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Health and Social Care Committee

The safety of maternity services in England

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Health and Social Care Committee

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Summary

At its best the NHS offers some of the safest maternal and neonatal outcomes in the world and England is making good progress towards halving the rate of stillbirths and neonatal deaths by 2025.[1] However, there remains worrying variation in the quality of maternity care which means that the safe delivery of a healthy baby is not experienced by all mothers.

Since shocking failures were uncovered at the University Hospitals of Morecambe Bay NHS Foundation Trust there has been a concerted effort to improve the safety of maternity services in England. However, major concerns have since been raised at the Shrewsbury and Telford Hospital NHS Trust and East Kent Hospitals University NHS Foundation Trust. There can be no complacency when it comes to improving the safety of maternity services and it is imperative that lessons are learnt from patient safety incidents.

Throughout our inquiry we have considered a range of issues related to the safety of maternity services in England. This report addresses the following issues:

- Supporting maternity services and staff to deliver safe maternity care
- Learning from patient safety incidents
- Providing safe and personalised care for all mothers and babies

In Chapter 1, we consider one of the essential building blocks of safe care–safe staffing and funding. We were concerned to hear that 8 out of 10 midwives reported that they did not believe that there were enough staff on their shift to be able to provide a safe service and every unit has rota gaps for doctors.[2] Appropriate staffing levels are a prerequisite for safe care. We recommend, as a matter of urgency, that the Government commits to funding the maternity workforce at the level required to deliver safe care to all mothers and their babies.

After a patient safety incident, too often families are not provided with the appropriate, timely and compassionate support they deserve. We heard from Darren Smith that after the tragic loss of his son, Baby Issac, he "just wanted an apology" and "to make sure that it did not happen to other people". Instead he faced a "battle" which was "nothing about improving the situation".[3] In Chapter 2, we explore how our current approach to patient safety incidents is resulting in rising clinical negligence costs without sufficient learning and perpetuating a culture of blame. We urge the Government to reform the clinical negligence system in a way that better meets the needs of families and establishes a less adversarial process which instead promotes learning.

1 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report]. The original definition of neonatal death set out by the Department of Health and Social Care in the National Maternity Safety Ambition included babies across all gestational ages. The Department later redefined this definition to include only babies born at greater than or equal to 24 weeks. The Government is on track to meet the 50% reduction in neonatal deaths when considering the revised definition. Further explanation can be found in pages 17–19 of the Expert Panel's report.

2 Q261 Gill Adgie, Q168 Edward Morris

3 Qq84–85 Darren Smith

In Chapter 3, we explore what women want and need from their maternity care. As we heard from Michelle Hemmington, whose son, Baby Louie, tragically died following mistakes in her care during labour, the central aim of maternity services must be to achieve "a safe, healthy, positive experience of birth and to come home with a baby".[4] Personalised care must go hand in hand with safety. We urge NHS England and Improvement to ensure every woman is fully informed about the risks of all their birthing options as well as the pain relief options that are available to them during labour.

In Chapter 3, we also explore inequalities in maternal and neonatal outcomes. Despite disparities being well documented for many years there has been little progress in closing the gap. We recognise that the underlying causes for this go beyond maternity care. However, we ask that the Government as a whole introduce a target with a clear timeframe to address the disparity.

At the same time our independent Expert Panel has conducted thorough analysis of the Government's progress in achieving its own maternity safety goals. The overall rating across all commitments is assessed as 'Requires Improvement' with 'Good' ratings for progress on key maternity safety goals, particularly reducing neonatal deaths and stillbirths but 'Inadequate' ratings for aspects of continuity of carer, personalised care, and safe staffing.[5]

4 Q2 Michelle Hemmington
5 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report].

1 Introduction

Providing safe maternity care for mothers and babies

1. The vast majority of NHS births in England are safe and at its best NHS care offers some of the safest maternal and neonatal outcomes in the world.[6] Progress in improving maternity safety has also been impressive with a 30% reduction in neonatal deaths and 25% reduction in stillbirths over the last decade and our Expert Panel rated progress in these areas as 'Good'.[7] But the improvement has come from a low base and if we had the same rate as Sweden approximately 1,000 more babies would survive every year.[8]

2. There also remains worrying variation in the quality of maternity care which means that the safe delivery of a healthy baby is not experienced by all mothers. The impact of any maternity incident for a family is a tragedy but such tragedies are often made worse because key lessons are not learned, and they end up being repeated.

3. At the instigation of the Chair of the Committee, then the Health Secretary, Dr Bill Kirkup CBE led an independent review to investigate maternity safety incidents between 2004 and 2013 at the University Hospitals of Morecambe Bay NHS Foundation Trust.[9]

4. In 2015 the Kirkup review uncovered "serious and shocking" problems with maternity care at the University Hospitals of Morecambe Bay NHS Foundation Trust.[10] The independent review catalogued "a series of failures at almost every level–from the maternity unit to those responsible for regulating and monitoring the Trust".[11] Dr Kirkup was clear that lessons must be learnt, and the investigation shone a spotlight on maternity safety.

5. Since then there has been a focus on improving the safety of maternity services in England. This includes the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts (EBC) programme, the National Maternity Review's clear vision for Better Births and the continuing work of the Maternity Transformation Programme (MTP). The Government remains committed to achieving the National Maternity Safety Ambition of halving stillbirths, neonatal deaths, brain injuries and maternal deaths by 2025.[12] A chronology of the various programmes, initiatives and investigations is set out in **Appendix 1**.

6. However, since the Morecambe Bay scandal, major concerns have once again been raised, at Shrewsbury and Telford Hospital NHS Trust and East Kent Hospitals University NHS Foundation Trust. The emerging findings from investigations into those trusts are a stark reminder that lessons still need to be learned and there can be no complacency when it comes to improving the safety of maternity services.

6 World Health Organisation, Maternal and newborn - Mortality/causes of death

7 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], pages 5; 13–36

8 Calculated based on data from - Office for National Statistics - Child and infant mortality in England and Wales; Organisation for Economic Co-Operation and Development – Health Status: Maternal and infant mortality

9 Morecambe Bay Investigation Report, 2015

10 Morecambe Bay Investigation Report, 2015

11 Morecambe Bay Investigation Report, 2015

12 Department of Health, Safer Maternity Care - The National Maternity Safety Strategy, 2017

7. Professor Ted Baker, Chief Inspector of Hospitals, Care Quality Commission (CQC), told us that whilst maternity services were improving, "we still had not learned all the lessons" and that maternity services were "not improving fast enough".[13] He reflected that elements from Morecambe Bay were still to be found in maternity services today; including a defensive culture, dysfunctional teams, and poor quality investigations without learning taking place.[14] During the opening session of the inquiry he told us that:

> 38% of our [CQC] current ratings for maternity services are that they require improvement for safety. That is a significant number, and larger than in any other specialty. It is a reflection of the cultural issues in maternity services nationally.[15]

8. In December 2020, Donna Ockenden released interim findings from an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. The review identified themes not dissimilar to Morecambe Bay. Donna Ockenden highlighted that the Immediate and Essential Actions directed at all trusts were not new and built on recommendations in previous reports. She stated that "had earlier recommendations been followed at the Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes we are investigating might not have occurred."[16]

9. We recognise that the failings seen at Morecambe Bay, Shrewsbury and Telford and East Kent are not reflective of all maternity services. However, nor are they unique, reflecting many underlying problems that contribute to a poor safety culture in other parts of the system.

Patient safety culture

10. The NHS Patient Safety Strategy, launched in 2019, set out the main features of a positive patient safety culture including a compelling vision, an openness to learning, psychological safety for staff, diversity and teamwork and leadership. However, NHS England & Improvement (NHSE&I) acknowledged that "culture change cannot be mandated by strategy, but its role in determining safety cannot be ignored."[17]

11. In January 2021 we held a private roundtable meeting with clinicians. At that meeting, we heard examples of a positive safety culture supporting staff in speaking openly after mistakes have been made. However, one clinician emphasised the challenge of achieving this:

> It's a really fine balance, as soon as the exec board gets sight of 'oh there's a dashboard' and you know it's red, it's orange, it's green, let's put performance markers on this, and culture, teamworking is such a sensitive, personal area that as soon as you start treating it as a performance dashboard, it loses the emphasis it's trying to make. It's really sensitive, but it's so important that we need to find ways of getting it right.[18]

13 Q24 Ted Baker
14 Q21 Ted Baker
15 Q20 Ted Baker
16 Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust - Emerging Findings and Recommendations, December 2020
17 NHS England and NHS Improvement, The NHS Patient Safety Strategy, July 2019
18 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

We recognise that it is not easy to measure culture. But throughout this report we identify ways to ensure there is a positive culture for both clinicians, mothers and families more uniformly across a large system.

Moving forward

12. The Department of Health and Social Care (the Department) and NHSE&I have a clear vision for improving maternity services which is shared by many key stakeholders, and the recommendations generated by a focus on maternity services over recent years have been largely welcomed. However, as Professor James Walker, Clinical Director of the Maternity Investigation Programme, Healthcare Safety Investigation Branch (HSIB), aptly told us, the implementation of recommendations is the next point of failure when working towards improving patient safety.[19]

13. This report sets out our conclusions and recommendations in three parts:

- Chapter 1 addresses the essential building blocks of safe care - first and foremost staffing numbers and funding, underpinned by leadership and training.
- Chapter 2 focuses on learning from patient safety incidents; first we consider the role of the newly formed Healthcare Safety Investigation Branch; we then examine the current clinical negligence system and how to reform it to allow a more positive learning culture to take root.
- Chapter 3 explores women's experience of care and considers the changes required to ensure safe care is a reality for every mother and her baby. This includes tackling unacceptable inequalities in outcomes; specific interventions to improve outcomes, including continuity of carer and screening; and finally, and most importantly, supporting informed choices and personalised care, to ensure that no woman faces pressure to have an unassisted vaginal birth.

14. We are incredibly grateful to parents and maternity service users Michelle Hemmington, Darren Smith, James Titcombe, Atinuke Awe and Clotilde Rebecca Abe for sharing their experiences with us during this inquiry. We thank them for the strength, courage, and humility they demonstrated while giving their powerful testimonies. Each account was a sharp reminder that not all births are the joyous occasion a family has patiently waited for. Improving the safety of maternity services is ultimately about protecting families from the unimaginable and life changing consequences hidden behind the statistics.

15. We also thank the clinicians who joined our roundtable. Their insights as frontline clinicians were invaluable to our inquiry and we were impressed by their passion for caring for mothers and babies.

19 Q215 James Walker

The Committee's Expert Panel

16. In summer 2020, as a Committee we commissioned an Independent Panel of Experts to assess the Government's progress in meeting its own targets in key areas of healthcare policy.[20] The first area we asked our Expert Panel to consider was maternity services given the large number of Government commitments made in this area. The Expert Panel conducted detailed analysis of the Government's progress against four key objectives (**Box 1**).

20 Health and Social Care Committee, Process for independent evaluation of progress on Government commitments, August 2020

Box 1: Expert Panel CQC-style Ratings - Overview

Overall, our Expert Panel rated the Government's progress against four key commitments for maternity services as:

Overall: Requires Improvement

Commitment	Rating
Maternity Safety *By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025*	**Overall:** Requires Improvement **Stillbirths:** Good **Neonatal deaths:** Good **Pre-term births:** Requires Improvement **Brain injuries:** Requires Improvement **Maternal deaths:** Inadequate
Continuity of Carer *The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.*	Requires Improvement
Personalised Care *All women to have a Personalised Care and Support Plan (PCSP) by 2021.*	Inadequate
Safe Staffing *Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.*	Requires Improvement

A further breakdown and summary of the Expert Panel's findings can be found in Chapter 2 for safe staffing and Chapter 3 for maternity safety, continuity of carer and personalised care.

Detailed analysis is published in the Expert Panel's independent report*: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England.*[21]

17. We're pleased to see that the Government is on track to meet its ambition of halving stillbirths and neonatal deaths by 2025. However, the findings from our Expert Panel clearly highlights that there is some way to go in achieving safe and personalised care for all.

21 The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England

2 Supporting Maternity Services and Staff to Deliver Safe Maternity Care

18. In this chapter we consider the essential building blocks of safe care, staffing levels and funding, which are underpinned by leadership and training. In particular, we consider what is needed to deliver safe staffing levels in maternity units across the country; how this should be calculated, and the funding required to make safe staffing a reality. We will also consider how to ensure multi-professional maternity teams are led in a manner which promotes patient safety and receive the training required to deliver safe care.

Safe staffing

19. In our first evidence session, we heard from Michelle Hemmington, whose son, Baby Louie, tragically died following mistakes in her care during labour. We are indebted to Michelle for the courage she showed in sharing her story with us. Michelle told us that the first thing said to her when she arrived at the hospital in labour was that she had “picked a bad day to have a baby as the unit was really busy”.[22] Although factors other than staffing contributed to Michelle and Louie’s tragedy, Michelle highlighted staffing as a key issue. She said that there needed to be “more staff involved” and that there needed to be “more staff on labour wards and in maternity”.[23]

20. Suboptimal staffing levels were identified in the Morecambe Bay report, and Professor Ted Baker, Chief Inspector of Hospitals at the Care Quality Commission (CQC), told us that after Morecambe Bay the CQC was “very assertive in insisting that units have the right level of staffing”.[24] He went on to tell us that a number of factors affected the level of staffing including “a big attrition rate” in trainee obstetrics and midwifery; incidences of bullying; and problems with the workplace culture:

> There is an issue of staff numbers, but there is also an issue of how we look after the staff we have. […] The number of midwives has been a constant issue over the last few years. Our perspective at the CQC is that we expect providers to have adequate staff to provide safe care. Where they do not, we will insist that they find those staff, but we recognise that many units have difficulty recruiting.[25]

21. Staffing is also one of the four Government commitments our Expert Panel chose to assess (**Box 2**). The Expert Panel overall rated progress towards achieving safe staffing as ‘Requires Improvement’, stating:

> There is a consistent message in the range of sources we evaluated that staffing across the whole area of maternity services requires improvement. While there have been recent improvements in the number of midwifery staff, persistent gaps in all maternity professions remain. Current recruitment initiatives do not consider the serious problem of attrition in a demoralised

22 Q1 Michelle Hemmington
23 Q2 Michelle Hemmington
24 Q31 Ted Baker
25 Q31 Ted Baker

> and overstretched workforce and do not adequately value professional experience and wellbeing. Staffing deficits undermine the ability of Trusts to achieve improvements in all areas. [Expert Panel][26]

Box 2: Expert Panel CQC-style Ratings–Safe Staffing

Safe Staffing: *Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.*

Overall: **Requires Improvement**

Commitment met	Inadequate
Funding/Resource	Requires Improvement
Impact	Inadequate
Appropriate	Requires Improvement

Further analysis can be found in the Expert Panel's independent report: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England.*[27]

22. Safe staffing means putting in place the right staffing levels for each maternity unit to ensure safe care is always possible, even at busy times. However, staff shortages have been a persistent problem. Health Education England calculated that the NHS remains short of 1,932 midwives[28] and a recent RCM survey indicated that, 8 out of 10 midwives (83% of those surveyed) reported that they did not believe that there were enough staff on their shift to be able to provide a safe service.[29] While the Government has told us that there are now 4.8% more obstetricians and gynaecologists on maternity units than there were in 2019, evidence from the Royal College of Obstetricians and Gynaecologists (RCOG) suggests that numbers still need to increase by 20%.[30] NHS Providers estimates this would require an extra 496 consultants working in Obstetrics and Gynaecology.[31]

23. Determining the right staffing levels for maternity units is complicated. A maternity unit's team involves healthcare professionals from a wide range of different disciplines, including midwives, obstetricians, operating department practitioners, maternity support workers, anaesthetists, and paediatricians. Many of those who work in maternity services do not always work exclusively in intrapartum care, with midwives and obstetricians also delivering antenatal and postnatal care, and obstetricians also working in gynaecology.

