HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Safety of maternity services in England, HC 677

Tuesday 15 December 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Laura Trott.

Questions 131 - 206

Witnesses

I: Atinuke Awe, co-Founder of FiveXMore Campaign, and Founder Mums and Tea; Professor Marian Knight, Professor of Maternal and Child Population Health, University of Oxford, and Lead, MBBRACE-UK; Professor Jenny Kurinczuk, Professor of Perinatal Epidemiology and Director, National Perinatal Epidemiology Unit, University of Oxford and Lead, MBBRACE-UK; and Clotilde Rebecca Abe, co-Founder, FiveXMore Campaign, Founder, Prosperitys and co-Chair Lambeth and St Thomas Hospital Maternity Voice Partnerships.

II: Donna Ockenden, Chair, Independent Maternity Review.

III: Professor Gordon Smith, Head of Department of Obstetrics and Gynaecology, University of Cambridge; Dr Edward Morris, President, Royal College of Obstetricians and Gynaecologists; and Gill Walton, Chief Executive, Royal College of Midwives.

Examination of witnesses

Witnesses: Atinuke Awe, Professor Knight, Professor Kurinczuk and Clotilde Rebecca Abe.

Chair: Good morning and welcome to the final evidence session of the year for the House of Commons Health and Social Care Select Committee. Today, we are pursuing our inquiry into maternity safety. We are going to look at a number of important issues that could reduce the number of babies and mothers harmed, or even dying, during childbirth. They include the advice that mothers receive on different ways to give birth, the number of scans they receive before childbirth, and safe levels of staffing.

We will be talking to the chief executive of the Royal College of Midwives, to the president of the Royal College of Obstetricians and Gynaecologists, and to Donna Ockenden, who is leading the inquiry into baby deaths at Shrewsbury and Telford trust and published her interim report last week.

Before we talk to them, we want to look at the very specific issue of the higher than average level of harm among mothers and babies from certain minority ethnic groups. On our first panel, we are very pleased to hear from Clo and Tinuke, two black mothers from London who both had poor experience of NHS maternity services. Following that, they set up the FiveXMore Campaign, named because black mothers are five times more likely to die during childbirth than other mothers. Their petition to Parliament has generated a huge amount of interest. In fact, this part of the Committee session has been set up in collaboration with Parliament's Petitions Committee.

Alongside them, we have Professors Marian Knight and Jenny Kurinczuk from MBBRACE-UK, which is a national collaborative programme that researches maternal and baby death and harm.

A very warm welcome to Clo and Tinuke. Sarah Owen is going to ask them some questions.

Q131 **Sarah Owen:** I have met Clo and Tinuke before, having heard their presentation from FiveXMore. I want to start with a couple of questions.

Tinuke and Clo, could you share your experiences of maternity care with the Committee, please? How did they lead to the FiveXMore Campaign?

Atinuke Awe: Thank you for inviting us here today. I would like to start off by saying that black women are not a homogeneous group, and we do not speak for all black women. However, through our own personal experiences, and engaging with black women in our various networks of over 25,000 black women across the country, we see that black women consistently have poor experiences.

I will go on to speak about some difficult experiences of pregnancy and childbirth, which some listeners may find disturbing. I will start off by giving my story of giving birth to my son back in 2017. There were signs

of pre-eclampsia, high blood pressure and protein in my urine from midway through my pregnancy, but it was not picked up, I was not monitored and I was not given any medication for it. 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.

When I got to the hospital, I was told that I could not leave the hospital without giving birth to my son. As a result, I was induced the next day. The midwife who induced me reassured me that it would take at least 24 hours for the hormones to work, but when I started feeling pain a few hours later and asked her to check, she would not check me over. She did not believe that I was in labour, and 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.

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. A lot of black mothers felt the same way, which increasingly became a cause of concern for me.

The MBBRACE 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. I am going to give you two accounts of some women and their families who have also been deeply affected by the disparity that we are seeing.

D'Lissa Parkes unfortunately passed away in 2015 giving birth to her daughter. I will read some words from her mother, Sylvia. "The doctor informed me that it was normal for baby's head to be high and free due to the fact that black women's pelvises were shaped differently. He held on to his truth at the inquest into her death, but this was addressed by the coroner who advised that this was unsafe. I will always maintain that her death could have been prevented if she was taken seriously when she attended the hospital on the day before she died and was sent home. I am not a medical expert, but I am her mum." Sylvia is the guardian and full-time carer of D'Lissa's daughter S'Riaah, who was born with multiple complications due to the nature of her birth.

