging away from a professional paternalism to one of personalised/person centred care at a national level is mirrored elsewhere.”

The Montgomery Ruling 2015: every woman is different from every other woman



Everyone is an individual



“Take the recent critical ruling about informed consent and how that is defined ie the Montgomery case. In this slide all the women may look homogenous but of course they are all individuals and that is what the Montgomery case picks up on.

Nadine Montgomery, a woman of small stature and with diabetes, argued all the way to the Supreme Court, that had she been properly informed of all of the risks directly relating to her personal characteristics she would have chosen a caesarean birth as opposed to a vaginal birth potentially changing the poor outcome of her birth for her child.

The judgement which went in her favour established that doctors (and other professionals) must tell women what they want to know and must not withhold information simply because they disagree with the decision the patient/woman is likely to make if that information is given.”

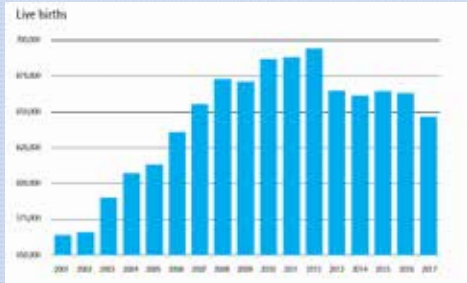
“What the ruling made very clear is that it is the individual user and their needs, values and preferences which must drive any clinical discussion not the views of the professional.

In the Montgomery case the solicitor representing the patient spoke of the decision as having ‘modernised the law on consent and introduced a patient focused test to UK law’.

This further underpins my point that in maternity services and in wider healthcare you don’t need to look very far to find support at a national level for person based care.

But maybe it is too much to ask the majority of services to implement change when everyone is struggling just to get through the day and deliver the basics. However in maternity services particularly I am not sure this can be our excuse.”

## Live Births



“The latest statistics from the RCM show that overall the birth rate is decreasing and despite an exodus of midwives from the profession numbers of midwives employed in the NHS are at an all time high.”

## Midwife Numbers



“Now of course as I have said earlier in this lecture expectations of care are high, complexity is increasing so it is not a simple equation and in increasingly difficult times we still need to argue for better resources.”

## Keep up the pressure



“But the point that I want to continue to illustrate is that this is not sufficient reason for lack of change because some services are getting it right. And furthermore resources being tight heightens the necessity to act because as I have already pointed out person centred care is known to also be cost effective care. Perhaps its fear. Perhaps people are scared of the consequences of person centred care and what patients/women will choose. I have already though noted that work from the Health Foundation suggests that in fact people make sensible choices and my own experience is that when women are told that their choice is possible it starts to build trust in services and with that trust often comes a change of decision.”



## The Montgomery Ruling 2015

But this is a false dichotomy ...the idea of a fully autonomous patient making choices completely independent of the doctors' input does not reflect the complex reality of medical decision making, nor does the caricature of a paternalistic doctor riding roughshod over patient's objections.

Montgomery and informed consent: where are we now? BMJ 2017;357:j2224 doi: 10.1136/bmj.j2224



"I like this quote from the British Medical Journal (BMJ) talking about the impact of patient-centred care and the patient making 'mad' choices (in the eye of the clinicians), "I remember a story a friend told me of a woman who had witnessed her sister's difficult birth and decided when she was pregnant she wanted a caesarean section. She went off to her ante natal appointment expecting a fight as she had a normal pregnancy and clinically there was no reason for a caesarean birth to be on the cards. Completely contrary to what she expected she was met by open minded professionals who told her that her choice was possible but also discussed in detail with her various options and scenarios and ensured that she got to know the same midwives and was able to discuss her options over a period of time. Ultimately she decided to see how her labour went and supported by a team who knew exactly what her feelings were went on to have a vaginal birth.

I think the fact of the matter is that policy direction is clear, there are resource constraints but often personalising care can help manage those constraints, that it isn't easy to do but neither is it impossible because there are examples of success and there is no need for fear.

I think the fact is that the issue is down to leadership and whether or not nursing and midwifery leadership is transformational or not.

Let me illustrate this.

We know from surveys of women that many women dislike the fact that in most units their partner cannot stay with them overnight either after the baby is born or when they are admitted to hospital perhaps in early labour."