24. Since 2001, Birthrate Plus® has been used as a planning tool to determine safe levels of midwifery staffing. Birthrate Plus® is enshrined in NICE guidance and is used by many

26 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, page 6
27 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, pages 5; 63–77
28 Letter from the Minister of State for Patient Safety, Suicide Prevention and Mental Health on the maternity workforce gap
29 Q261 Gill Adgie
30 Q228 Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care, Q168 Edward Morris
31 NHS Providers (MSE0114)

maternity units to plan their staffing requirements. However, there is no equivalent for obstetricians. The RCOG told us that urgent action was needed to rectify this, as not only were staff shortages widespread, there was also was no agreed way of establishing safe and appropriate staffing numbers. Dr Edward Morris, President of the RCOG, set out the extent of the problems as he told us "every single unit in the country has gaps in the rota of junior doctors and senior trainees who are delivering the service, which shows that we have a significant problem in staffing those rotas".[32]

25. In the light of this issue, the RCOG set out a proposal for a rapid research and workforce planning exercise to establish safe staffing levels. Its proposals included: interviews with O&G clinical directors, clinicians, women and their families, in depth study of innovative multidisciplinary models for working, evaluation of the efficiency of current junior doctor rotas and consultant job plans and updating the RCOG's previously published standards for maternity care and workforce.[33]

26. Timely pain relief is crucial to the delivery of safe and personalised care in labour, something we discuss more fully later in this report. Almost 21% of women receiving pain relief during labour require input from an anaesthetist.[34] However, the Royal College of Anaesthetists has recorded a workforce gap of 11.8% for consultant anaesthetists, equivalent to 1,054 FTE, with an unfunded gap of 374.[35]

27. **The Expert Panel overall rated progress towards safe staffing as 'Requires Improvement'. Appropriate staffing levels are a prerequisite for safe care, and a robust and credible tool to establish safe staffing levels for obstetricians is needed. We were pleased that following our evidence session, the Department has committed to fund the Royal College of Obstetricians and Gynaecologists to develop a tool that trusts can use to calculate obstetrician workforce requirements that will be in place by autumn 2021.[36] This work should also enable trusts to calculate anaesthetist workforce requirements within maternity services. We will contact the Department and RCOG for the outcome of this work in October 2021.**

28. However, the development of a tool to calculate workforce requirements is only a first step towards ensuring safe staffing. Although Birthrate Plus® has existed as a tool to determine midwifery staffing levels for many years, those running maternity services report that even when is used to assess staffing needs, trust boards often refuse to fund the necessary expansion in midwifery posts. Gill Adgie, Regional Head, Royal College of Midwives (RCM), explained the problem in the following terms:

> It is the gap [...] between what Birthrate Plus® says and the funded establishments. What we know from our Directors of Midwifery is that if a head of midwifery needs 30 more midwives in a service based on Birthrate Plus®, when she goes to the trust board with a business case, it is quite often knocked back.[37]

32 Q168 Edward Morris

33 The Royal College of Obstetricians and Gynaecologists (RCOG) (MSE0113)

34 Bamber JH, Lucas DN, Plaat F, Russell R. Obstetric anaesthetic practice in the UK: a descriptive analysis of the National Obstetric Anaesthetic Database 2009–14. Br J Anaesth. 2020 Oct;125(4):580–587. doi: 10.1016/j.bja.2020.06.053. Epub 2020 Jul 28. PMID: 32736825

35 NHS Providers (MSE0114)

36 Letter from the Minister of State for Patient Safety, Suicide Prevention and Mental Health on the maternity workforce gap

37 Q235 Gill Adgie

29. In March 2018, the Department committed to increasing the number of available midwifery training places in England by more than 3,650 over a four-year period. The increase was introduced in the 2019 academic year, with an additional 650 training places, rising to 1,000 in subsequent years. However, Gill Adgie told us that while the expansion in training places was welcome, it did not provide a guarantee of a direct expansion in staffing levels in the units that needed them:

> To put it plainly, if the head of midwifery has a whole-time establishment of 100 midwives, but has 10 vacancies, and the Birthrate Plus assessment says they need 30 more midwives to provide a safe service, actually that service needs 40 midwives. There probably are not the newly qualified midwives at the moment to fill those vacancies across the country.[38]

30. Following our evidence session, the Department provided us with gap analysis of the midwifery workforce. Health Education England (HEE) estimated that maternity services are currently short of 1,932 midwives. This included 844 vacant but funded posts and additional 1,088 posts that were not funded but would be required for trusts to reach the safe staffing levels recommended by Birthrate Plus®.[39]

31. Staffing levels were also identified as "a huge barrier" and a "major issue" by the frontline clinicians that attended our roundtable sessions.[40] They pointed out that even when a unit appeared on paper to be fully staffed, when sickness and attrition rates were taken into account the reality was very different:

> I would say the optimal numbers to fill shifts would be more than they currently are, but that's what they're funded for. They staff what they're funded for. So, if there's a challenging maternal situation which requires a second set of eyes on a CTG, or potentially there could have done with being two midwives in that room instead of one. I know loads of midwives who just don't even get their breaks because they're stuck in a room because things just get challenging. Funding is definitely an issue. [Midwife][41]

> Staffing […] is the main cog […] in all of this when things start to unravel at the seams. So you can put all these clever interventions in place about taking team working to the next level, about culture, about lots of things but actually if there's just not enough bodies in the system to be able to aspire to those kind of goals, then you're doing lots of clever things for no reasons really. And spending a lot of time, a lot of money […] So actually, the number one thing is staff. [O&G Trainee Doctor][42]

32. Our attendees at the roundtable session also told us that rota gaps can lead both to burnout in staff who must try to cover those gaps, and to safety issues relating to working with locums:

38 Q234 Gill Adgie
39 Letter from the Minister of State for Patient Safety, Suicide Prevention and Mental Health on the maternity workforce gap
40 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
41 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
42 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

> But the fact that staffing numbers are poor across the board which leads to gaps, which leads to people covering those gaps, either internal or external candidates, which then leads to people working over their hours to try and help, to try and help fill those gaps which then leads to people getting worn out, which then leads to illness. [Paediatric Trainee Doctor][43]

> If there are rota gaps you then end up with people taking locum[s], so you tend to come to a night shift as a junior person and have never met the person you're working with, who in order to practise safely you need to have a really good level of communication with so you can call them to say I've just seen 5 people in triage, these are my plans, are these correct. [O&G Trainee Doctor][44]

33. The frontline clinicians who spoke to us also pointed out that staffing shortages can have a safety impact during the antenatal period as well as during labour and delivery:

> A lot of problems often start in the antenatal period. [In] our antenatal clinics we sometimes have 60 plus patients per antenatal clinic and you only have five or six minutes per patient to actually see them and that's often when a lot of problems can start. And often a lot of misunderstanding can happen as well during the antenatal period. [O&G Trainee Doctor][45]

Funding for staffing

34. Witnesses to this inquiry made clear to us that funding is a critical factor in the delivery of safe staffing levels. In her oral evidence, Gill Walton, Chief Executive, Royal College of Midwives, told us that despite maternity services having been underfunded for a long time they were still "subject to cuts every year" which resulted in "the essential components of safe maternity care" being affected "year after year".[46]

35. In response to the interim findings of the Ockenden report, NHSE&I announced a welcome £46.7 million funding package to provide 1000 more midwifery posts, bridging the gap between the current funded establishment and recommended establishment.[47] An additional £10.6 million was also provided to increase the obstetric consultant workforce by 80 FTE in 2021–22. However, this would not be sufficient to fund the 496 consultants required to reach the recommended 20% increase in obstetric consultants.[48] NHS Providers estimated that the funding increase required for that 20% increase in obstetricians is £81 million per annum.[49] Furthermore, NHS Providers highlighted the fact that midwives and obstetricians are only part of the team of healthcare professionals delivering maternity services and estimated that an additional £121 million would be

43 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
44 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
45 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
46 Q166 Gill Walton
47 NHSE&I, Letter - Investment in Maternity Workforce and Training, April 2021
48 NHSE&I, National Response to the First Ockenden Report, March 2021
49 NHS Providers (MSE0114)

needed to tackle gaps in the anaesthetic, maternity support worker, and neonatal nurse workforce. NHS Providers concluded that to fully fund the wider maternity team would require an annual extra recurrent funding of at £200 - £350 million.[50]

36. **With 8 out of 10 midwives reporting that they did not have enough staff on their shift to provide a safe service, it is clear that urgent action is needed to address staffing shortfalls in maternity services. Evidence submitted to our inquiry estimates that as a minimum, there need to be 496 more obstetricians and 1,932 more midwives. While we welcome the recent increase in funding for the maternity workforce, when the staffing requirements of the wider maternity team are taken into account–including anaesthetists to provide timely pain relief which is a key component of safe and personalised care - a further funding commitment from NHS England and Improvement and the Department will be required to deliver the safe staffing levels expectant mothers should receive.**

37. ***We recommend that the budget for maternity services be increased by £200–350m per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as Trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.***

38. ***We further recommend that the Department work with the Royal College of Obstetricians & Gynaecologists and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts to enable trusts to deliver safe obstetric staffing over the years to come. This work should also consider the anaesthetic workforce.***

Training and learning together

39. The concept and importance of multi-professional team working is not unique to maternity care. However, it is important to consider the unique environment in which those teams work. There is a breadth of healthcare professionals and services—perhaps wider than most specialties—who look after a mother throughout her pregnancy and ensure the safe delivery of her baby into the world. That care spans the antenatal period through to postpartum and is delivered in hospitals and in the community. Reflecting on the multi-professional nature of maternity care, Charlie Massey, Chief Executive and Registrar, General Medical Council (GMC), told us:

> Ultimately, to provide the best care to women, we need teams that work effectively together, where leadership is shared, where there is a clear purpose and where responsibilities are understood. That is the area where reviews and inquiries have repeatedly pointed to there being a gap.[51]

40. An anaesthetic trainee that attended our roundtable told us that "the culture within the delivery suite is say very different to what you'd see in an orthopaedic centre or in paediatrics".[52] They said that "midwives tend to stick together, theatre staff tend to stick together, and the obstetrics team tend to stick together" and commented that communication was not always effective:

50 NHS Providers, Letter from NHS Providers on maternity workforce expansion, June 2021
51 Q226 Charlie Massey
52 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

> I think that people need to understand what the roles and responsibilities of each other are, what we can and can't do, and improve the respect for each other's professions. [Anaesthetic Trainee Doctor][53]

41. In its written evidence, the Department stated that through the Maternity Safety Training Fund (MSTF), over £8.1 million had been distributed to 136 NHS Trusts across England to deliver maternity safety continuing professional development (CPD) training in 2016. That funding supported the delivery of over 30,000 training places across multi-professional teams. In addition to that funding, the Department also said that a new core curriculum for professionals working in maternity and neonatal services was being developed by the Maternity Transformation Programme (MTP) in partnership with professional organisations, clinicians, and service users. That curriculum was aimed at addressing variations in safety training and competency assurance across England and to enable the workforce to bring a consistent set of updated safety skills as they move between services and Trusts.[54] More recently, a further £9.4 million has been announced to improve training in minimising incidents of brain injury during labour.[55]

42. NHS Resolution has also established a financial reward for trusts that meet certain standards. Its Maternity Incentive Scheme (MIS) enables trusts that have achieved all 10 safety actions to recover an element of their contribution to the Clinical Negligence Scheme for Trusts (CNST).[56] One of those actions, Safety Action 8, requires trust to provide evidence that 90% of staff have attended in-house multi-professional maternity emergencies training. In 2019–20, 93% of trust achieved Safety Action 8.[57]

43. However, despite the high proportion of trusts achieving Safety Action 8, both the RCM and RCOG highlighted inconsistent levels of uptake of the training specified by the Maternity Incentive Scheme:

> Due to aforementioned staffing constraints, including rota gaps, alongside funding constraints, we know that not all training is equal, effective, or utilised by all staff. Furthermore, the scheme does not mandate that all trusts must meet all of the safety actions. Instead it rewards trusts that meet ten safety actions, therefore uptake nationally is patchy.[58]

44. Baby Lifeline is a charity that promotes the safe care of pregnant women and newborn babies and provides training to maternity staff. It found in 2017/18 that fewer than 8% of

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53 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

54 Department of Health and Social Care (MSE0062)

55 HM Treasury, Spending Review 2020

56 NHS Resolution, Maternity Incentive Scheme. The 10 safety action actions for 20/21 include demonstrating: the use of the perinatal mortality review tool, submitting data to the Maternity Service Data Set (MSDS), transitional care services to avoid term admissions to neonatal units, an effective system of clinical workforce planning, an effective system to midwifery workforce planning, compliance with the 5 elements of the Saving Babies' Lives care bundle, a mechanism for gathering service user feedback and coproduction using Maternity Voices Partnerships, 90% of maternity staff have attended multi-professional emergencies training, that Trust safety champions are meeting bimonthly with Board level champions and 100% of qualifying cases are reported to HISB and to NHS Resolution's Early Notification scheme.

57 NHS Resolution, Maternity incentive scheme year two national results

58 The Royal College of Obstetricians and Gynaecologists & Royal College of Midwives (MSE0023)

trusts were providing all the training set out in the Saving Babies Lives Care Bundle.[59] It is likely that things improved in 2018 although the global pandemic has almost certainly had a detrimental impact more recently. And while 79% of trusts mandate training in co-morbidities, training in cardiovascular co-morbidities, the leading cause of death during pregnancy and up to six weeks after birth, was provided by fewer than a third of trusts.[60] Baby Lifeline told us that a key barrier to increasing the uptake of that training was staffing and resources.[61]

45. The RCM and RCOG are among many to argue that recurrent funding for training needs to be reinstated. In their joint submission, the Royal Colleges highlighted the risk that without ongoing financial support the benefits of the MSTF would "diminish over time in particular for those trusts that had not yet achieved a sustainable programme of learning".[62] Commenting on HEE's evaluation of the MSTF, the Royal Colleges said that:

> HEE should follow the recommendations of the evaluation and reinstate regular funding for effective training programmes to improve care, outcomes and costs in maternity settings.[63]

46. Concerns about training were also raised by frontline maternity services professionals at our roundtable. The most fundamental of those concerns was in relation to persistent difficulties in accessing training:

> There are huge issues in practice about access to training, especially for midwives and nurses where there's mandatory training put on, but because they're busy or short of staff they don't necessarily have the opportunities to actually attend. [Midwife][64]

> Staffing is very much an issue, if you don't have adequate staff people don't get released to go on training. [Paediatric Trainee Doctor][65]

> It's just down to staffing. The problem with the staffing is that if it's so minimal then actually you can't release people. Study leave requests are often denied so how can we develop if we aren't given the tools to develop. [O&G Trainee Doctor][66]

47. Providing back-fill staffing to enable maternity professionals to take time away from their main responsibilities to attend training was seen as crucial, but often that backfill was not provided. The clinicians at our roundtable also described how, very often, training was cancelled at short notice because the people delivering it were themselves frontline

59 Saving Babies Lives Care Bundle (SBLCB) is guidance developed to improve stillbirths and early neonatal deaths. This initially included four elements are care widely recognised as evidence-based and/or best practice including: reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement and effective fetal monitoring during labour. Version 2 of SBLCB was launched in March 2019, including an additional element to reduce preterm birth.