Sharmika Dockery ended up with retained placenta that was not detected until 11 days after giving birth to her son. She went to seek help from

health professionals on numerous occasions. Her midwife said that she was sweating through the bedsheets at night because she was breastfeeding. Her GP said that she was in pain because everything was stuck together. When she finally got help in the hospital, she was told she could not receive surgery straightaway because her head was not falling off, even though she was taken to hospital in an ambulance. Sharmika now has to live with chronic abdominal hip and leg pain, which has affected her life and her relationship with her son, even to this day, seven years after she gave birth. These stories are just a small example of what it is like to give birth as a black woman in the UK.

Why the campaign? I am showing my age, but, looking back at the previous confidential inquiries into maternal death before it was called MBRRACE, we see that as early as 1991—when my mum gave birth to me—she had a higher risk of dying as a black woman. They did not know just how much because data on ethnicity was not previously collected in the UK. Over the years, we have seen that gap widening. We see that black women are over-represented among the deaths. The MBRRACE report in 2018 mentioned that action was needed to address that disparity.

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. I decided to join forces with my friend, Clotilde, the founder of the social enterprise Prosperitys, which supports black and south Asian mothers through their pregnancies. We both saw that there was a problem, and we started the FiveXMore campaign as a way to address it. We feared that, if nothing was done, our daughters and loved ones, should they choose to give birth, would be 10 or 15 times more likely to die, based on the current trajectory of the statistics.

We have been able to harness the power of social media to build and grow our campaign, and speak to black women from across the country. Over the past year, we have been busy raising awareness of the campaign and the statistics, and driving tangible action for change to happen fast. Thank you.

Q132 **Sarah Owen:** Thank you, Tinuke.

Clo, can you tell us a bit more about the FiveXMore Campaign and your petition?

Clotilde Rebecca Abe: We started a petition because we wanted to improve maternal mortality rates and healthcare for black women in the UK. The petition reached over 187,000 signatures. We were able to gain a lot of signatures in a short amount of time, and we are waiting to debate the petition in Parliament. The support we gained from the petition led us to partner with organisations such as the Royal College of Obstetricians and Gynaecologists. We are now a member of the Race

Equality Taskforce, which was created earlier this year. We collaborated with them to create five steps for health professionals, so that they can take better care of women.

We partnered with Clifford Chance. They have helped us on a legal basis. Clifford Chance provides us with pro bono legal support and has created guidelines clearly stating women's legal rights and explaining more about NHS complaint procedures.

We also partnered with the Positive Birth Company. It has given us a free pregnancy digital package that we offer to 100 black women every month. We created the UK's first maternal health awareness week. We had hundreds of people reposting and using our hashtags. There were over 100,000 views of our online event. We launched steps for birthing partners to support the birthing woman or the birthing person.

We submitted evidence, which is one of the reasons why we are here, to the Health and Social Care Committee call for evidence; 450 women participated in the survey that we submitted. There was an open call from the ethnic disparities inquiry, so we submitted evidence to that recently. We have given talks to university students, upcoming medical professionals, doctors and midwives on our steps and on things they can do to reduce inequalities.

We have written articles on patient safety learning in journals, and have been featured in various publications such as the *BMJ*, the *Guardian* and many more. Recently, we presented at the NCT AGM and conference, the MBRRACE conference, the International Midwife Conference and the Royal College of Midwives.

At the FiveXMore campaign we do not want to scare women, but rather to empower them with knowledge and support through the six recommended steps that we created for black mums to be able to advocate for themselves, to empower them to take control of their pregnancy and to know their rights. We also have resources, factsheets and multiple partnerships with other organisations.

Q133 **Sarah Owen:** Thank you so much for your evidence. You are both an inspiration.

Clo, you talked about the six different points that people can have. What do you feel needs to change to address the disparity and prevent future harm from occurring?

Clotilde Rebecca Abe: There needs to be greater investment from the NHS to understand why there is huge disparity in health outcomes for black women. We believe the issue is deeper than mortality. 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. There is no data on near misses, morbidity and illnesses and poor outcomes for black women. I know that I am not alone in thinking that we cannot change it all, but something needs to be done. Once we can start to uncover the experiences of black women going through the maternity service and making a target to do better, we will have a better outcome for all black women.