"Ten years ago when I started as CEO of the RCM one or two leaders of midwifery services were changing this policy. Others were not. The nay sayers cited lack of space, privacy and health and safety considerations (men may run around drunk in their underpants), (they will burn themselves making cups of tea). Some of these are of course legitimate challenges which arise from the fact that women are being cared for in a communal space but despite this ten years on I would guess about 50% of units have changed their policy. But why only 50%? Interestingly reports from services who have found ways to enable this choice first of all point out that not all women choose it so the numbers are less than might have been expected, note that the men themselves are very conscious of privacy and dignity issues and that the number of complaints about postnatal care dropped dramatically. It is in my view down to the desire of the leaders in those units to ensure care is as women centred as possible, or not, to ensure women have choices, or not. It is to do with can do midwives or can't do midwives. Its to do with whether midwives want services that are women centred or institution centred."

National Institute for Health & Care Excellence (NICE) Guidelines on Induction

Women with uncomplicated pregnancies should usually be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy. The exact timing should take into account the woman's preferences and local circumstances.

**Figure 1.2 Functions of Management and Leadership**

Management Produces Order and Consistency	Leadership Produces Change and Movement
<b>Planning and Budgeting</b> <ul style="list-style-type: none"> <li>• Establish agendas</li> <li>• Set timetables</li> <li>• Allocate resources</li> </ul>	<b>Establishing Direction</b> <ul style="list-style-type: none"> <li>• Create a vision</li> <li>• Clarify big picture</li> <li>• Set strategies</li> </ul>
<b>Organizing and Staffing</b> <ul style="list-style-type: none"> <li>• Provide structure</li> <li>• Make job placements</li> <li>• Establish rules and procedures</li> </ul>	<b>Aligning People</b> <ul style="list-style-type: none"> <li>• Communicate goals</li> <li>• Seek commitment</li> <li>• Build teams and coalitions</li> </ul>
<b>Controlling and Problem Solving</b> <ul style="list-style-type: none"> <li>• Develop incentives</li> <li>• Generate creative solutions</li> <li>• Take corrective action</li> </ul>	<b>Motivating and Inspiring</b> <ul style="list-style-type: none"> <li>• Inspire and energize</li> <li>• Empower subordinates</li> <li>• Satisfy unmet needs</li> </ul>

SOURCE: Adapted from *A Force for Change: How Leadership Differs From Management* (pp. 3-8), by J. P. Kotter, 1990, New York: Free Press.

"A further example relates to induction of labour. The evidence tells us that, women with uncomplicated pregnancies should usually be offered induction of labour between 41 +0 weeks and 42+0 weeks to avoid the risks of prolonged pregnancy. The exact timing should take into account the woman's preferences and local circumstances.

Now lets imagine a woman has chosen to have her baby in a hospital where induction is not offered on a Saturday or a Sunday or bank holidays. She wants to wait as long as she can to increase the chance of her going into spontaneous labour but does not want to risk letting her pregnancy continue after 42 weeks. Unluckily for her 42 weeks lands on bank holiday Monday. She either has to have her labour induced later than she wants and later than is advised...OR have her induction three whole days earlier than planned. The staff on the unit, despite her protestations can offer her no alternative. Its hard to know what the arguments against this would be. Inductions do lead to the necessity for more interventions but we now have labour ward theatres available 24/7 and medical staff also available 24/7 and if what is desired is to reduce pressure on these costly services surely giving this woman a chance of going into spontaneous labour makes much more sense than forcing her to have an earlier and therefore possibly tougher induction?

This woman's care I would argue is neither person centred, evidence based or cost effective. It is illogical and institution centred.

So what we need is high quality leadership. Leadership which whilst recognising that we do need frameworks and standards understands that there is always a need to have flexibility in these and understands that our services need to change to meet the individual needs of users rather than the other way round. I would argue that in nursing and midwifery we still have too much management and not enough leadership"

"When what we need is leaders who will have the confidence and trust in both the people receiving services and the people providing services.

Nurses and midwives must far more often be expected to speak for the patient/the woman rather than the institution and enabled to do this and guidelines and standards need to be interpreted to enable flexible care.

I have seen this in action in relation to the design of midwifery led units (MLUs)."