60 Baby Lifeline (MSE0075)

61 Baby Lifeline (MSE0075)

62 Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (MSE0023)

63 Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (MSE0023)

64 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

65 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

66 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

professionals and had been called away to clinical duties. The trainers time was not safeguarded and as a result, on some occasions, training had to be delivered by more junior "stand in" staff, at a lower standard.[67]

48. In response to the interim findings of the Ockenden report, NHSE&I announced an additional £26.5m is being made available to support Trusts with the backfill costs of training as a multi-disciplinary team. NHSE&I have written to Trusts with the expectation that the investment through this additional funding route is ringfenced.[68]

49. The frontline professionals we heard from also highlighted difficulties for student midwives and newly qualified midwives to gain appropriate experience and supervision, as mentors are too stretched with their own clinical duties to provide this.[69]

50. Roundtable attendees also highlighted the importance of multi-professional training:

> I would go back to the point that interdisciplinary training is really important. One of the challenges we've had in the past is that different groups of people are trained in different ways. We have a current situation where a lot of the training now is online so there is no opportunity for interaction and quite often that's where the nub of the problem is. It isn't necessarily about the knowledge of how to deal with a particular situation or condition, it's actually how you understand each other's role and who should be doing what and when. [Midwife][70]

Crucially, this must also include students, who often aren't invited to in-house or emergency training, and to visiting teams like anaesthetists and theatre staff. One anaesthetist described providing basic training to midwives about pain relief options, reporting that it had greatly improved the multi-professional relationships, and, consequently, the service provided to patients.[71]

51. Another attendee highlighted to us the importance of midwives and doctors training together from very early on:

> I think there is some kind of future in thinking about how midwives and doctors train together but from an early stage in their career. The reason I say that is I think our speciality is really unique in terms of there is no other specialty where a women could go through right from booking, right to having a baby without seeing a doctor for example or doing the whole process with a doctor. And sometimes that baton is passed very quickly, and in quite difficult circumstances, and I don't know if we work together enough to allow that to happen as seamlessly as it should do because when things go wrong this is one of the problems that happens. So going forward I guess, yes we need to do the MDT training and all the multi-disciplinary

67 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

68 NHSE&I, Letter - Investment in Maternity Workforce and Training, April 2021

69 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

70 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

71 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

> stuff, life skills and drills, human factors all of that needs to be a priority, and it is it's part of the incentive scheme it's something that all trusts need to do, but I think we need to go a little further in trying to understand the relationships that the professionals have in the first instance and nurturing them from a very early stage rather than just in a training setting. [O&G Trainee Doctor][72]

52. **The 2016 Maternity Safety Training Fund was widely welcomed by healthcare professionals and it is clear to us that the Fund delivered positive outcomes. However, for those positive outcomes to endure, more funding is required to embed on-going and sustainable access to training for maternity staff.**

53. **Training is essential for staff to deliver safe care. Evidence submitted to our inquiry highlighted that insufficient staffing is not only impacting the number of healthcare professionals available to deliver care for mothers and their babies but also the ability of staff to participate in vital training.**

54. ***We recommend that a proportion of maternity budgets should be ringfenced for training in every maternity unit and that NHS Trusts should report this in public through annual Financial and Quality Accounts. It should be for the Maternity Transformation Programme board to establish what proportion that should be; but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.***

55. **While it is encouraging that 93% of trusts are meeting the training objective set out in the Maternity Incentive Scheme, it is disappointing that only 8% of units across the UK are meeting the very highest standards of training, as set out in the Saving Babies Lives Care Bundle. It is also disappointing to hear the implementation of training still described as 'variable'.**

56. ***We recommend that a single set of stretching safety training targets should be established by the Maternity Transformation Programme board, working in conjunction with the Royal Colleges and the Care Quality Commission. Those targets should be enforced by NHSE&I's Maternity Transformation Programme, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Care Quality Commission through a regular collaborative inspection programme.***

72 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

3 Learning from Patient Safety Incidents

57. In this chapter we focus on learning from patient safety incidents and consider the impact of the Healthcare Safety Investigation Branch (HSIB) on maternity services. The chapter will also explore the extent to which the current approach to clinical negligence impacts on learning and perpetuates a culture of blame. We also consider alternative ways of providing redress for families that also improves standards of care, drawing on learning from other nations leading the way.

58. The Morecambe Bay Investigation found that the response by the trust to maternity incidents was "grossly deficient" and that there had been a "repeated failure to investigate and properly and learn lessons".[73] The first Ockenden Report reviewing maternity care at the Shrewsbury and Telford Hospital NHS Trust has echoed those concerns, describing investigations as "cursory" and failing to identify underlying issues in maternity care with evidence of blame instead being shifted to mothers.[74]

59. Human error will sometimes happen. However, the approach after any error must be centred around learning and improvement rather than blame. Professor Ted Baker, Chief Inspector of Hospitals, Care Quality Commission, told us that:

> It is really important that we all accept our own fallibility and accept others' fallibility. If we get to the mindset that mistakes must mean that someone is incompetent or in some way malevolent, I think that is entirely wrong. We have to accept the fact that humans are fallible, and that the professional response is to investigate thoroughly, openly and honestly and to learn from that to try to prevent a similar mistake being made by others.[75]

The role of the Healthcare Safety Investigation Branch (HSIB)

60. In 2016, the National Maternity Review, Better Births, highlighted that there was no standard approach for investigations. It said that when things went wrong, there should be "a rapid investigation, support for staff involved, openness and honesty with the family". To achieve this, the review recommended that the Healthcare Safety Investigation Branch (HSIB) set a common, national standard for high quality serious incident investigations.[76]

61. As a result, in 2018 HSIB established its maternity programme to conduct independent investigations for maternity safety incidents. The aim of the programme was to "bring a standardised, learning-oriented and person-centred approach to safety investigations that would produce insight to help reduce maternity safety incidents across the NHS".[77] These HSIB investigations have now replaced local trust serious incident investigations for eligible maternity incidents including intrapartum stillbirths, early neonatal deaths, severe brain injuries for babies delivered at term and maternal deaths during pregnancy or 42

73 Morecambe Bay Investigation Report, 2015
74 Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust - Emerging Findings and Recommendations, December 2020
75 Q27 Ted Baker
76 The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for Maternity Care ,2016
77 Healthcare Safety Investigation Branch (MSE0044)

days postpartum for any cause related to or aggravated by pregnancy or its management.[78] By March 2019, the programme was operational in all 130 trusts providing maternity care and between April 2018 and July 2020 HSIB had progressed 1421 referrals to investigation, with 977 investigations completed.[79]

Impact for families

62. The National Maternity Review, Better Births highlighted that not all trusts and investigations involved families in a caring and compassionate way.[80] In her powerful testimony, Michelle Hemmington told us:

> We received a letter from the hospital informing us that there would be an internal investigation into the death of our son. It was only after I contacted the hospital to find out more about this investigation that we were invited to participate. I think if I had not contacted the hospital we would not have been involved at all.[81]

She went on to say:

> Parents are the ones who have gone through it. They have been there from the beginning all the way through to the end. It is really important to take their views into account. When Louie died, we were made out to be just angry and wanting blame. That was not the case at all. We wanted to know what had happened with our child and his death. It is focusing on the parents' experience and what they have been through, and a full and proper investigation of that.[82]

63. HSIB told us it had embedded family engagement throughout its investigation process and it recognised that "meaningful engagement" with families during an investigation delivered "better learning, higher-quality reports and an improved experience of the investigation for all involved".[83] The improvement in family engagement is borne out in HSIB data that indicates that 88% of families engaged with HSIB's maternity investigations during 2019–20, compared with 34% of families that were involved in trust investigations.[84] Written evidence submitted to this inquiry also reflected an improvement in family engagement in investigations.[85]

64. **Involving families in a compassionate manner is a crucial part of the investigation process. Too often, maternity investigations have failed to do this in a meaningful way. Families must be confident that their voices are heard and that lessons have been learnt**

78 This is in line with the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts criteria for reporting includes term deliveries (≥37+0 completed weeks of gestation) resulting in: intrapartum stillbirth, early neonatal death (first week of life), severe brain injury diagnosed in the first 7 days of life. This excludes accidental causes and suicides - HSIB Investigation Criteria

79 Healthcare Safety Investigation Branch (MSE0044)

80 The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for Maternity Care, 2016

81 Q1 Michelle Hemmington

82 Q14 Michelle Hemmington

83 Healthcare Safety Investigation Branch (MSE0044)

84 Healthcare Safety Investigation Branch (MSE0044)

85 See, for example, Surrey Heartlands Local Maternity System (MSE0011), Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (MSE0023), Action against Medical Accidents (MSE0033), DISCERN research team (MSE0038), The Shelford Group (MSE0043),

to prevent the tragedy they have endured being repeated. We welcome the independent nature of HSIB investigations and believe that HSIB has taken considerable steps to improve family engagement in investigations. However, it is important that they continue to pursue improvements in this area to ensure all investigations are informed by the experience of families.

Impact for trusts and clinicians

65. Investigations must appropriately support trusts and clinicians to learn from patient safety incidents. Professor James Walker, Clinical Director of Maternity Investigation Programme at the Healthcare Safety Investigation Branch (HSIB), told us that HSIB provided an opportunity for staff to feel listened to; and wider investigations had the benefit of including services outside the maternity unit, for example ambulance services, A&E and primary care. He said that this was an important aspect of HSIB's work to better inform trusts:

> Because we are in there all the time, we pick up the progress of change but also progress of no change. We can tell the trust that there are themes, and that this incident happening now is the same as the one they had four months ago, so therefore they should be looking at that and why it happens. There is a lot more cumulative information that we can give back to trusts now, which they did not have before.[86]

66. However, written evidence we received expressed concern that trusts have not always found HSIB investigations to be timely which had the potential to undermine the ability of trusts to conduct internal investigations, spread and implement learning locally and maintain a positive relationship with families.[87] The Shelford Group reflected that whilst member trusts overall had a positive experience with regional HSIB teams, slow turnaround times and conflicting internal reports presented challenges:

> The HSIB investigation process is felt to be extremely slow, and at times resulting in poor quality reports with factual inaccuracies. The elongated timeframes of the HSIB investigation process can be challenging for families, trusts and CCGs with the majority of trusts continuing with parallel investigations to ensure that immediate actions are put in place although it is understood that timescales for reports has been significantly reduced in recent months. Challenges can also arise when outcomes from internal investigations do not align with those of HSIB although feedback from families has welcomed the independent nature of HSIB's investigations and reports.[88]

NHS Providers agreed with that view. It said that for HSIB investigations to be valuable, "turnaround time needs to be significantly quicker, with lessons learned being available much sooner so Trusts can implement relevant actions in a timely way".[89]

86 Q230 James Walker
87 See, for example, Manchester University NHS Foundation Trust (MSE0004), Surrey Heartlands Local Maternity System (MSE0011), Sussex Local Maternity System (MSE0026), The Shelford Group (MSE0043).
88 The Shelford Group (MSE0043)
89 NHS Providers (MSE0016)

67. HSIB has recognised this as an area for improvement and now aim to complete investigations within six months.[90] In oral evidence, Professor Walker told us that over 90% of HSIB reports are now published within 6 months.[91] However, HSIB explained that whilst most trusts welcomed its reports and acted promptly on recommendations, that was not always the case:

> For various reasons, some trusts have struggled to recognise the information we are presenting to them or to prioritise the actions necessary to address the risks. We understand the many pressures on trusts and that maternity services are a product of systems not all within the full control of individual organisations; sometimes solutions do not appear easily achievable.[92]

68. Another factor affecting the implementation of HSIB recommendations was that its findings were not always fed back past the head of midwifery or the safety manager. To address this, HSIB has introduced quarterly review meetings[93] and we received evidence to suggest mechanisms have now been put in place to ensure visibility of maternity investigations at a senior management level.[94]

69. However, when we heard from clinicians at our roundtable, they told us that investigations do not always meaningfully engage with those outside the senior management team which limited opportunities to learn and change:

> Even though they [incidents] may be investigated, there's not enough learning, and particularly there's not enough communication from risk teams and senior consultants to trainees who are on the front line doing their day-to-day jobs, and as a result change is slow to happen. [O&G Trainee Doctor][95]

> I feel in many of these instances I haven't always been actively involved in the investigations and haven't been fully kept up to date with ongoing investigations and findings, which is something I think is really important as someone who has been involved in these instances and is constantly worried about the outcome of the investigation. It's very useful to be kept constantly up to date with where things are. [O&G Trainee Doctor][96]

70. That said, we also heard examples of good practice with effective communication and dissemination of learning:

> At one unit I worked at the consultant who was doing the investigation would email the team involved regardless of the outcome—whether it's positive or negative [O&G Trainee Doctor][97]

90 Healthcare Safety Investigation Branch (MSE0044)
91 Q229 James Walker
92 Healthcare Safety Investigation Branch (MSE0044)
93 Q229 James Walker
94 Healthcare Safety Investigation Branch (MSE0044), The Shelford Group (MSE0043)
95 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
96 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
97 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

The trainee doctor told us that communication was really important for the juniors:

> Because until you're a registrar you're not really on the line for anything that goes wrong, but obviously the first time you understand how HSIB works, and the first time you understand what the process is going to be if something goes wrong, that shouldn't only begin when you are there […] So I think learning about how things are investigated, and indeed the reports on things that have been investigated, whether or not they're particularly significant or whether, they've just kind of been looked at and case closed, that should be filtered down to all of the staff—and the midwives as well—whoever was in the room, should be included in that email and that allows all the staff members to say 'ok I now understand what happened' and that's really valuable learning. [O&G Trainee Doctor][98]

71. **We believe that HSIB's ability to take a broad and independent view of the services and factors contributing to maternity incidents is a valuable step in the right direction to learning from maternity incidents. It is essential that an independent, standardised method of investigating the most serious incidents is maintained. However, there is still work to be done to improve the timeliness of investigations and the relationship between HSIB and trusts to ensure there is local ownership of recommendations made and investigations maximise learning at the local level. That relationship should not be confined to senior management; all members of the team, and in particular junior members of the clinical team, should be able to engage with an investigation in a manner which increases learning and the implementation of recommendations. Trusts should also improve local and regional sharing of key learnings particularly through Local Maternity Systems (LMS).**

72. **Clinicians of all disciplines should also receive training before they are qualified in how they should respond to the sorts of error that these investigations may uncover. This would include help for clinicians on accepting a degree of fallibility. Being unable to respond appropriately to mistakes is harmful to the mental health of the clinicians themselves but it also reduces their ability to learn from their errors.**

73. ***We recommend that HSIB investigations continue, but that HSIB reviews how it engages with trusts to ensure that the investigation process works in a timely and collaborative manner which optimally supports local learning and development. That review should include processes to ensure that healthcare professionals at all levels and across multidisciplinary team are able to engage with HSIB investigations. We further recommend that HSIB actively consults trainee doctors and midwives in that review.***

74. ***In addition, we recommend that HSIB shares the learning from its maternity reports in a more systematic and accessible manner. A top level summary of individual cases together with the key learnings derived from them should be shared rapidly across the NHS.***

98 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

Collating insights across the system

75. There are several organisations collating insights on maternity outcomes and the standard of maternity services. However, this must be done in a coordinated manner to provide meaningful oversight of maternity services. Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health at NHSE&I, emphasised the importance of good quality data and told us "we cannot tolerate people not taking data seriously".[99]

76. However, whilst trusts recognise the value of data collection, they also highlight the current burden of providing this information:

> The variety of national programmes [is] creating an extremely high burden for services to provide data in different formats, in order to meet different requirements. This is resource intensive, and the number of metrics far exceeds that of other acute care services which can prove challenging. In general, responding to multiple data requests also carries the risk of distracting services from focusing on quality improvement, often when that data has already been submitted elsewhere and could be obtained from another source. [The Shelford Group][100]

77. Some argued that there are still significant gaps in the information collected. For example the eligibility criteria for HSIB investigations is relatively narrow and does not always ensure cases that offer the greatest potential for learning are investigated.[101] HSIB acknowledged that 'some events which currently fall outside the programme but have high levels of harm or potential harm, or where there are significant levels of parental concern, could usefully be included'.[102]

78. We also heard examples of when relevant information was not shared between organisations, questioning the ability of the whole system to effectively work together to identify and address struggling trusts. Shrewsbury and Telford NHS Trust received £1 million for achieving all 10 safety actions in line with NHS Resolution's Maternity Incentive Scheme just weeks before being rated inadequate by the CQC and the Ockenden Review is currently investigating a series of incidents at the trust.[103]

79. Dr Jolly told us an intelligence-led approach is the "gamechanger" needed alongside data to effectively monitoring maternity services:

> Beyond data, the exciting development is that we no longer use just data for the quality surveillance of our maternity services. We have merged it with an intelligence-led approach to monitoring maternity services so that we can identify units where things are going wrong much earlier. That is a collaboration with HSIB, with NHS Resolution—the early notification scheme—with CQC and with the deaneries, with the colleges. It is intelligence about what it is like to work in the unit and what the culture

99 Q61 Matthew Jolly
100 The Shelford Group (MSE0043)
101 MBRRACE-UK/PMRT (MSE0028), DISCERN research team (MSE0038)
102 Healthcare Safety Investigation Branch (MSE0044)
103 In year 1 of the Maternity Incentive Scheme, Shrewsbury and Telford reported achieving all 10 safety actions. When trusts were asked to re-confirm and verify their compliance, 4 safety actions had been mis-declared. BCC News - Shropshire baby deaths: Trust will return £1m it received for 'good care'

> in the unit is like. That is being funnelled up through our regional chief midwives. We are putting a whole escalation process in place so that [we] have our finger on the pulse of what is happening in maternity services.[104]

80. **We recognise the effort of individual organisations to collect data and insights on maternity care. The potential value of this information to drive improvements in maternity care is clear. However, at present these insights are not being fully utilised.**

81. ***NHSE&I must streamline the data collection process to reduce the burden for trusts. The Department must ensure that insights collected by all bodies are collated in a coordinated manner and shared across organisations in a timely manner. As part of this process, the Department must assess current data gaps and develop a plan to address these. Particular focus should be given to using data to understand the causes of and reduce the variation between maternity units. National measures are driving improvements overall but there are some units being left behind. We need to know why.***

Rethinking the current approach to clinical negligence

82. The National Maternity Review, Better Births, described the process for compensating birth injuries as failing on its three objectives to provide rapid and compassionate support to parents; effective learning for staff and improved outcomes; and reduced incidences of harm.[105] Yet, maternity incidents remain the single highest cost of claims against the NHS in England.[106] In 2019–20, NHS Resolution paid out £2.3 billion in compensation and associated costs for maternity claims, representing 40% of all claim payments.[107] Furthermore, damages awarded for birth injury claims has increased by £449 million (350%) between 2006–07 and 2016–17.[108] Staggeringly, the £1bn paid out in maternity compensation in 2018/19 was nearly twice the wage bill for all of England's obstetricians and gynaecologists combined.[109] In 2017, the National Audit Office (NAO) highlighted the cost of clinical negligence to trusts as "significant and rising fast, placing increasing financial pressure on an already stretched health system".[110] Furthermore, the NAO warned that the Department's and NHS Resolution's actions were "unlikely to stop the growth in the cost of clinical negligence claims" and that "without more fundamental change, clinical negligence claims are likely to continue to rise in the next few years".[111]

83. Even more concerning is how much of this rising bill goes on lawyers' fees with potentially around a third of the total compensation bill for the NHS actually going on legal fees.[112] If we were better at learning from and eliminating mistakes, this money could be spent on the provision of safe maternity care.