Chair: That is a perfect moment to bring in Professor Marian Knight, who is Professor of Maternal and Child Population Health at the University of Oxford, and also works with MBRRACE. She specialises in maternal health.

I know that you have just completed some research on the safety of mothers and babies, Professor Knight. Thank you very much for joining us. Tell us your reaction to what Clo and Tinuke were saying, and about what your research indicates.

Professor Knight: Many of the points that Clo and Tinuke raised are absolutely crucial to the problem. They particularly reflected the issue of women presenting repeatedly and their symptoms not being recognised as significant, and their voices not being heard. That is definitely an important point when thinking about maternity safety and the issues that we see underlying maternal deaths.

I need to make it clear at the beginning that we are not talking about maternal deaths in childbirth as a result of childbirth complications. The majority of women who die will die from medical and mental health problems that are made worse by pregnancy, or by the care they receive because they are pregnant. When thinking about safety, particularly when thinking about addressing inequalities, we need to think much more broadly than just maternity services. The message that I have drawn from the more recent research is that we need to think much more widely than the professional groups of midwives and obstetricians.

We undertook a specific inquiry looking at potential biases, structural and others, that were affecting the care of women from different aggregated ethnic groups. Again, reflecting what Clo and Tinuke said, we describe them as aggregated ethnic groups because, as we know, all black women are different. We must remember that women are individuals.

We found that there was no difference in the causes from which women were dying across those aggregated ethnic groups when looking at black women, Asian women, white women or women from other groups. There were no differences when looking at the care of women who died. In our overall assessment of the quality of care, we felt that across every ethnic group about 40% of women might have had a different outcome. They might not have died if they had had different care.

What the group identified, however, were 17 clear biases in the care that women received, on the basis of additional, more detailed, inquiry. I will

talk about the three leading themes that our expert assessors found. They were from a range of professional groups and researchers, and from different ethnic backgrounds.

The first was what they called "Not like me." That 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.

The second most frequent theme we observed was complexity—clinical, social and cultural. The vast majority of women who die have multiple and complex problems. Our systems are not set up. 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, but we also identified some of the things that Clo, Tinuke and the women in their network have expressed quite clearly. For example, 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.

Clearly, language issues spread across a number of the themes. Our assessors certainly felt that continued reliance, for example, on family members as interpreters was a potential micro-aggression. Certainly, if you are relying on a young nephew to interpret for you, you are not going to be able to disclose some of the potentially personal issues that are affecting you in your pregnancy.

Q134 **Chair:** Professor Knight, is there any evidence that the problem is getting worse or better? What are the trend lines behind that?

Professor Knight: The disparity in maternal mortality rates between black and white women has been getting wider. When I took over leading the inquiry there was a threefold difference in mortality between black and white women. In the report we published in 2019, it had reached a fivefold difference, as Clo and Tinuke picked up, and one of the reasons I felt that in 2018 I had to put it front and centre was that I could not go on just documenting it. They have done a fantastic job of raising awareness since that report and helping to get some of the actions started.

Q135 **Chair:** Thank you. I think Tinuke wants to come back in with something that she thought could be put right.

Atinuke Awe: Yes, I did. Thank you so much. In terms of solutions and what we think needs to change, as I mentioned previously, my traumatic experience was not unique, and that is the issue. It is based on the collective stories we have heard, which are backed up by the research. There is clearly an issue, as we know. Maybe I do not speak for all black women, but I know what would have been helpful for me, and when I speak to other women, they say the same thing.

On that basis, we honestly think that the NHS needs to commit to a target to close the gap and end the disparity immediately. Black women only account for 4% of births, according to the MBRRACE report, yet are five times more likely to die. The issue has been going on for decades. There is a clear indication that something needs to be done right away. The Human Rights Committee pointed out in a recent report that the NHS acknowledges and regrets that it has no target. We think this would be the perfect starting point to work towards something targeted, to end the disparity.

Based on our consultation and the written evidence we have submitted to this inquiry, black women are not being given information to make informed decisions about their care and birth options. We found that, of the 400 black women who were questioned, about 78% did not receive advice or guidance on how to make an informed decision about home births, and 70% about water births; 73% were not presented with caesarean sections as an option; 85% of black women were not given advice or guidance about having an assisted birth, so would not have been in a position to understand what that entails. Certainly, in my personal experience of having to have an assisted birth, I did not know what it entailed. I was not given any prior information about it.