## Improving the birthing environment



"In my role as Chief executive of the Royal College of Midwives I have visited many maternity units up and down the country. All are far more homelike and welcoming than is normal in hospital buildings. However some are more homelike and more welcoming than others. Take the issue of plants. Some MLUs have no plants, some have plastic plants and some have real plants. Why should this be? The answer is the issue of the strength of the midwifery voice and how well they have advocated amongst other voices e.g. infection control staff and the works department staff as to what a MLU is. The fact is an MLU provides care that is really no different from a homebirth. We have real plants in our homes so why not in a MLU where women should be fit and healthy and not susceptible to infection. By focusing on leadership we can change the culture of nursing and midwifery and I believe see more practice that reflects those principles that were dear to Elsie Stephenson.

The culture of nursing and midwifery in Elsie's day was very hierarchical. I have read that members of the Scottish nursing community expressed their shock that Elsie had been appointed. She had no university education and had limited teaching experience. This shock highlighted a focus on qualifications for their own sake rather than on the person and her ability to learn, to innovate and change things."

"Things were not much different when I was a young midwife. I remember a terrible day as a community midwife when in an attempt to complete my morning visits successfully I got in very early to work, picked up one of the 'pool' cars and drove a considerable way to the end of my patch to undertake my first visit. I had failed to sign the car out properly. My nursing officer called me made me drive all the way back again. This knocked at least two hours off the time I had to spend with women before getting to my busy clinic and exemplified a lack of trust in myself and a failure to enable person centred care or to focus on outcome not process. Today nurses and midwives still far too often work in services based on command and control, hierarchies and rules. Guidelines themselves are seen not as that but as clinical rules. Nurses and midwives learn obedience and are afraid to challenge. They themselves become can't do people rather than can do. Of course we need high standards and safe frameworks but if we are to transform healthcare we need systems where we acknowledge that professionals can take responsibility for the care they provide, respect each other and trust and trust each other."



## Transformational Leadership

- calls for responsive ways of leading
- emphasises caring, nurturing, intuition, emotions matter
- focuses on people, their potential and communication
- is vibrant, energising, inspiring, exciting
- transmits a vision and a sense of mission and creates meaning and purpose
- changes become opportunities, possibilities

"We need transformational leadership. If we are to transform services. We need cultures where we see change as possible, where things are allowed not forbidden, where we are open to learning from those who have succeeded in changing the way we do things and where we focus much more on outcomes not process. We particularly need to encourage nurses and midwives who want to see things change and support them to innovate and to try things out regardless of years of qualification or position.

So we need person centred care and to achieve that we need transformational leadership.

But what about the model of care? Does that matter.

I believe that we can rapidly make strides in developing person centred care within our current models of care as I have illustrated with partners being enabled to stay overnight even in a hospital service.

However, I do think that if alongside personalised care we develop models based on building a relationship between patient and professional or in maternity services mother and midwife we could achieve even greater change.

It simply makes intuitive sense that if you know someone and understand them you will be better able to deliver care more efficiently and effectively and meet their personal needs. Happily there is now increasing high quality evidence that care delivered through relationships does indeed lead to better outcomes. Lets take maternity services as an example. At the moment in many services women see many different midwives during the course of their pregnancy, birth and postnatal care. Surveys show that most women do not meet a midwife they know and trust when they are in labour.

Continuity of carer, is a model where a woman gets to know her own midwife."

## Continuity of Carer

Aims to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decision



"Continuity of Carer aims to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decision and is recommended in again both Best Start and Better Births."

## What is it?

- midwifery care
- continuity throughout a woman's journey
- a small team of four to six midwives, one of whom could be a buddy and take responsibility for care if the midwife is not available
- an identified obstetrician linking with the team
- having a known midwife at the birth. Ideally her own midwife, but if not possible, a midwife from the team

"Continuity of Carer is a model based on midwifery care, continuity throughout a woman's journey, a small team of four to six midwives, one of whom could be a buddy and take responsibility for care if the midwife is not available, an identified obstetrician linking with the team, having a known midwife at the birth. ... ideally her own midwife, but if not possible, a midwife from the team."