104 Q54 Matthew Jolly
105 The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for Maternity Care ,2016
106 Claims are managed by NHS Resolution on behalf of trusts through the Clinical Negligence Scheme for Trusts (CNST). NHS Resolution (MSE0057)
107 NHS Resolution (MSE0057)
108 National Audit Office, Managing the costs of clinical negligence in trusts, 2017
109 The £1bn cost of maternity blunders: Jeremy Hunt exposes damning toll of lawsuits against NHS | Daily Mail Online
110 National Audit Office, Managing the costs of clinical negligence in trusts, 2017
111 National Audit Office, Managing the costs of clinical negligence in trusts, 2017
112 Sonia Macleod (Researcher at The Centre for Socio-Legal Studies) (MSE0108)

84. NHS Resolution told us that it had "committed to focus on maternity" and had launched initiatives such as the Maternity Incentive Scheme, rewarding trusts that achieved 10 maternity safety actions, and the Early Notification Scheme for birth injuries.[113]

Providing what families need

85. While legal redress provides families with financial compensation, that is not the only or primary reason for pursing litigation. Important motivations for families are the desire to prevent similar incidents in the future; the need for an explanation and apology; and the importance of accountability.[114]

86. This was reflected in both the powerful testimonies we heard from our lived experience witnesses and in the written evidence we received. We were moved by Darren Smith's reflections on the tragic loss of his son Baby Isaac who sadly died of a severe brain injury five days after birth. We are incredibly grateful to Darren for sharing his story. Darren told us:

> The reason we ended up pursuing it was that we wanted an apology. We were in a position where we could ask questions. We could try to make sure that it did not happen to other people, but the messages we were receiving were so mixed that nothing made sense […]. The whole of the medical negligence process is made to be a battle. It should not be, but it feels, going through that process, that the reality is that, when you get into the medical negligence process, there is nothing about improving the situation.[115]

87. We heard from Dr Sonia Macleod, Researcher in Civil Justice Systems, Centre for Socio-Legal Studies, Oxford University, that "at present, litigation is the only way people can obtain redress".[116] However, legal action is not guaranteed to address a family's other needs. For example, courts cannot force an apology nor force an organisation to implement change.[117] Furthermore, the litigation process is lengthy, adversarial and fails to address the wider emotional and psychological needs of patients and families. The approach to clinical negligence in the United Kingdom has cultivated a culture of defensiveness and blame, preventing families getting the transparency and accountability they need and deserve. This sentiment was echoed by many providing evidence to the inquiry and it was reflected in the National Maternity Review.[118]

Ending the blame culture and establishing a learning culture

88. Maternity care is delivered by multi-disciplinary teams working across organisations and therefore the underlying causes of patient safety incidents are often complex and multifactorial. When a claim is raised, NHS Resolution manages the claims on behalf

113 NHS Resolution (MSE0057)
114 NHS Resolution (MSE0057), Sonia Macleod (Researcher at The Centre for Socio-Legal Studies) (MSE0108)
115 Qq84–85 Darren Smith
116 Q121 Sonia Macleod
117 Sonia Macleod (Researcher at The Centre for Socio-Legal Studies) (MSE0108)
118 For example: Sands UK (MSE0008), Association for Improvements in the Maternity Services (AIMS) (MSE0010), Surrey Heartlands Local Maternity System (MSE0011), NHS Providers (MSE0016), Birthrights (MSE0018), Birth Trauma Association (MSE0022), Association of Radical Midwives (MSE0032), Action against Medical Accidents (MSE0033), East & North Herts NHS Trust (MSE0070), Baby Lifeline (MSE0075). The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for Maternity Care ,2016

of a trust. The legal defendant is always the trust, not an individual clinician,[119] and the General Medical Council (GMC) told us that cases as a result of individual clinical failings alone were incredibly rare.[120] However, both the Nursing and Midwifery Council (NMC) and the GMC acknowledged that this did not match the perception of clinicians and contributes to a culture of blame. Charlie Massey, Chief Executive and Registrar, General Medical Council, told us that many doctors on the frontline felt that if they made "an innocent, everyday mistake" it was likely to lead to the GMC taking serious action against them.[121] In a similar vein, Andrea Sutcliffe, Chief Executive and Registrar, Nursing and Midwifery Council, told us that the blame culture existed and that it inhibited people from speaking up. That was a serious concern because people "do not learn from things that go wrong" and therefore "the failures continue to happen".[122] Andrea Sutcliffe also explained that system failures were potentially endemic if that was not addressed:

> As a regulator, we obviously have a very important role to address that […]. I do not think that we protect the public by making nearly 725,000 nurses, midwives and nursing associates afraid of their regulator. Unfortunately, some of them are, because of things that have happened in the past and the myths that are perpetuated about what the NMC is for.[123]

89. The current mechanism for awarding compensation is based on proving clinical negligence..[124] We heard evidence that rather than promoting openness and learning this also perpetuates a culture of apportioning blame. Dr Jenny Vaughan, Consultant Neurologist and Learn not Blame Policy Lead at Doctors' Association UK, stressed to us that it was "important that you do not just look at one individual; you look at the organisation". However, she told us that this did not happen. Rather, there was a tendency for employers to say "who is to blame here?".[125] Dr Macleod explained to us the effect of this on both clinicians and culture:

> If we think about it from a clinician's point of view, in a maternity incident, they are investigated by HSIB if they meet the "each baby counts" criteria. HSIB comes in and says, "We are looking at this in a non-adversarial, investigative way. We are looking not for blame but to establish what happened." At the same time, the same clinician has to report, via their legal team, to the early notification system, which inevitably is looking to establish liability and blame. That is simply a reflection of what the system does. The clinician is pulled two ways at the same time. It is not surprising, therefore, that what we get is inhibition on an open culture. On the one hand, we are saying, "Come and tell us what happened. Be open with us." On the other hand, there is the perception that, if they tell us what happened, they might be blamed.[126]

119 NHS Resolution (MSE0057)
120 Q210 Charlie Massey
121 Q218 Charlie Massey
122 Q207 Andrea Sutcliffe
123 Q207 Andrea Sutcliffe
124 Qq93–94 Helen Vernon
125 Q115 Jenny Vaughan
126 Q121 Sonia Macleod

90. Compensation based on finding fault could theoretically make sense if such a process acted as a deterrent by encouraging clinicians to practice more safely. But there is no evidence to suggest this happens. In practice it is the reverse: fear of litigation stifles learning which ultimately makes the system less safe for patients.

Considering alternative approaches

91. There was consensus from our witnesses that the United Kingdom's approach to compensation is not the optimal solution either for families or the healthcare system.[127] A review of compensation schemes around the world found that "a quiet but notable shift has occurred away from adversarial court-based dispute resolution to administrative compensation schemes". The result of that shift has been significantly lower costs.[128]

92. The Swedish approach to improving maternity safety has been cited by a number of contributors as an example of good practice.

The Swedish Model[129]

In 1975, Sweden introduced a no-blame compensation scheme for medical injuries administered by healthcare insurers. Compensation in awarded based on whether an incident was considered avoidable rather needing to prove negligence. The decision about whether an incident is considered avoidable is taken by an experienced specialist.

In 2007, LÖF (Swedish Patient Insurer) established the Safe Maternity Care Project aiming to decrease the frequency preventable delivery associated brain injuries.

Sweden observed a 50% reduction in serious avoidable birth injuries from 2000 to 2016. It is felt that Sweden's approach to awarding compensation which encourages transparency from healthcare professionals and a willingness to learn from patient safety incidents promoted by the Safe Maternity Care Project has contributed to this successful reduction.

93. In his oral evidence, Dr Pelle Gustafson, Chief Medical Officer at LÖF, the Swedish Patient Insurer, told us that the Swedish approach started with the principle that "the best injury is an injury that never happens". He said that to achieve that first, "you have to do what you can to prevent the injuries from happening. Secondly, if disaster still strikes, you have to have a system that addresses it".[130] Dr Gustafson explained that under the Swedish system compensation is paid if it had been established that care had not been given "according to best practice" which negates the need to prove negligence.[131] This he asserted, had contributed to Sweden's success in improving maternity safety outcomes by promoting openness from clinicians:

> The major thing was to try to make it not dangerous or risky to open up about it, and to remove the obstacles, actual or imagined, that are there. If you feel threatened, perhaps in your professional existence, as well as in

127 Q125 Sonia Macleod, Q130 Jenny Vaughan, Qq105–108, Q111 Pelle Gustafson
128 S Macleod and C Hodges, Redress Schemes for Personal Injuries (Hart, 2017).
129 The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for Maternity Care, 2016, LöF, Final Report Safe Delivery Care: Round 2, 2017
130 Q104 Pelle Gustafson
131 Q108 Pelle Gustafson

> your ability to support your family, and it depends on you admitting that something has not gone the way it should go, of course the threshold is much higher. The removal of those obstacles is important.[132]

94. Dr Macleod also explained to us that New Zealand had also adopted a similar approach:

> One of the interesting things in New Zealand is that they switched from using medical malpractice to using treatment injury. Medical malpractice was much more akin to negligence. It was that sort of threshold. Treatment injury is much more like avoidable harm. When New Zealand made that shift, the average time that their claim processing took dropped from over five months to 13 days. That time drop for processing means faster resolution and faster learning. It was attributed to the fact that clinicians were prepared to say, "Yes, something went wrong," when they would not have been prepared to say, "I was to blame for what happened."[133]

95. Dr Macleod told us that having "avoidability" as a threshold for compensation was "hugely key to driving faster learning and a much better process, not just for the clinicians but for the families on the receiving end of it".[134] Dr Gustafson also described a constant dialogue with the professional organisations and their members including the obstetricians, midwives and paediatricians which enabled information to continuously feedback in both directions. He also outlined collaboration with Swedish quality registers to provide data at national and local level which was fed back directly to a specific unit.[135] In addition, he also emphasised the importance of dissolving professional hierarchies and putting trust in the professionals:

> One of the main parts of our project has been to try to disarm the hierarchy by saying that on a national level the midwives and the obstetricians produce best practice. They develop things together; it is not that the midwives do one thing and the obstetricians do another thing. That signal is so important at local level. If they can co-operate at national level, they can co-operate at local level.[136]

96. In addition to contributing to safer overall levels of maternity care and improved learning amongst clinicians, the approach taken by Sweden and others is considerably less expensive.[137]

Reform of the litigation process

97. The National Maternity Review, Better Births recommended a Rapid Resolution and Redress (RRR) Scheme. Building on learning from international approaches, it proposed an insurance-based system for families whose babies born at term had suffered harm during labour resulting in serious injury. Under that system it was not necessary to establish negligence to secure financial redress. Rather the test would be one of causation—whether

132 Qq106–107 Pelle Gustafson
133 Q122 Sonia Macleod
134 Q122 Sonia Macleod
135 Q109 Pelle Gustafson
136 Q110 Pelle Gustafson
137 S Macleod and C Hodges, Redress Schemes for Personal Injuries (Hart, 2017).

the harm was the probable consequence of the treatment provided or not provided during birth. Under that test, parents could claim redress without having to go through the courts. The scheme would be offered as an option and parents would still have the right to go through the courts should they wish.[138]

98. The Rapid Resolution and Redress Scheme envisioned by Better Births has not been implemented in full. The Department conducted an impact assessment and consultation in relation to the scheme in 2017, but no further progress has been made.[139] Dr Macleod argues that although some positive changes have been introduced, without moving away from a blame based litigation system, the full benefits would not be achieved.[140]

99. NHS Resolution has introduced the Early Notification Scheme (ENS). That scheme has been designed to encourage the early reporting of infants born at term a potential severe brain injury following labour. Under it, trusts are required to report incidents meeting the RCOG's Each Baby Counts criteria within 30 days.[141] In the first year of the Early Notification scheme, 746 qualifying cases were reported and 24 families received an admission of liability, formal apology and in some cases, financial assistance, within 18 months of the incident. NHS Resolution described this timeframe as "unprecedented for claims related to brain injury and/or cerebral palsy".[142] That step-change was confirmed to us by Helen Vernon, Chief Executive of NHS Resolution:

> Before that scheme was introduced, it would take six and a half years for us to hear about a case. Now that timeframe is four and a half months. The reason is that we can accelerate the investigation of compensation entitlement, make small interim payments to meet needs when they arise, ensure that the trust does the right thing in being open and transparent with the family, and feed learning back to the trust and the wider system at the time when it is most relevant to them.[143]

100. At present compensation is calculated on the cost of providing private healthcare even when care is provided by the NHS. This is based on legislation that predates the NHS.[144] Compensation is also based on loss of potential earnings. We heard this is "partly determined by parental income and socioeconomic status".[145] Nadine Dorries, Minister of State for Patient Safety, Suicide Prevention and Mental Health told us that this is "absolutely wrong" and "these are outdated practices. It is an outdated system".[146]

138 The National Maternity Review Report - Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for Maternity Care, 2016
139 Department of Health, Rapid Resolution and Redress Scheme for Severe Avoidable Brain Injury at Birth – Impact Assessment ,2017. Department of Health, A Rapid Resolution Redress Scheme for Severe Avoidable Birth Injury: Government Summary Consultation Response, 2017
140 Sonia Macleod (Researcher at The Centre for Socio-Legal Studies) (MSE0108)
141 Each Baby Counts criteria for reporting includes term deliveries (≥37+0 completed weeks of gestation) resulting in: intrapartum stillbirth, early neonatal death (first week of life), severe brain injury diagnosed in the first 7 days of life
142 NHS Resolution (MSE0057)
143 Q92 Helen Vernon
144 Sonia Macleod (Researcher at The Centre for Socio-Legal Studies) (MSE0108), The Medical Defence Union (MDU) (MSE0036)
145 Q123 Sonia Macleod
146 Q276 Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care

This contrasts with other countries where future earnings are calculated from the average national wage.[147] With a publicly funded healthcare and partly funded social care system compensation should be based entirely on need not circumstance.

101. **It is clear to us that in its current form the clinical negligence process is failing to meet its objectives for both families and the healthcare system. Too often families are not provided with the appropriate, timely and compassionate support they deserve. For those delivering maternity care, the adversarial nature of litigation promotes a culture of blame instead of learning after a patient safety incident. Alternative approaches are already in place in other countries where the use of a threshold of 'avoidability' rather than 'negligence' to award compensation has helped to tackle the debilitating culture of blame, accelerate learning and provide timely support to patients and their families. We believe that adopting such an approach is an essential next step in shifting the culture in maternity services away from blame to one of learning.**

102. **Providing appropriate financial redress to families after an incident is important. However, the rising costs of maternity claims without sufficient learning and outdated mechanisms for calculating compensation is unsustainable. It is particularly unfair that wealthier families receive more compensation for a severely disabled child than poorer families because likely lost earnings are taken into account. Therefore, we welcome the Government's proposal to review clinical negligence in the NHS more broadly. We note that elements of the Rapid Resolution and Redress scheme have been implemented. However, we are disappointed that the scheme has not be been implemented in full. Until it is, there is a high risk that the fundamental changes needed to improve the safety of maternity services will fail to be achieved.**

103. ***While the review of the negligence system is underway, we recommend the Department must implement the Rapid Redress and Resolution Scheme in full. We also recommend the Department provides the Committee with the scope and timetable for its review of clinical negligence by September 2021.***

104. ***We recommend that following that review, the Department brings forward proposals for litigation reforms that award compensation for maternity cases based on whether an incident was avoidable rather than a requirement to prove clinical negligence. That approach would allow families to access compensation without the need for the courts in the vast majority of cases and establish a substantially less adversarial process.***

105. ***In addition, we recommend that the Department and NHS Resolution remove the need to compensate on the basis of private healthcare provision where appropriate NHS care is available; and that compensation is standardised against the national average wage to prevent unjust variability in compensation payouts.***

106. ***Finally, given their recognition of the role the professional regulators have in ending the blame culture, we recommend that the General Medical Council and the Nursing and Midwifery Council review what changes are required to their remits or working practices to reduce the fear clinicians have of their regulators and allow them to open up more about mistakes that are made.***

147 Qq123–124 Dr Sonia Macleod

4 Providing Safe and Personalised Care for All Mothers and Babies

107. In this chapter we consider women's experience of maternity care and the changes required to ensure that personalised, safe care is reality for every mother and her baby. We focus on the steps needed to be taken to tackle unacceptable inequalities in outcomes; specific interventions to improve outcomes, including continuity of carer and screening; and finally and most importantly, supporting informed choices and personalised care, to ensure that no woman faces pressure to have an unassisted vaginal birth.