Of the respondents, 94% were unaware of the role of the Health and Safety Investigation Branch, and were unaware of how to make a complaint when they had bad experiences during their pregnancy and childbirth, even when they were at risk of losing their life because of the negligent care that they had received. Of respondents who engaged with HSIB to raise a concern, 74% did not receive a follow-up. On that basis, we would recommend that more awareness should be raised so that black women can make more informed decisions and be confident going into pregnancy, childbirth and beyond.

We would like to minimise the use of the word BAME in maternity services. The term BAME, as you know, stands for black and Asian minority ethnic. We feel that it is a term that puts anybody who is not white into the same category. Labelling women as BAME disregards the fact that black women have had a higher risk for a very long time. We believe, especially when it comes to maternity services, that you should say black if you mean black.

Q136 **Laura Trott:** I want to follow up on the stat you just gave about the fact that 74% of black women you surveyed, who contacted HSIB, did not actually get a response. That is absolutely extraordinary. Can you give a little bit more detail? Was there anything that anyone said to you particularly about their experience with HSIB that you would like to share with the Committee?

Atinuke Awe: I do not have any specific experiences of people who tried to complain to HSIB, but I was very shocked as well when I saw that. Overall, from speaking to the women in our community, I feel that there is just a sense of, "What's the point of even complaining because we don't know if anything is going to happen, and we don't know if anything is going to change?" I think that statistic quite rightly shows that. I hope that answers your question.

Laura Trott: We will ask it later on, of the people on the panel.

Q137 **Chair:** Finally, on this panel, I want to bring in Professor Jenny Kurinczuk, who is Professor of Perinatal Epidemiology and Director of the National Perinatal Epidemiology Unit, at Oxford, and also works with MBRRACE. Thank you very much for joining us.

I want to ask for your reaction, first of all, on the basis of your research to the issues faced by some black women, as we have heard this morning. In previous evidence sessions, we have heard evidence from Sweden. We know that, if we had Swedish neonatal death rates, 1,000 more babies would survive every year in England. Could we have your overall view as to why we have that disparity?

Professor Kurinczuk: I will pick up on the issue of baby deaths in particular, because Marian has already spoken to the issue of mothers who die. I highlight the fact that overall our perinatal mortality rate is currently falling. It has fallen by about 15% from 2015 to our most recent figures, which we published last week, in 2018. We are seeing a fall in all groups of different women; nevertheless we see disparity between the experience of babies dying—stillbirths and babies who die in the neonatal period—for women who are black and black British, where there is a twofold increased risk of babies dying compared with white babies. There is a 60% excess risk for Asian and Asian British babies.

That disparity has not changed over time. If anything, there is a suggestion that it might have slightly increased. What we are doing in relation to all the national initiatives to reduce perinatal death is clearly working; the rates are going down, but it is clear that we are not managing to tackle the difference that different women experience.

We have a few insights into what the differences may be due to. We have been carrying out work in Oxford looking at a range of adverse baby outcomes from neonatal death and infant death to pre-term birth. We know that between a quarter and a third of the variation between different ethnic groups can be explained by deprivation. The problem with that as an explanation is that deprivation in itself as a headline figure is

important, but it provides little understanding about what the variation is due to. We certainly need more research to explain those differences. The differences are not the same for different women, as Tinuke mentioned. We lump women together because that is the way we get the statistics and the figures, but we have to remember that, underlying that, there are individual women and women from different ethnic groups.

Some of the excess variation might be due to the higher risks that some groups of women face. For example, we know from Bradford that congenital anomalies explain the higher mortality in babies of Pakistani origin. That has been very well documented in the Born in Bradford data. Some of that is due to increased risk of having a congenital anomaly, but also to variations in acceptability and uptake of, for example, termination of pregnancy following prenatal diagnosis.

It is clear that we need to undertake further research. We have further research under way and will be able to tell you about it at a later point. There is quantitative work being led by the MBRRACE team in Leicester. We are about to embark on a confidential inquiry into the deaths of babies to mothers who are black and black British, and that will start in the new year.

It is really important to remember in the middle of all of this that the individual families who experience a baby death need to know why their baby died. For 90% of parents of stillbirths, the review they get of why their baby died will be a local review. We have the perinatal mortality review tool now that can help staff in trusts to carry out robust, standardised reviews of all the stages of care, so that it is possible to identify, through every stage of care, where improvements in care can be made. It is an incredibly powerful tool not only to help parents understand why their baby died, and any implications for future pregnancies, but to learn the lessons so that care can be improved. That is for everyone, but, bearing in mind that there are increased risks for women of particular ethnic origin, it will have a disproportionate effect on understanding why their babies die.