## Outcomes of continuity of carer: Sandal et al 2016

- 7 times more likely to be attended at a birth by a midwife they know
- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 155 less likely to have regional analgesia
- 24% less likely to experience pre-term birth
- 16% less likely to have an episiotomy
- More likely to have a positive birth experience than women who don't know their midwife (England CoC survey 2015)

## Is caseloading sustainable? 25yr history of caseloading at Kings.

Year	Event	History
1994	Midwifery	Set up with support from the Independent midwives from the South East London Midwifery Practice (IMWP), some think of their caseload comprised of women planning a home birth across the Kings area and one IMWP concept of women with serious mental health issues (SMH).
1996	Reorganisation	The specialist branches set up to deliver continuity to those women, providing personal, independent and professional care across all settings.
1998	Albany	The IMWP was subcontracted to work for Kings, changing it name to the Albany based in the community in Peckham, an area of considerable deprivation, the Albany cared for single women while retaining their self-employed, independent status. Albany's model differed to the midwives who would be their own business (SME), except for when they were on home leave (S.E. 13 years, the Albany achieved a 0.5 per cent home birth rate and 16 per cent caseload satisfaction rate in an 18-24 population with a perinatal mortality rate of 5.8/1000 at a time when the national rate was 13.2/1000 (Green et al 2007). The Albany's contract was cancelled in 2000 amidst significant controversy (Centre for Midwifery and Child Enquiries (CMACE) 2000; Edwards and Dudgeon 2010; Wainwright 2010).
2000	Outward	Three newly qualified midwives were inspired by changing (Midwives (London) Ltd (MFL) at that time) and the needs of East London's South Midwifery Practice (SMP) to approach Cathy Edwards about carrying another caseload team to them, sub-contracting an Albany caseload, drawing from women from a local GP in East Dulwich.
2004	Same	A MFL caseload team - the Levels - was started up by Cathy Edwards and the new head of midwifery, Nuala Harwood, in response to increasing local demand in affluent East Dulwich for home births. Based at a GP surgery, they also accepted a mixed-risk caseload.
2008	Albany	Following the closure of the Albany practice, practice based women transferred Nuala Harwood to launch a new Kings caseload team in Peckham, based at a local children's centre, drawing 10 women from her local GP surgeries.

Octavia Wiseman, Sadie Holland in all4maternity.com 1<sup>st</sup> Sept 2018

"The Cochrane review of continuity of carer is unequivocal about the benefit continuity of carer models of care deliver for women and babies. However we are a long way from delivering services based on this evidence. What is the problem? It is at least in part due to a lack of funding but in my view one of the key blocks are midwives themselves ... leaders say this is impossible to deliver. But how can they hold that position when the evidence is clear this model will lead to better outcomes for women. Is it ethical not to support this significant change? Of course services can't change overnight but some are making progress. I believe this is yet another example where we will only see change when nurses and in this case midwives step up to the plate..."

(Sandall J, Soltani H, Gates S & Devane D. Midwifery-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting. Cochrane Systematic Review, 28th April 2016)

"An article has recently been published which makes my point called: 'Is caseloading sustainable? 25 year history of caseloading at Kings College Hospital'

It discusses how at Kings College Hospital in South London a series of leaders including myself have over 25 years have sustained caseloading or continuity of carer models. The model has been adapted over time and it is not yet available to every woman but it has been possible to deliver a relational model of care to 20% of the 5-6000 women who give birth at Kings.

This slide shows the continuity of carer teams that were established during the time I worked at Kings. I left there around 11 years ago and the model continues to be sustained and developed..."

### The new Larkhall team in Scotland

- 210-220 women a year
- Caseload of 35 for a full time midwife WTE
- The caseload has been weighted manually – according to risk factors and also social vulnerabilities
- Members of the new team: Community and hospital midwife mixture and one NQM midwife – one is a single parent and one with an elderly mum.
- Started 30 July – All midwives keeping a diary about workload, on calls, feelings, work/life balance
- 50 midwives volunteered. If all worked in a continuity model over the next 18 months – that would be 7 teams - 1,500 women giving birth in a continuity model – that's 1/3 of the women giving birth in Lanarkshire



“And in Scotland we are now seeing examples of teams being set up based on continuity of carer and most encouragingly a significant number of midwives volunteering to take part in such new models.”

### Courage



“So to conclude I believe very strongly that if we are to be true to Elsie Stephenson’s legacy and reap the benefits of delivering care based on the principles she advocated we need nursing and midwifery leaders who have the courage through transformational leadership to innovate and transform our services so that person centred care is delivered through models based on relationships. In maternity services this means changing our model of care delivery so it is based on continuity of carer.

This can completely transform how women experience healthcare services and can, through trusting them to be in charge of their own lives and to make decisions for themselves, help them to be strong in other areas.

If we can achieve that I believe Elsie Stephenson would be as proud of us as we are of her.”

Thank you



“Thank you”



In memory of Elsie Stephenson

With special thanks to Dame Cathy Warwick and everybody involved in organising this lecture