Inequalities in outcomes

108. At our third evidence session we heard from Atinuke Awe and Clotilde Rebecca Abe, co-founders of Five X More. Five X More is a grass roots campaign that is "dedicated to supporting mothers with its campaigning work and recommendations. It focuses on empowering Black women to make informed choices and advocate for themselves throughout their pregnancies and after childbirth." It is also "committed to calling on those in power to change the outcomes for Black women".[148] Atinuke Awe told us of her experiences of pregnancy and childbirth:

> There were signs of pre-eclampsia, high blood pressure and protein in my urine from midway through my pregnancy […] It was not until a last-minute midwife appointment at the end of my pregnancy that it was picked up. By that time, I was so swollen that I was advised to go straight to the hospital by my midwife, which of course was really worrying to hear as a first-time mum […] I was left for hours without any pain relief. By the time my waters finally broke and I was checked over, the midwife realised that I was 8 centimetres gone. I had indeed progressed really quickly in a short amount of time. I was rushed to the delivery suite, as my baby's heart rate was dropping. In the end, I ended up having an assisted delivery because, honestly, I was too exhausted. I did not have the strength to push my son.

Atinuke Awe explained to us how that experience affected her:

> I was left feeling that I was not important and that I was not listened to at all. My pain was not taken seriously. The more I spoke to women in my immediate network, through Mums and Tea, which is a social network for mothers to connect, I found that my experience was not an isolated one. I was not alone in having a really poor experience […]. The MBRRACE report came out in 2018, telling us that black women are indeed five times more likely to die, which validated our voices and our experiences. One of the key messages of the campaign is that, as we like to say, there are real people behind the statistics.[149]

148 About—FIVEXMORE
149 Q131 Atinuke Awe

109. In 2020, Five X More launched a petition "Improve maternal mortality rates and health care for black women in the UK" which gained over 187,000 signatures.[150] They told us they started the petition because they believed that not enough was being done to address the disparity in outcomes:

> This is a consistent issue that we believe has been worsening over the years. It has led us to believe that it was not important enough to those in charge of maternity services or the decision makers, as the number was steadily rising as opposed to going down.[151]

110. Inequalities in maternal and neonatal outcomes have been well documented for many years, but we heard that there has been little progress in closing the gap. A recent report by the Joint Committee on Human Rights concluded that "the NHS acknowledge and regret this disparity but have no target to end it".[152] During our inquiry, Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer, told us:

> The wider determinants of health are not just related to 40 weeks of pregnancy. We have the social deprivation, financial deprivation, inequality, discrimination and racism that many people who get pregnant and use our maternity services have to contend with.
>
> In the maternity space, I cannot say categorically when we will close the gap on equity—the five times more likely—and the neonatal challenge for black and Asian babies.[153]

111. Many contributors to this inquiry emphasised addressing inequalities as a necessary part of the safety agenda.[154] Birthrights told us that "a litmus test" for a safe maternity service was, how safe maternity care is for more vulnerable groups of women and their families. It described this as "an overlooked but essential aspect of safety".[155] Dr Daghni Rajasingam, Consultant Obstetrician and Deputy Medical Director at Guys and St Thomas' Hospital NHS Foundation Trust, also highlighted the importance of making services safer for the very vulnerable group of women. If that work was done, she was confident that "we will start learning systems issues and will make services safer for all women and their babies".[156]

112. During our inquiry we heard that most maternal deaths are women who die from medical problems that are aggravated by pregnancy or by the care they received because they were pregnant.[157] MBRRACE-UK highlighted that 20% of those who died in 2015–17

150 Improve Maternal Mortality Rates and Health Care for Black Women in the U.K Petition
151 Q131 Atinuke Awe
152 Joint Committee on Human Rights, Black people, racism and human rights, November 2020
153 Q307 Professor Jaqueline Dunkley-Bent
154 Examples include: Sands UK (MSE0008), Birth Trauma Association (MSE0022), Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (MSE0023),Nursing and Midwifery Council (MSE0025), Care Quality Commission (MSE0042), The Shelford Group (MSE0043), Maternity Action (MSE0050), The Health Foundation (MSE0066), East & North Herts NHS Trust (MSE0070), Group B Strep Support (MSE0045), HealthWatch England (MSE0069), Soo Downe OBE, Lesley Page CBE, Mary Renfrew, Helen Cheyne, Billie Hunter CBE, Jane Sandal CBE, Helen Spiby (MSE0072), Manchester University NHS Foundation Trust (MSE0004), Association for Improvements in the Maternity Services (AIMS) (MSE0010)Mrs Caroline Flint (MSE0015), Birthrights (MSE0018), Action against Medical Accidents (MSE0033) DISCERN research team (MSE0038)
155 Birthrights (MSE0018)
156 Q251 Daghni Rajasingam
157 Q133 Marian Knight

where known to social services and 6% were at severe or multiple disadvantage (including a mental health diagnosis, substance misuse and domestic abuse).[158] Reflecting on maternity safety, Professor Marian Knight, Professor of Maternal and Child Population Health, University of Oxford, and Lead for MBRRACE-UK, told us that when addressing inequalities, "we need to think much more broadly than just maternity services" and recent research had convinced her of the need to "think much more widely than the professional groups of midwives and obstetricians.[159]

113. Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health at NHSE&I, agreed. He said that in order to achieve equity for women "we need to go the extra mile for those who are the most vulnerable", and highlighted the example of the Saving Babies Lives Care Bundle as positive action in this respect:

> We have designed best practice care and have put in place a way of identifying those who are at greatest risk. In areas where we have worse outcomes, we need to do more, and target those people and give them absolutely the best-quality care to address the disparities between different units.

However, he cautioned that more had to be done and that people in the sector were "absolutely determined to carry on exploring how else we can improve".[160]

114. In response to the petition 'Improve maternal mortality rates and health care for black women in the UK',[161] the Department outlined the following as actions:

- Funding research into the factors associated with the higher risk of maternal death for Black and South Asian women.
- The Long Term Plan commitment to implement enhanced and targeted continuity of carer model for Black, Asian and minority ethnic (BAME) women, as well as for women from the most deprived area. This includes a commitment for 75% of women from BAME background to receive continuity of care by 2024.
- The promotion of greater service user participation in the design and delivery of maternity services through Maternity Voice Partnerships (MVPs). This includes funding to provide additional support for BAME parent representatives.[162]

Factors associated with the higher risk of maternal death for Black and South Asian women.

115. Professor Knight, who led the research into the underlying ethnic disparities in maternal mortality in the United Kingdom, told us that there was "no difference" in the causes from which women were dying across aggregated ethnic groups when looking at Black women, Asian women, white women or women from other groups.[163] However, she

158 MBRRACE-UK Report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17, 2019
159 Q133 Marian Knight
160 Q62 Matthew Jolly
161 Improve Maternal Mortality Rates and Health Care for Black Women in the U.K Petition
162 Improve Maternal Mortality Rates and Health Care for Black Women in the U.K Petition
163 Q133 Marian Knight

went on to explain that the research identified a number of themes that were considered potential explicit or structural biases impacting on care received. She described the three most frequent were "not like me", complexity and microaggressions:

> "Not like me."[…] was observed most in black women. Assessors felt that staff needed more listening, learning and nuance around women's background, making sure that women received individualised care, and thinking about place of birth, language, cultural factors and the socioeconomic background, to enable the most appropriate care, as opposed to the default one size fits all […]
>
> Complexity—clinical, social and cultural. The vast majority of women who die have multiple and complex problems. Our systems are not set up [for this]. There is definite evidence of structural biases that impact on women receiving the care they need—for example, clinics based at different hospitals requiring different appointments, with communication not necessarily occurring between them. Clinical complexity was a theme observed equally among all ethnic groups. It was a theme for white women, Asian women and black women.
>
> The third most frequent theme observed was micro-aggression. It was perhaps most predominant among Asian women […] there were racial or ethnic stereotypes, such as black women having lower pain thresholds. A particular concern was women who do not necessarily speak English fluently. Agitation was assumed to be due to mental health problems, when they were actually seriously physically ill. That misinterpretation was on the basis of their language.[164]

Hearing and listening to the voices of mothers

116. Professor Dunkley Bent emphasised to us the importance of hearing the voice of mothers from Black, Asian and minority ethnic backgrounds and that the voice of mothers must not be restricted to "those who have advantage and speak well".[165] She explained that Maternity Voices Partnerships (groups of user representatives, commissioners, doctors and midwives) helped this by prioritising mentoring schemes for Black, Asian and minority ethnic parents and a focus on "the context of where communities are to be able to provide purposeful and meaningful care that will drive up outcomes".[166]

117. The evidence we received from Local Maternity Systems welcomed the role of Maternity Voices Partnerships (MVPs) but reflected that "the biggest challenge from the MVPs is that they often don't represent the population that most need support - eg deprived and BAME".[167] The Shelford Group recommended that "resource should be made available and work expanded to ensure the voices of all are heard, particularly from an equality perspective".[168]

164 Q133 Marian Knight
165 Q69 Jaqueline Dunkley-Bent
166 Q69 Jaqueline Dunkley-Bent
167 Manchester University NHS Foundation Trust (MSE0004)
168 The Shelford Group (MSE0043)

118. Clotilde Rebecca Abe, co-founder of Five X More, also emphasised the need for co-production to address inequalities but highlighted that too often that was not achieved:

> There needs to be more research into the much wider issue and it needs to be co-created by and include black women and lived experience. Black women who are experts in their fields need to be part of the research. There is lack of representation in the strategy and the delivery. When we are involved or invited, it often feels very tokenistic.[169]

119. Importantly, reflecting on the complaints and investigation process a midwife in our clinician roundtable told us:

> The sad reality is, when you are black, Asian, or from a diverse ethnic background you are less likely to complain, you are more likely to take the first review given to you, and all you need to do is look at your local PALS complaint procedure to see that they're not representative of the communities we care for, which shows that we've potentially got a huge number of blanketed near-misses which we're not even aware of.[170]

120. The Government has made significant progress in its ambition to improve maternal and neonatal outcomes. However, there remains marked disparities in outcomes for mothers and their babies. Our Expert Panel assessed progress against the Maternity Safety Ambition (**Box 3**). The Expert Panel overall rated progress against this commitment as 'Requires Improvement', stating:

> To improve birth outcomes for women and babies, significant focus has been directed towards improving maternity safety, with promising trends in reducing unnecessary deaths and disability. However, changes to the way progress is measured makes it difficult to attribute improvements to Government intervention. Significant health inequalities for women from minority ethnic and socio-economically disadvantaged backgrounds persist which have not been adequately addressed in current improvement plans. [Expert Panel][171]

169 Q133 Clotilde Rebecca Abe

170 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

171 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], page 6

Box 3: Expert Panel CQC-style Ratings–Maternity Safety

Maternity Safety: *By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025*

Overall: **Requires Improvement**

Commitment met	
• Stillbirth	Good
• Neonatal deaths	Good
• Pre-term births	Requires Improvement
• Brain injury	Requires Improvement
• Maternal deaths	Inadequate
Funding/Resource	Requires Improvement
Impact	Requires Improvement
Appropriate	Good

Further analysis can be found in the Expert Panel's independent report: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England.*[172]

Continuity of carer

121. In December 2017, NHS England published, its five year forward view for maternity safety, Implementing Better Births: Continuity of Carer.[173] In its summary, NHS England said:

> At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.[174]

122. Continuity of carer refers to consistency in the midwife or clinical team providing care for a woman and her baby throughout pregnancy, labour and the postnatal period. The aim of continuity of carer is for a woman and her responsible clinician to develop a relationship over time, so that she receives coordinated, timely and appropriate care which meets the needs of her and her baby.[175] Professor Dunkley-Bent told us in February 2021 that there were 2,322 midwives providing continuity of carer to one sixth of women who

172 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], pages 13–36
173 NHS England, Implementing Better Births: Continuity of Carer, 2017
174 NHS England, Implementing Better Births: Continuity of Carer, 2017
175 NHS England, Implementing Better Births: Continuity of Carer, 2017

birth in England each year; and that 94,458 women are now benefiting from continuity of carer, compared to 10,500 two years ago.[176] Professor Dunkley-Bent, pointed us to the following benefits of continuity of carer:

- Women having a midwife who is with them and who is their named professional during their pregnancy, birth and afterwards have a better pregnancy experience.
- Women are more likely to disclose intimate concerns that they have not disclosed to others.
- Continuity of carer reduces the pre-term birth rate by 24%.
- Having somebody you trust and can develop a relationship with, as in continuity of carer, would enable and support a woman to be empowered and have these conversations. What is normal birth? What is a C-section? What are forceps? What will happen if I have an epidural? They would be able to speak candidly in those terms.[177]

She went on to say that if without that continuity, many women felt "embarrassed" or that "their questions are silly or not valid", and that a strong relationship with the clinical lead ensures that women can have those "frank conversations".[178]

123. Research has also shown that midwifery-led continuity of carer can improve outcomes for mothers and babies, including a 16% reduction neonatal mortality, 24% reduction in preterm birth and increase the experience of care for mothers.[179]

124. Despite these benefits, Donna Ockenden felt a lack of continuity of carer was not a factor in the tragedies that occurred at Shrewsbury and Telford:

> We have looked at the 250 cases, and the issue of continuity of carer […] did not come up as something that would have influenced women's care. It did not come up as, "If only we'd had that, it would have made a difference."[180]

125. However, we did hear evidence that when care is disjointed, vulnerable women and babies can be left to fall through the gaps. For example, suicide is the leading cause of maternal death between six weeks and one year after childbirth.[181] Professor Knight told us:

> The vast majority of women who die by suicide have sought help on multiple occasions, but nobody has recognised the overall pattern because there isn't holistic care. We have very siloed systems and women's voices are not necessarily heard.[182]

176 Q306 Jaqueline Dunkley-Bent
177 Q67 Jaqueline Dunkley-Bent
178 Q67 Jaqueline Dunkley-Bent
179 Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5
180 Q161 Donna Ockenden
181 MBRRACE-UK Report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016–18, 2020
182 Q141 Marian Knight

126. When asked whether the continuity of carer model could address such issues, Professor Knight said that there was "absolutely no doubt" that a trusted relationship with a midwife, or a group of midwives or health professionals, enabled women to disclose their concerns about symptoms and feel listened to and that this would "make a difference".[183]

127. The clinicians in our roundtable also told us how continuity of carer helps provide more personalised care for the women they look after:

> The continuity part of this is important, because once people have a [professional] relationship with a woman […] then they are invested in that woman as an individual. They see her as an individual, they see her holistically within a whole paradigm of care and they have that sort of motivation, you know it's a very human thing isn't it to give that relational care which means that they're communicating with colleagues to dot i's and cross t's to ensure that things are followed up and that things happen in a timely manner. [Midwife][184]

128. However, while there was a consensus in the benefits of continuity of carer, Dr Jo Mountfield, Vice President for Workforce and Professionalism, Royal College of Obstetricians, expressed concerns about the practicalities of delivering care in that way:

> Of course having continuity of carer for every woman is a really good idea, but the reality of delivering that […] is really challenging. It boils down to not just the cost but midwives wanting to work in that way. [Jo Mountfield][185]

These challenges have been most obviously seen at Worcester NHS Trust.[186] This was also highlighted by attendees at our roundtable:

> There's a lot of evidence to say how valuable it is for women. But there is something about supporting the needs of the doctors and midwives who would actually be delivering that. [Midwife][187]

> I welcome very much [continuity of carer], but practically speaking my understanding from midwives is that it can be a difficult model to work in. […] I am speaking in terms of lifestyle rather than being on call, struggling to get away. Working patterns can be quite tricky in the continuity of care model. [O&G Trainee Doctor][188]