Q138 **Chair:** Because you are someone who looks at all the research, what do you think are the main things they do differently in a country like Sweden? They have a neonatal death rate around half of ours. What would be your main recommendations?

Professor Kurinczuk: I don't think I am in a position to answer that question. Their healthcare system is organised differently. They refer babies differently. They provide different neonatal care services. I do not think I have a good answer, I am afraid.

Q139 **Chair:** Let me ask the question in a different way that maybe you can answer. On the basis of your research, you have talked about particular risks surrounding people from certain minority ethnic groups as having a higher than average prevalence for both maternal and baby deaths. What are the other groups of people where we see a higher than average risk

of these tragedies happening?

Professor Kurinczuk: Women who are from deprived backgrounds across the board. There is a gradient of risk if we look at it by various base measures of deprivation. There is a twofold increased risk for women who are in the most deprived compared with the least deprived groups, and women who engage in lifestyle-related activities. For example, there is an increased risk of stillbirth associated with smoking. The risk changes with maternal age. Young women and older women have an increased risk. A lot of those factors are related to each other, as I described in why deprivation is related to ethnicity. The research to identify the individual risk factors, and the extent that we need to modify those risk factors, is still under way for a lot of these issues. We are a little way behind in our understanding for baby deaths compared with mother deaths at the moment.

Q140 **Barbara Keeley:** Professor Knight, my question is around the higher maternal mortality rates among different groups of women. Do the causes of mortality vary between ethnicities? It is important for us to understand that.

Professor Knight: No, they do not. When you compare across different groups, the causes do not vary. Two thirds of women die from medical or mental health problems that you can get outside pregnancy but which are made worse by pregnancy. Almost all of the women who die have pre-existing or known medical or mental health co-morbidities. That is why we have to start before pregnancy; we need to make sure that women's medication or health is optimised as well as it can be before they get pregnant. That picks up the point that Tinuke made about women being informed before pregnancy. It is obviously beyond and outside maternity services because we are talking about other medical specialities or, indeed, general practice.

We note that there is a bias simply because you are pregnant. Women can have really concerning symptoms, and heart disease is a case in point. The leading cause of maternal death is heart disease. Women present with central chest pain, breathlessness and pain going down the arm, symptoms that, if they were a middle-aged or older man, would immediately be picked up as heart disease. Yet, because women are pregnant, it is assumed that it is a symptom due to pregnancy. In relation to the care pregnant women receive, particularly from inexperienced or junior staff, when they are admitted to acute medical settings, for example, it is assumed that many of their symptoms are due to pregnancy, as opposed to being due to quite concerning physical illness. That is why, with maternity safety, we have to think more broadly than just maternity services.

Q141 **Taiwo Owatemi:** I want to ask about maternal suicide after birth, which is something you have spoken quite a lot about. Can you tell us more about what causes it? I believe it is not spoken about enough. Does your research show that women from black, Asian or minority ethnic

backgrounds are at higher risk of committing suicide post-birth?

Professor Knight: You are absolutely right; it is one of those taboo subjects that is not talked about as much as it should be. Again, the data do not show that women from black or other aggregated ethnic minority groups have a higher risk of suicide, but they show that women present frequently with symptoms that are dismissed or normalised. Again, for me it is a structural bias in our systems. Women present to many different health professionals; they might present to an emergency department or they might present to their GP, but nobody sees the overall pattern and recognises the distress they are in. 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. That is why, on several occasions, we have raised that repeated presentation has to be a red flag, and there should be an emphasis on making a diagnosis, rather than simply excluding diagnoses.

Q142 **Chair:** Professor Knight, I want to ask whether continuity of carer could have a big role in addressing some of these issues. It is an issue that Professor Dunkley-Bent is looking to introduce for three quarters of minority ethnic women by the end of the Parliament, from memory. Do you think that has a role to play—if you have a single team of midwives whom you meet ahead of birth, during birth and post-birth?

Professor Knight: There is absolutely no doubt that if you have a trusted relationship with your midwife, or a group of midwives or health professionals, so that you feel able to disclose when you are concerned about symptoms, and you feel listened to when you report your symptoms, it will make a difference.