129. Dr Niamh Maguire, Consultant Obstetrician and Clinical Lead for Sussex Local Maternity System, also highlighted to us the risk that continuity of carer can result in brand-new midwives being "pushed out into the community" at a very early stage in their career which can result in them feeling unsupported.[189] Furthermore, Clotilde Rebecca

183 Q142 Marian Knight
184 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
185 Q260 Jo Mountfield
186 Independent, Women and babies at risk at hospital where doctors are censored and midwives fear working, April 2021
187 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
188 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
189 Q259 Niamh Maguire

Abe believed that continuity of carer was "a great model" if it worked well but noted that it may not always be possible because the midwife "might not be there at the end". Clotilde emphasised to us that "you really need her at that crucial point, when you get to the end".[190]

130. The Ockenden Review team shared similar concerns regarding the successful roll out of continuity of carer:

> Staff want to do their best and work within a framework of messaging that is realistic and woman-focussed but they have not been supported to do this as CoC [continuity of carer] was introduced without additional funding. A change of this magnitude must come with the staffing resources to facilitate it and the ears to hear when safety concerns are raised. Safe staffing levels are critical to this discussion.[191]
>
> We do not doubt for one moment the positive impact that CoC [continuity of carer] has on some women's overall satisfaction and pregnancy outcomes. Our concerns are focussed on an ambition which has been rolled out with the expectation to implement with what appears to be limited thought given to the impact on the workforce providing the service.[192]

131. When she gave oral evidence, Nadine Dorries, Minister of State for Patient Safety, Suicide Prevention and Mental Health, acknowledged that due to the working patterns of midwives, it was not always possible to have the same midwife "from the second that you either self-refer or are referred by your GP to the maternity unit, until the point of birth".[193] Rather, the Minister stressed that the objective was for a woman to remain with the same midwife "through pre-delivery care".[194] She went on to say that for a midwife to be on call 24 hours a day was not a working pattern that all midwives "will commit to or want to commit to", nor did she believe that they should be asked to commit to such a working pattern.[195] In relation to capacity, the Minister stressed that it was not a question of "whether we have the numbers" but "whether we have the ability in terms of the expectations on midwives to do it".[196]

The role of continuity of carer in tackling health inequalities

132. The Department and NHSE&I have highlighted continuity of carer as a major action point to address inequalities in maternity outcomes. In 2019, the Long Term Plan committed to providing continuity of carer for 75% of women from Black, Asian and minority ethnic communities and those from the most deprived backgrounds.[197] In oral

190 Q145 Clotilde Rebecca Awe
191 Donna Ockenden (EPE0025)
192 Donna Ockenden (EPE0025)
193 Q304 Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care
194 Q304 Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care
195 Q304 Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care
196 Q306 Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care
197 NHS England, The NHS Long Term Plan, 2019

evidence, Professor Dunkley-Bent told us that there were 165 midwifery continuity teams placed in areas "where many black, Asian or mixed-race ethnicity women are currently living", and that there were 214 teams placed in areas of deprivation.[198]

133. Although this represents good progress, the skill set and expertise of those midwives was equally important. Atinuke Awe told us that it needed to be "the right midwife and set of midwives". As an example, she told us that if the midwife did not know the statistics and poor outcomes for black women the care provided would not address those inequalities.[199]

134. Professor Knight agreed. She told us that the "crucial thing" was that the group of midwives had "the right expertise".[200] Without that, continuity of carer would not make the difference it was intended to deliver. In conclusion, she stressed to us that it could not be a "one size fits all" approach.[201] One of our attendees at the roundtable also highlighted the importance of this:

> It needs to prioritise more vulnerable people to begin with because the barriers and the trust that needs to be built up there is extremely important. But the staff also need to be completely competent and be trained to the level where they can give it. They need to understand the biases that they carry and also their lack of knowledge around informed consent. [Midwife][202]

135. The Government has committed to 'the majority of women' benefiting from continuity of carer by 2021.[203] Our Expert Panel assessed progress delivering the continuity of carer model (**Box 4**). The Expert Panel overall rated progress against this commitment as 'Requires Improvement', stating:

> This is an important commitment with a strong evidence base. Effort has been directed towards achieving this target, but lack of clarity over its definition, lack of reliable data collection method to evidence progress, and lack of clear resources and organisational support for its implementation has made it difficult to evidence and achieve. Continuity of Carer represents a major change to maternity systems and services and further support is required to ensure Trusts are enabled to successfully manage this scale of organisational change. [Expert Panel][204]

198 Q306 Jaqueline Dunkley-Bent
199 Q143 Atinuke Awe
200 Q142 Marian Knight
201 Q142 Marian Knight
202 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
203 NHS England, Implementing Better Births: Continuity of Carer, 2017
204 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], page 6

Box 4: Expert Panel CQC-style Ratings–Continuity of Carer

Continuity of Carer: *The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.*

Overall: Requires Improvement

Commitment met	Inadequate
Funding/Resource	Requires Improvement
Impact	Requires Improvement
Appropriate	Good

Further analysis can be found in the Expert Panel's independent report: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England.*[205]

136. **England remains a largely safe place to give birth and efforts to increase the safety of maternity services have led to further improvements. However, the Expert Panel overall rated the Government's progress on maternity safety outcomes as 'Requires Improvement'. The Expert Panel highlighted that the Government's commitment to halve the rate of stillbirths, neonatal deaths, brain injuries and maternal deaths is not currently achieving equitable outcomes, with women and babies from minority ethnic and socio-economically deprived backgrounds at greater risk when compared to their white or less deprived peers. We acknowledge the positive steps the Department and NHS England and Improvement have taken, including the commitment to continuity of carer for 75% of women from Black, Asian and minority ethnic groups. We support the principles of the continuity of carer model but conclude that further work is required to ensure it can be implemented in a sustainable manner. The Expert Panel overall rated progress towards delivering continuity of carer as 'Requires Improvement'. Continuity of carer alone is also unlikely to resolve the deep seated and long-standing inequalities persisting in maternal and neonatal outcomes.**

137. ***Having the right skill set, as noted above, is crucial for the successful implementation of continuity of carer. We therefore recommend that those involved in delivering this model have received appropriate training and that all professionals are competent and trained in all areas that they work in, particularly in relation to Black mothers where the disparities are the greatest.***

138. ***Given the underlying causes of these outcomes for women from Black, Asian and minority ethnic groups relate to a range of issues beyond the remit of the Department, we recommend that the Government as a whole introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department must lead the development of a strategy to achieve this target and should include consultation with mothers from a variety of different backgrounds.***

205 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], pages 5; 37–51

Screening

3rd trimester scans

139. During pregnancy all women have a scan at 12 and 20 weeks. Women with additional risk factors may also be offered additional scans throughout their pregnancy. However, there is a body of opinion that an additional routine scan in the 3rd trimester could improve outcomes for babies.[206] Professor Gordon Smith, Professor of Obstetrics and Gynaecology at the University of Cambridge, told us that introducing a routine scan at 36 weeks could allow for the detection of breech pregnancy earlier, preventing emergency c-sections or high-risk breech vaginal deliveries. Professor Smith explained that while midwives routinely performed palpation to determine whether the baby was headfirst or otherwise, that procedure detected only between 50% to 70% of non-cephalic presentation.[207] For the remainder, the woman loses the opportunity to consider external cephalic versions (where the baby is turned) or discuss a planned caesarean section or a planned vaginal breech birth.[208] Professor Smith told us "there isn't a research question left, other than the best way to implement it".[209]

140. A 3rd scan has the potential to identify other risk factors for stillbirths. However, further research is required to prove the clinical usefulness of a 3rd scan for those risk factors.[210] In March 2021, the UK National Screening Committee considered the addition of a 3rd scan for breech presentation.[211]

141. **We were pleased to hear that the UK National Screening Committee believed that the current evidence for a 3rd trimester breech presentation scan "looks promising" and may be a "suitable candidate for a screening programme once further research had been published in the coming years".**[212]

Testing for Group B Streptococcus

142. Group B Streptococcus (GBS) is the most frequently identified cause of severe infection in newborns. On average, at least one baby a week in the United Kingdom dies from GBS infection, and 70 babies a year are left with lifelong disabilities as a result of contracting meningitis or sepsis in their first days of life.[213]

143. In 2017, updated guidelines stipulated that all women should receive information about GBS, the use of Enriched Culture Medium (ECM) where testing was recommended, and identified women who should be offered antibiotics during labour.[214] However, a recent report found 20% of trusts had not updated their local guidelines since 2017 and the majority were using the wrong swab and lab methods for testing for GBS. The Minister of

206 Wastlund D, Moraitis AA, Dacey A, Sovio U, Wilson ECF, Smith GCS. Screening for breech presentation using universal late-pregnancy ultrasonography: A prospective cohort study and cost effectiveness analysis. PLoS Med. 2019 Apr 16;16(4):e1002778. doi: 10.1371/journal.pmed.1002778. PMID: 30990808; PMCID: PMC6467368.

207 Q174 Gordon Smith

208 Q174 Gordon Smith

209 Q175 Gordon Smith

210 Qq174–178 Gordon Smith, Edward Morris

211 UK NSC minutes March 2021

212 UK NSC minutes March 2021

213 Q270 Minister of State for Patient Safety, Suicide Prevention and Mental Health

214 Royal College of Obstetricians and Gynaecologists, Group B Streptococcal Disease, Early-onset (Green-top Guideline No. 36)

State for Patient Safety, Suicide Prevention and Mental Health, told us that she was aware of these shortcomings and that she had written to the CEOs of all trusts on the matter making clear that trusts "ensure that they are using the ECM testing as of the moment they receive the letter".[215]

144. Screening for GBS in pregnancy is not currently recommended for all women.[216] However, in 2019, new research investigating the use of universal screening compared to current risk based testing was announced,[217] and the UK National Screening Committee will review its recommendation on screening after that research trial has concluded.[218]

Supporting informed choices and providing personalised care

145. Pregnancy and childbirth are normal, physiological processes. Moreover, they can be a time of unprecedented joy. But they are not without risk both to mother and to baby, and skilled support and intervention from maternity services are often required. In the UK, nearly 40% of women giving birth have an instrumental delivery or caesarean section.[219] For first-time mothers this rises to 50%.[220]

146. The report of the Morecambe Bay investigation describes the "pursuit of normal childbirth 'at any cost'"[221] Similar themes have emerged from the interim Ockenden report into Shrewsbury and Telford. When she came before us, Donna Ockenden said that the review had:

> Spoken to hundreds of women who said to us that they felt pressured to have a normal birth [...] at that trust, there was a multi-professional, not midwife-led, focus on normal birth pretty much at any cost.[222]

147. This alone was not responsible for the tragedies that occurred, it was one amongst a constellation of other failings at these units. Our expert witnesses told us that these very badly failing units should not be taken as an indication that such problems are widespread.[223] However, we were shocked to hear from Clotilde Rebecca Abe that a mum she supported was made to feel like a failure by her midwife, because she opted for a caesarean section. Clotilde told us that the woman "felt like a failure because she felt that she had let the midwife down".[224] 'Anecdotal evidence like this suggests that, in some cases at least, there is still clinician-led pressure for women to choose vaginal delivery, even when this may not be in their best interests.

148. Michelle Hemmington simply and eloquently argued that rather than the method of delivery, the outcome of the birthing process must be the focus, with all professionals working together:

215 Q271 Minister of State for Patient Safety, Suicide Prevention and Mental Health
216 The UK NSC recommendation on Group B Streptococcus screening in pregnancy
217 Department of Health and Social Care, Approval for new trial to prevent Group B Strep in newborn babies
218 Q270 Minister of State for Patient Safety, Suicide Prevention and Mental Health
219 National Maternity and Perinatal Audit, Clinical Report 2019/ This represents the proportion of women birth giving birth to a singleton baby at term who required an instrumental birth (including forceps or ventouse) or caesarean birth (elective or emergency).
220 National Maternity and Perinatal Audit, Clinical Report 2019
221 The Report of the Morecambe Bay Investigation, 2015
222 Q151 Donna Ockenden
223 Q172 Edward Morris; Q43 Bill Kirkup
224 Q145 Clotilde Rebecca Abe

> Consultants, registrars, and midwives all need to be working together and to be joined up. At the end of the day, the outcome is to have a safe, healthy, positive experience of birth and to come home with a baby. They should all be working together to achieve that.[225]

149. The midwives we heard from—including England's most senior midwife, Professor Jacqueline Dunkley-Bent, told us that it was "not in a midwife's DNA" to support normal birth at any cost.[226] Donna Ockenden told us that the pursuit of normal childbirth was not a midwifery issue, but was a multi-professional issue ingrained in the culture of both obstetricians and midwives at Shrewsbury and Telford.[227] The obstetricians we heard from were equally emphatic that any ideology-driven practice that prioritised normal childbirth above safety had to be "wiped out".[228]

150. Instead, we heard that personalised care, shaped to a woman's own risks and situation, and that can be adapted quickly if situations change, was the best policy. Dr Bill Kirkup, explained this approach to us:

> There is a slightly simplistic view that there is only one lever we can pull: either lots of intervention and it is safe, or much less intervention and it is a normal birth but it is not safe […] That is too much of an oversimplification. People sometimes describe the debate, and try to frame the debate, in those terms. I think there are multiple levers; we can have lots of appropriate normal births, and we can also have a safe service provided that we do the right things to maintain surveillance of the service and make sure that we give safe care as well as appropriate care.[229]

151. Professor Baker, Chief Inspector of Hospitals, Care Quality Commission, agreed that care needed to be "individualised" and that the woman's "needs and her risks" had to be taken into account.[230] Furthermore, he said that each woman needed to be given advice to make the right decisions for herself and not be told "you have to do it this way or that way."[231] Professor Baker explained it in the following terms:

> She should be given the choice and understanding how to do it … The sense of normality against intervention, as if you have to choose one or the other, is nonsense. You have to have what is right for you under the circumstances. When the risk changes, the service needs to be able to escalate care rapidly to make sure that you get consistent and safe care.[232]

152. In a similar vein, Dr Jolly, National Clinical Director for Maternity and Women's Health at NHSE&I, told us that "different women have different agendas about what they want to do" and that their views needed to be respected. He explained that the job of the clinician was "to do the best possible risk assessment, communicate clearly and respect women's autonomy".[233]

225 Q2 Michelle Hemmington
226 Q59 Jacqueline Dunkley-Bent
227 Q151 Donna Ockenden
228 Q172 Edward Morris
229 Q43 Bill Kirkup
230 Q44 Ted Baker
231 Q44 Ted Baker
232 Q44 Ted Baker
233 Q57 Matthew Jolly

153. At our roundtable, we heard from one clinician that they had worked in a place where an "antagonistic atmosphere" did exist between different professions, with doctors' ID cards not allowing them into certain parts of the unit without permission.[234] However, we were encouraged to hear that majority of attendees had not experienced a culture that promoted 'normal birth' at the expense of safety:

> In my experience in the trust I've been in, it's actually quite the opposite […] I've not found that at all. It's usually the women pushing for the normal births in a lot of circumstances and it's the staff—not that they push for caesareans but […] it kind of comes into the defensive practise thing, they're frightened of things going wrong with vaginal births in what is probably outside of their comfort zone so they try and get the women to have a caesarean. [Midwife][235]
>
> I haven't come across it; I haven't seen it exist. [Midwife][236]
>
> This is something I've not come across at all in my training […] people putting so-called normality above safety. [Midwife][237]
>
> There is overwhelming evidence that a physiological birth benefits women and babies and there isn't as far as I'm aware an ideology that promote this to the detriment of women. There shouldn't be. If women need interventions, we should be there intervening, absolutely straight away, we shouldn't be delaying. [Midwife][238]

154. Instead, our attendees highlighted the pressures of the wider community, social media, and antenatal classes as contributing to "a big expectation of normality" amongst expectant parents, who, in their view, were often given insufficient information about many aspects of their pregnancy and labour:

> I think that we have to look at the wider community and in particular social media to look at what images are produced across that and the impact that has on women's expectations. I think there's a big expectation around normality, there's an expectation that it will all go well, and going back to the role that the midwife has to play in the antenatal period in terms of managing expectations and being clear about what the women wants. [Midwife][239]
>
> The difficulties that I've experienced is certainly around parental ideology and expectation around what their birth is going to be. I think there is a benefit to knowing what you would like to have for your birth, and what the

234 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
235 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
236 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
237 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
238 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
239 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021

> options are if you have the choice, but there really needs to be an emphasis on mother and baby coming out of this in the healthiest way possible. If physiological birth is the way, and it can happen, then that's fantastic but it's not a failure if it can't. And the fact that, particularly in antenatal classes, sometimes there isn't the awareness there of what can go wrong, what will happen if things don't go exactly optimally and actually having the healthy mother and baby at the end of it is a success. [Paediatric Trainee Doctor][240]

> I think with respect to normal birth ideology, I think there are very few women who aren't holding out for a completely physiological birth. Almost everyone wants that, and the problem is not I don't think generally midwives [...] of course when things are getting tetchy they would call us. The problem is that the women have read online, and gone to NCT, and been exposed so much about how important a physiological birth is, which doesn't really need to be underlined. Most people know that they don't want to be in hospital, and they don't want drips and these horribly invasive things and that's underlined at the cost of the other things [...] teaching people to be flexible and teaching people what could happen is very important at any stage. [O&G Trainee Doctor][241]

155. We heard the IDECIDE tool is being developed to establish better choice and consent procedures to ensure that women have access to full and unbiased evidence about the risks associated with C-sections and other interventions and also with physiological vaginal birth.[242] Gill Walton, Chief Executive, Royal College of Midwives, told us:

> The most important thing is that when women are making choices, whether it is a home birth or a caesarean section, they understand clearly the risk and benefits of those choices, because there are risks and benefits in all choices.[243]

156. However, the RCM cautioned that making time and space to educate women and families about their choices and the risks and benefits takes clinical time and resources. The RCM explained that the ability to provide the necessary education and advice depended on having "enough workforce, enough midwives and enough obstetricians to make sure that we can have conversations with women, from an early stage, around informed choice and what their options are".[244] In particular, when women attended antenatal clinics, they would often see midwives that were "harassed and overworked" and as a result were reticent to ask all the questions they wanted answering.[245] Gill Adgie, stressed that to overcome this it was vital to have "enough staff in the right places and enough time to be able to have those conversations with women".[246]

157. A clinician at our roundtable explained the difficulties of trying to discuss these things in a pressurised situation:

240 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
241 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
242 Qq58–59,Q63 Matthew Jolly, Jaqueline Dunkley-Bent
243 Q187 Gill Walton
244 Q267 Gill Adgie
245 Q267 Gill Adgie
246 Q267 Gill Adgie

> I'm very much of the opinion that women need to have all of the options laid on the table. To try and explain forceps to a woman in the last ten minutes of her labour can be really traumatic sometimes for us, and for them. [O&G Trainee Doctor][247]

158. As well as the mode of delivery, pain relief during labour is an essential component of safe, personalised care. However, we heard that this does not always happen. Atinuke Awe told us that her pain was not taken seriously, and she was "left for hours without any pain relief".[248]

159. The Expert Panel chose personalisation as a key policy to examine (**Box 5**). The Expert Panel overall rated progress towards personalised care as 'Inadequate', stating:

> This is an important aspiration and is likely to improve safety and satisfaction for women. However, there has been inadequate consideration of ways to mitigate potential barriers to impactful care planning. PCSPs represent a significant change in workplace culture and aim to empower women as lead decision makers in their own care. However, lack of clarity about how plans will be used to inform service delivery planning has resulted in PCSPs becoming a potentially time-consuming tick box exercise. [Expert Panel][249]

Box 5: Expert Panel CQC-style Ratings–Personalised Care

Personalised care: *All women to have a Personalised Care and Support Plan (PCSP) by 2021.*

Overall: Inadequate

Commitment met	Inadequate
Funding/Resource	Inadequate
Impact	Inadequate
Appropriate	Requires Improvement

Further analysis can be found in the Expert Panel's independent report: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England.*[250]

160. During our evidence session on patient choice, we heard that the collection of central data on Caesarean section (C-section) rates, and the "penalisation" of maternity units with high rates, had the potential to act as a perverse incentive to reduce C-section rates to the detriment of safety. Dr Daghni Rajasingam, Consultant Obstetrician and Deputy Medical Director at Guys and St Thomas' Hospital NHS Foundation Trust, explained to

247 Health and Social Care Committee, Safety of Maternity Services in England Inquiry Transcript from Roundtable with Maternity Clinicians, January 2021
248 Q131 Atinuke Awe
249 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], page 6
250 The Health and Social Care Committee's Expert Panel: *Evaluation of the Government's progress against its policy commitments in the area of maternity services in England*, 5 July 2021, HC 18 [report], pages 5; 52–62

us that on the one hand, she wanted to give every woman the choice to have a caesarean section, if that is what she chooses. On the other hand, however, as head of service in her directorate, she was penalised doing so.[251] She described the caesarean section rate as a whole as "one of the key parameters and metrics that we look at" but that it was not intelligent data:

> Every caesarean section that we do contributes to our caesarean section rate. […] We absolutely need to look at caesarean section rates but in a much more intelligent way, using the Robson criteria. If you remove the broad caesarean section rate, you enable clinicians to have a very different conversation with women wanting to explore that.[252]

161. Gill Walton of the Royal College of Midwives agreed that this was not appropriate. She told us "for some time, services were performance managed on things like their caesarean section rates and their forceps and ventouse rates, and were penalised when they went up" and should be replaced with "the right targets for maternity services, promoting a woman-centred approach that is about good birth".[253]

162. In his oral evidence, Dr Matthew Jolly, noted the importance of monitoring C-section rates but stated that they should not be used to "performance-manage" trusts.[254] He told us that the NHS had not used C-section rates as a performance metric "for many years" but acknowledged that witnesses to our inquiry perceived that it was happening. In response to that perception he said that the NHS needed to "work hard to stop that".[255]

163. In relation to current monitoring of trusts, Dr Jolly explained that in January 2021, the NHS introduced a national maternity dashboard that included 14 clinical quality approved metrics on which trusts were assessed. Three of these are based around the Robson criteria. Dr Jolly explained to us that the dashboard was used to divide trusts into quartiles:

> If you are at one extreme, you need to have a conversation and think about why you are there […] It is all about using the data to create a better understanding of our maternity services, so that we can reflect and improve.[256]

164. **The central aim of maternity services must be to achieve, in the words of Michelle Hemmington, "a safe, healthy, positive experience of birth and to come home with a baby". And yet, during the course of this inquiry, we heard of women who were made to feel like a failure for having a Caesarean Section. We have heard clear agreement among those working in maternity services, that "the only birth is a safe birth", and we challenge all those working in leadership positions in maternity services in NHS England and Improvement, the Royal Colleges, and individual services, to take action to enshrine that ideology at the heart of England's maternity services. Furthermore, those organisations need to work hard to stamp out the damaging ideological focus on "normality at any costs", which caused such huge loss and suffering at Morecambe Bay**

251 Q264 Daghni Rajasingam
252 Qq264–265 Daghni Rajasingam
253 Q197 Gill Walton
254 Q311 Matthew Jolly
255 Q311 Matthew Jolly
256 Q311 Matthew Jolly

and Shrewsbury and Telford - and may exist in other trusts today. We heard that senior leaders in maternity services no longer use the term 'normal birth' and we urge an end to the use of this unhelpful and potentially damaging term.

165. **The Expert Panel overall rated the Government's progress towards providing personalised care as 'Inadequate'. We believe that personalisation must go hand in hand with safety and women must be fully and impartially informed about the safety risks associated with all birthing options. Women should also be provided with clear information about the likelihood of interventions.**

166. **Timely and appropriate pain relief is also an essential part of safe and personalised care, and we believe that every woman giving birth in England should have a right to their choice of pain relief during birth, in line with clinical advice on what would be safest for them and their baby.**

167. ***We recommend that NHS England and Improvement establish a working group comprising of women and their families, organisations providing support for women throughout their pregnancy and clinicians to develop a set of actions for maternity services to consider in order to ensure no woman feels pressured to have a vaginal delivery and is always informed clearly what the safest option is for her birth. The working group's remit should also include researching and addressing the wider societal factors, including media and social media, that put pressure on women to want to have an unassisted birth.***

168. ***It is deeply concerning that maternity units appear to have been penalised for high Caesarean Section rates. We recommend an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently. NHS England and Improvement must write to all maternity units to ensure that they are aware of this change.***

Conclusions and recommendations

Supporting Maternity Services and Staff to Deliver Safe Maternity Care

1. The Expert Panel overall rated progress towards safe staffing as 'Requires Improvement'. Appropriate staffing levels are a prerequisite for safe care, and a robust and credible tool to establish safe staffing levels for obstetricians is needed. We were pleased that following our evidence session, the Department has committed to fund the Royal College of Obstetricians and Gynaecologists to develop a tool that trusts can use to calculate obstetrician workforce requirements that will be in place by autumn 2021. This work should also enable trusts to calculate anaesthetist workforce requirements within maternity services. We will contact the Department and RCOG for the outcome of this work in October 2021. (Paragraph 27)

2. With 8 out of 10 midwives reporting that they did not have enough staff on their shift to provide a safe service, it is clear that urgent action is needed to address staffing shortfalls in maternity services. Evidence submitted to our inquiry estimates that as a minimum, there need to be 496 more obstetricians and 1,932 more midwives. While we welcome the recent increase in funding for the maternity workforce, when the staffing requirements of the wider maternity team are taken into account–including anaesthetists to provide timely pain relief which is a key component of safe and personalised care - a further funding commitment from NHS England and Improvement and the Department will be required to deliver the safe staffing levels expectant mothers should receive. (Paragraph 36)

3. *We recommend that the budget for maternity services be increased by £200–350m per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as Trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.* (Paragraph 37)

4. *We further recommend that the Department work with the Royal College of Obstetricians & Gynaecologists and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts to enable trusts to deliver safe obstetric staffing over the years to come. This work should also consider the anaesthetic workforce.* (Paragraph 38)

5. The 2016 Maternity Safety Training Fund was widely welcomed by healthcare professionals and it is clear to us that the Fund delivered positive outcomes. However, for those positive outcomes to endure, more funding is required to embed on-going and sustainable access to training for maternity staff. (Paragraph 52)

6. Training is essential for staff to deliver safe care. Evidence submitted to our inquiry highlighted that insufficient staffing is not only impacting the number of healthcare professionals available to deliver care for mothers and their babies but also the ability of staff to participate in vital training. (Paragraph 53)

7. *We recommend that a proportion of maternity budgets should be ringfenced for training in every maternity unit and that NHS Trusts should report this in public through annual Financial and Quality Accounts. It should be for the Maternity*

Transformation Programme board to establish what proportion that should be; but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training. (Paragraph 54)

8. While it is encouraging that 93% of trusts are meeting the training objective set out in the Maternity Incentive Scheme, it is disappointing that only 8% of units across the UK are meeting the very highest standards of training, as set out in the Saving Babies Lives Care Bundle. It is also disappointing to hear the implementation of training still described as 'variable'. (Paragraph 55)

9. *We recommend that a single set of stretching safety training targets should be established by the Maternity Transformation Programme board, working in conjunction with the Royal Colleges and the Care Quality Commission. Those targets should be enforced by NHSE&I's Maternity Transformation Programme, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Care Quality Commission through a regular collaborative inspection programme.* (Paragraph 56)

Learning from Patient Safety Incidents

10. Involving families in a compassionate manner is a crucial part of the investigation process. Too often, maternity investigations have failed to do this in a meaningful way. Families must be confident that their voices are heard and that lessons have been learnt to prevent the tragedy they have endured being repeated. We welcome the independent nature of HSIB investigations and believe that HSIB has taken considerable steps to improve family engagement in investigations. However, it is important that they continue to pursue improvements in this area to ensure all investigations are informed by the experience of families. (Paragraph 64)

11. We believe that HSIB's ability to take a broad and independent view of the services and factors contributing to maternity incidents is a valuable step in the right direction to learning from maternity incidents. It is essential that an independent, standardised method of investigating the most serious incidents is maintained. However, there is still work to be done to improve the timeliness of investigations and the relationship between HSIB and trusts to ensure there is local ownership of recommendations made and investigations maximise learning at the local level. That relationship should not be confined to senior management; all members of the team, and in particular junior members of the clinical team, should be able to engage with an investigation in a manner which increases learning and the implementation of recommendations. Trusts should also improve local and regional sharing of key learnings particularly through Local Maternity Systems (LMS). (Paragraph 71)

12. Clinicians of all disciplines should also receive training before they are qualified in how they should respond to the sorts of error that these investigations may uncover. This would include help for clinicians on accepting a degree of fallibility. Being unable to respond appropriately to mistakes is harmful to the mental health of the clinicians themselves but it also reduces their ability to learn from their errors. (Paragraph 72)

13. *We recommend that HSIB investigations continue, but that HSIB reviews how it engages with trusts to ensure that the investigation process works in a timely and*

collaborative manner which optimally supports local learning and development. That review should include processes to ensure that healthcare professionals at all levels and across multidisciplinary team are able to engage with HSIB investigations. We further recommend that HSIB actively consults trainee doctors and midwives in that review. (Paragraph 73)

14. *In addition, we recommend that HSIB shares the learning from its maternity reports in a more systematic and accessible manner. A top level summary of individual cases together with the key learnings derived from them should be shared rapidly across the NHS.* (Paragraph 74)

15. We recognise the effort of individual organisations to collect data and insights on maternity care. The potential value of this information to drive improvements in maternity care is clear. However, at present these insights are not being fully utilised. (Paragraph 80)

16. *NHSE&I must streamline the data collection process to reduce the burden for trusts. The Department must ensure that insights collected by all bodies are collated in a coordinated manner and shared across organisations in a timely manner. As part of this process, the Department must assess current data gaps and develop a plan to address these. Particular focus should be given to using data to understand the causes of and reduce the variation between maternity units. National measures are driving improvements overall but there are some units being left behind. We need to know why.* (Paragraph 81)

17. It is clear to us that in its current form the clinical negligence process is failing to meet its objectives for both families and the healthcare system. Too often families are not provided with the appropriate, timely and compassionate support they deserve. For those delivering maternity care, the adversarial nature of litigation promotes a culture of blame instead of learning after a patient safety incident. Alternative approaches are already in place in other countries where the use of a threshold of 'avoidability' rather than 'negligence' to award compensation has helped to tackle the debilitating culture of blame, accelerate learning and provide timely support to patients and their families. We believe that adopting such an approach is an essential next step in shifting the culture in maternity services away from blame to one of learning. (Paragraph 101)

18. Providing appropriate financial redress to families after an incident is important. However, the rising costs of maternity claims without sufficient learning and outdated mechanisms for calculating compensation is unsustainable. It is particularly unfair that wealthier families receive more compensation for a severely disabled child than poorer families because likely lost earnings are taken into account. Therefore, we welcome the Government's proposal to review clinical negligence in the NHS more broadly. We note that elements of the Rapid Resolution and Redress scheme have been implemented. However, we are disappointed that the scheme has not be been implemented in full. Until it is, there is a high risk that the fundamental changes needed to improve the safety of maternity services will fail to be achieved. (Paragraph 102)

19. *While the review of the negligence system is underway, we recommend the Department must implement the Rapid Redress and Resolution Scheme in full. We also recommend the Department provides the Committee with the scope and timetable for its review of clinical negligence by September 2021.* (Paragraph 103)

20. *We recommend that following that review, the Department brings forward proposals for litigation reforms that award compensation for maternity cases based on whether an incident was avoidable rather than a requirement to prove clinical negligence. That approach would allow families to access compensation without the need for the courts in the vast majority of cases and establish a substantially less adversarial process.* (Paragraph 104)

21. *In addition, we recommend that the Department and NHS Resolution remove the need to compensate on the basis of private healthcare provision where appropriate NHS care is available; and that compensation is standardised against the national average wage to prevent unjust variability in compensation payouts.* (Paragraph 105)

22. *Finally, given their recognition of the role the professional regulators have in ending the blame culture, we recommend that the General Medical Council and the Nursing and Midwifery Council review what changes are required to their remits or working practices to reduce the fear clinicians have of their regulators and allow them to open up more about mistakes that are made.* (Paragraph 106)

Providing Safe and Personalised Care for All Mothers and Babies

23. England remains a largely safe place to give birth and efforts to increase the safety of maternity services have led to further improvements. However, the Expert Panel overall rated the Government's progress on maternity safety outcomes as 'Requires Improvement'. The Expert Panel highlighted that the Government's commitment to halve the rate of stillbirths, neonatal deaths, brain injuries and maternal deaths is not currently achieving equitable outcomes, with women and babies from minority ethnic and socio-economically deprived backgrounds at greater risk when compared to their white or less deprived peers. We acknowledge the positive steps the Department and NHS England and Improvement have taken, including the commitment to continuity of carer for 75% of women from Black, Asian and minority ethnic groups. We support the principles of the continuity of carer model but conclude that further work is required to ensure it can be implemented in a sustainable manner. The Expert Panel overall rated progress towards delivering continuity of carer as 'Requires Improvement'. Continuity of carer alone is also unlikely to resolve the deep seated and long-standing inequalities persisting in maternal and neonatal outcomes. (Paragraph 136)

24. *Having the right skill set, as noted above, is crucial for the successful implementation of continuity of carer. We therefore recommend that those involved in delivering this model have received appropriate training and that all professionals are competent and trained in all areas that they work in, particularly in relation to Black mothers where the disparities are the greatest.* (Paragraph 137)

25. *Given the underlying causes of these outcomes for women from Black, Asian and minority ethnic groups relate to a range of issues beyond the remit of the Department,*

we recommend that the Government as a whole introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department must lead the development of a strategy to achieve this target and should include consultation with mothers from a variety of different backgrounds. (Paragraph 138)

26. We were pleased to hear that the UK National Screening Committee believed that the current evidence for a 3rd trimester breech presentation scan "looks promising" and may be a "suitable candidate for a screening programme once further research had been published in the coming years" (Paragraph 141)

27. The central aim of maternity services must be to achieve, in the words of Michelle Hemmington, "a safe, healthy, positive experience of birth and to come home with a baby". And yet, during the course of this inquiry, we heard of women who were made to feel like a failure for having a Caesarean Section. We have heard clear agreement among those working in maternity services, that "the only birth is a safe birth", and we challenge all those working in leadership positions in maternity services in NHS England and Improvement, the Royal Colleges, and individual services, to take action to enshrine that ideology at the heart of England's maternity services. Furthermore, those organisations need to work hard to stamp out the damaging ideological focus on "normality at any costs", which caused such huge loss and suffering at Morecambe Bay and Shrewsbury and Telford - and may exist in other trusts today. We heard that senior leaders in maternity services no longer use the term 'normal birth' and we urge an end to the use of this unhelpful and potentially damaging term. (Paragraph 164)

28. The Expert Panel overall rated the Government's progress towards providing personalised care as 'Inadequate'. We believe that personalisation must go hand in hand with safety and women must be fully and impartially informed about the safety risks associated with all birthing options. Women should also be provided with clear information about the likelihood of interventions. (Paragraph 165)

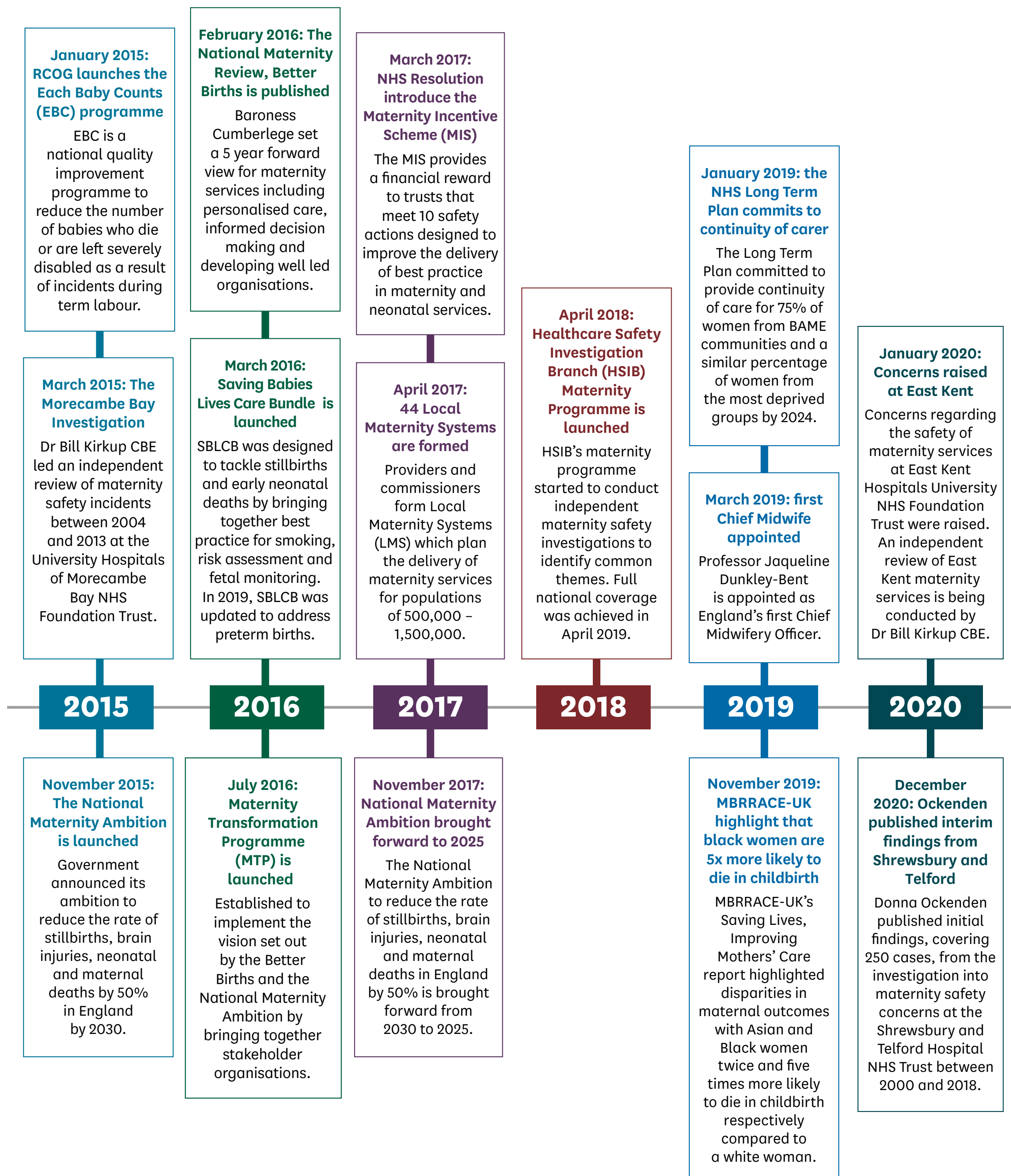
29. Timely and appropriate pain relief is also an essential part of safe and personalised care, and we believe that every woman giving birth in England should have a right to their choice of pain relief during birth, in line with clinical advice on what would be safest for them and their baby. (Paragraph 166)

30. *We recommend that NHS England and Improvement establish a working group comprising* of *women and their families, organisations providing support for women throughout their pregnancy and clinicians to develop a set of actions for maternity services to consider in order to ensure no woman feels pressured to have a vaginal delivery and is always informed clearly what the safest option is for her birth. The working group's remit should also include researching and addressing the wider societal factors, including media and social media, that put pressure on women to want to have an unassisted birth.* (Paragraph 167)

31. *It is deeply concerning that maternity units appear to have been penalised for high Caesarean Section rates. We recommend an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is*

replaced by using the Robson criteria to measure Caesarean Section rates more intelligently. NHS England and Improvement must write to all maternity units to ensure that they are aware of this change. (Paragraph 168)

Appendix: Maternity Safety Timeline



Formal minutes

Tuesday 29 June 2021

Virtual meeting

Members present:

Jeremy Hunt, in the Chair

Rosie Cooper

Dr James Davies

Dr Luke Evans

Barbara Keeley

Sarah Owen

Anum Qaisar-Javed

Dean Russell

Laura Trott

Draft Report (*The safety of maternity services in England*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 168 agreed to.

Summary agreed to.

A paper was appended to the Report as Appendix 1

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Tuesday 6 July 2021 at 9.00 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 29 September 2020

Miss Michelle Hemmington, Co-founder, Campaign for Safer Births Q1–14

Dr Bill Kirkup, Chairman, Morecambe Bay maternity investigation and East Kent maternity investigation; **Professor Ted Baker**, Chief Inspector of Hospitals, Care Quality Commission Q15–49

Professor Jacqueline Dunkley Bent, Chief Midwifery Office, NHS England and NHS Improvement; **Dr Matthew Jolly**, National Clinical Director for Maternity and Women's Health, NHS England and NHS Improvement Q50–70

Tuesday 03 November 2020

James Titcombe, bereaved parent; **Darren Smith**, bereaved parent Q71–85

Helen Vernon, Chief Executive, NHS Resolution; **Dr Pelle Gustafson**, Chief Medical Officer, Lof (Swedish Patient Insurer) Q86–111

Dr Sonia MacLeod; **Dr Jenny Vaughan**, Consultant Neurologist, Learn Not Blame, Law and Policy Lead, Doctors' Association UK Q112–130

Tuesday 15 December 2020

Tinuke Awe, Co-founder, FiveXMore Campaign; **Professor Marian Knight**, Professor of Maternal and Child Population Health, University of Oxford; **Professor Jenny Kurinczuk**, Professor of Perinatal Epidemiology & Director, National Perinatal Epidemiology Unit, University of Oxford; **Clotilde Rebecca Abe**, Co-founder, FiveXMore Campaign Q131–145

Donna Ockenden, Chair, Independent review into Maternity Services at The Shrewsbury And Telford Hospitals - Maternity Admin Q146–165

Professor Gordon Smith, Professor of Obstetrics and Gynaecology, University of Cambridge; **Dr Edward Morris**, President, The Royal College of Obstetricians and Gynaecologists (RCOG); **Gill Walton**, Chief Executive, The Royal College of Midwives (RCM) Q166–206

Tuesday 19 January 2021

Charlie Massey, Chief Executive, General Medical Council; **Andrea Sutcliffe**, Chief Executive, Nursing and Midwifery Council; **Professor James Walker**, Clinical Director of Maternity Investigation Programme, Healthcare Safety Investigation Branch Q207–231

Sara Ledger, Head of Research, Baby Lifeline; **Niamh Maguire**, Obstetric Clinical Lead, Sussex Local Maternity System; **Jo Mounfield**, Vice President for Workforce and Professionalism, Royal College of Obstetricians and Gynaecologists; **Doctor Daghni Rajasingam**, Consultant Obstetrician, The Shelford Group; **Gill Adgie**, Regional Head, Royal College of Midwives Q232–269

Tuesday 02 February 2021

Nadine Dorries MP, Minister of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care; **William Vineall**, Director of NHS Quality, Safety and Investigations, Department of Health and Social Care; **Sarah-Jane Marsh**, Chief Executive, Birmingham Women's and Children's Hospital; **Dr Matthew Jolly**, National Clinical Director for the Maternity Review, NHS England; **Professor Jacqueline Dunkley-Bent**, Chief Midwifery Officer, NHS England and NHS Improvement Q270–325

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

MSE numbers are generated by the evidence processing system and so may not be complete.

1 Action against Medical Accidents (MSE0033)

2 Andrews, Sarah (Care Manager , Local authority) (MSE0091)

3 Association for Improvements in the Maternity Services (AIMS) (MSE0010)

4 Association of Personal Injury Lawyers (MSE0046)

5 Association of Radical Midwives (MSE0032)

6 Baby Lifeline (MSE0075)

7 Birth Trauma Association (MSE0022)

8 Birthrights (MSE0018)

9 British Association of Perinatal Medicine (MSE0082)

10 British Intrapartum Care Society (MSE0106)

11 British Maternal & Fetal Medicine Society (MSE0100)

12 British Pregnancy Advisory Service (MSE0048)

13 British Society of Urogynaecology (MSE0078)

14 Caesarean Birth (MSE0035)

15 Campaign for Safer Births (MSE0064)

16 Care Quality Commission (MSE0042)

17 Dale, Mr Trevor (Managing Director, Atrainability Ltd) (MSE0096)

18 Department of Health and Social Care (MSE0062)

19 DISCERN research team (MSE0038)

20 East & North Herts NHS Trust (MSE0070)

21 Fernyhough, Chris (Office Manager, Perinatal Institute) (MSE0107)

22 Five x More (MSE0077)

23 Flint, Caroline (Retired Midwife, retired NCT Teacher, author of 6 books on midwifery., The Birth Centre Ltd) (MSE0006)

24 Flint, Mrs Caroline (MSE0015)

25 General Medical Council (MSE0076)

26 Group B Strep Support (MSE0045)

27 HealthWatch England (MSE0069)

28 Healthcare Safety Investigation Branch (MSE0081)

29 Healthcare Safety Investigation Branch (MSE0044)

30 Hopson, Chris (Chief Executive, NHS Providers) (MSE0112)

31 Infant Feeding Alliance (MSE0054)

32 Irwin Mitchell (MSE0047)

33 Jowitt, Mrs Margaret (proprietor, birthupright.co.uk) (MSE0041)

34 Kapur, Professor Narinder (Visiting Professor of Neuropsychology, University College London); and University College London, Ataullah, Dr Ifat (Retired consultant obstetric and gynaecological consultant, University College London) (MSE0020)

35 Kemp, Mr Ian (MSE0055)

36 Kirkup, Dr Bill (Independent Health Service Investigator, Independent) (MSE0061)

37 Kooy, Brenda van der (Midwife, Private Midwives) (MSE0059)

38 Lownds, Mr Kenneth (MSE0053)

39 Leigh Day (MSE0051)

40 MBRRACE-UK/PMRT (MSE0028)

41 Macleod, Sonia (Researcher, The Centre for Socio-Legal Studies) (MSE0108)

42 Macrae, Prof Carl (Professor of Organisational Behaviour and Psychology, University of Nottingham) (MSE0073)

43 Malik, Captain Omar (Safety Researcher, Self-employed) (MSE0017)

44 Manchester University NHS Foundation Trust (MSE0004)

45 Massey, Charlie (Chief Executive and Registrar, General Medical Council (GMC)) (MSE0110)

46 Maternity Action (MSE0050)

47 Medical and Dental Defence Union of Scotland (MDDUS) (MSE0099)

48 Meyer-Lewis, Mrs Deborah (MSE0088)

49 Morris, Dr Edward (President, The Royal College of Obstetricians and Gynaecologists (RCOG)) (MSE0113)

50 NCT (National Childbirth Trust) (MSE0049)

51 NHS Providers (MSE0115)

52 NHS Providers (MSE0016)

53 NHS Resolution (MSE0057)

54 Northumbria University (MSE0105)

55 Nursing and Midwifery Council (MSE0085)

56 Nursing and Midwifery Council (MSE0025)

57 Page, Prof Lesley (Visiting Professor in Midwifery , King's College London); Downe, Prof Soo (Professor of Midwifery , University of Central Lancashire); and Renfrew, Professor Mary (Professor of Mother and Infant Health , University of Dundee) (MSE0072)

58 Powers QC, Dr Michael (Barrister, Clerksroom, Equity House, Taunton TA1 2PX); and Steer, Professor Philip (Emeritus Professor of Obstetrics and Gynaecology at Imperial College London, Imperial College, London) (MSE0007)

59 Racher, Kerry (External Affairs Advisor, NHS Providers) (MSE0114)

60 Royal College of Obstetricians and Gynaecologists; and Royal College of Midwives (MSE0023)

61 Royal College of Paediatrics and Child Health (MSE0013)

62 Royal College of Physicians (MSE0009)

63 Sandall CBE, Professor Jane and Mackintosh, Dr Nicola (MSE0039)

64 Sands UK (MSE0008)

65 Sharma, Miss Sunita (Consultant Obstetrician and Gynaecologist, Chelsea and Westminster Hospital NHS Foundation Trust) (MSE0012)

66 Smoking in Pregnancy Challenge Group; and Action on Smoking and Health (MSE0101)

67 Society of Clinical Injury Lawyers (SCIL) (MSE0068)

68 Surrey Heartlands Local Maternity System (MSE0011)

69 Sussex Local Maternity System (MSE0026)

70 Sutcliffe, Andrea (Chief Executive and Registrar, NMC) (MSE0111)

71 The Health Foundation (MSE0065)

72 The Health Foundation (MSE0066)

73 The Healthcare Improvement Studies (THIS) Institute, University of Cambridge (MSE0040)

74 The MASIC Foundation (MSE0080)

75 The Medical Defence Union (MDU) (MSE0036)

76 The Professional Standards Authority for Health and Social Care (MSE0071)

77 The Shelford Group (MSE0043)

78 Twins Trust (MSE0058)

79 University Hospital Southampton (MSE0027)

80 Williams, Catherine (MSE0079)

81 Wright, Zoe (Midwife and Founder, The Real Birth Company) (MSE0109)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311
1st Special	Process for independent evaluation of progress on Government commitments	HC 633
2nd Special	Delivering core NHS and care services during the pandemic and beyond: Government Response to the Committee's Second Report of Session 2019–21	HC 1149
3rd Special	Drugs policy: Government Response to the Committees First Report of Session 2019	HC 1178