The crucial thing is that it has to be the right group. That group of midwives must have the right expertise. It would be useful to get Clo's and Tinuke's thoughts on this. If it is the wrong midwife, or the wrong group of midwives, it is not going to make the difference. The women who die have complex and multiple problems. It has to be a team with the right expertise. Many of the discussions about what is the right type of care for you need to take place at the very beginning of pregnancy or, indeed, before pregnancy. It cannot be one size fits all.

Q143 **Chair:** Tinuke, how much would it help if you had a single team of midwives who were looking after you pre, during and post-birth?

Atinuke Awe: Continuity of carer would be a fantastic model if it was definitely something that could be implemented, as the NHS has said. I know that in my case, with the fact that my pre-eclampsia was not picked up in a timely manner, if I had been seeing the same midwife or the same two midwives, it would not have got to the stage that it got to. Honestly, that is the truth.

I echo Professor Knight's belief that it has to be the right midwife and set of midwives. Let's say, for instance, they do not know the statistics when

it comes to black women especially; there may be other factors that mean it is all the same, if that makes sense. It is important that there is more awareness raising of the poor outcomes for black women first. That will then help midwives do what they need to do to make sure that the women are at the centre of their care, and that they are getting the best care at the end of the day. I echo everything that Professor Knight said. It would be a great model if it could be implemented, but it has to be the right midwives.

Q144 **Chair:** We are shortly going to hear from Donna Ockenden, who did a report into the baby deaths at Shrewsbury and Telford trust. One of the factors she identified was that mothers were sometimes put under pressure not to have C-sections, and to have so-called natural births. Is that something you have come across at all in your network? Were people being steered away from C-sections?

Atinuke Awe: Unfortunately, I cannot speak on that. I have not heard much about the review, and it is not my area of expertise. What I would like to point out, going back to the evidence that we submitted, is that women are not being given the right information. That is as much as I can say.

Q145 **Chair:** Clo, do you want to add anything finally to wrap up?

Clotilde Rebecca Abe: I want to go back to the point about continuity of care. Ideally, it is a great model if it works well, as Marian and Tinuke said. From my own pregnancy experience, I didn't have continuity of care with my first son. That experience was so beautiful. It was a positive birth, because when I was in labour the midwife I had gave me personalised care. She really got to know me. I had only known her for a short amount of time because I gave birth within three hours of knowing her, but she built a rapport with me. She got to know who I was, and we built a great relationship, which, in turn, allowed me to have a great pregnancy and birth experience. I had a very good vaginal birth because of the relationship I had with that midwife for that short amount of time.

Continuity of care is all well and good, but if you have one or two midwives during your pregnancy, does that midwife deliver your baby? That is where continuity of care sometimes may not work because the midwife might not be there at the end. You really need her at that crucial point, when you get to the end.

On whether women are pushed to have a C-section, a lot of women that I have come across are not pushed to have a C-section. A lady I was supporting not long ago was pushed to have a vaginal birth, and because the midwife really wanted her to have a vaginal birth and was pushing her to, she ended up having a C-section because the pressure was too much for her. She was, like, "I can't do it, I can't do it." The midwife was saying, "You can do it, just do it," but it was so aggressive that it threw her off and she said, "I can't do this any more." She felt like a failure because she felt that she had let the midwife down.

Chair: That is very powerful testimony. Thank you both, Clo and Tinuke, for joining us this morning. We really appreciate it. Thank you, Professors Kurinczuk and Knight, for joining us from Oxford University. We appreciate you giving up your time.

Examination of witness

Witness: Donna Ockenden.

Q146 **Chair:** In our second panel this morning, we have just one witness. Donna Ockenden has been conducting an independent inquiry into baby deaths at Shrewsbury and Telford trust, which was actually something I commissioned her to do when I was Health Secretary. The initial report was published last week, as everyone knows.

Thank you very much for joining us, Donna Ockenden, and thank you for the excellent work that you and your team have done. Clearly, even though it is only an interim report, there is a huge number of lessons that need to be learned. One thing in particular will have shocked a lot of people when you published the report last week. Why did it take so long for the issues to come to light? They go back decades. Knowing, as we know now, that I would not have asked you to do this report in the first place if it had not been for the campaigning of Rhiannon Davies and Richard Stanton and Kayleigh and Colin Griffiths after their tragedies, what do you think was going on? Were the mistakes that led to so many deaths deliberately covered up, or was something else happening?

Donna Ockenden: Good morning, Mr Hunt, and thank you very much for asking me to join you today.

The one issue that stands out above everything else is failure to listen to families. As you know, the Secretary of State cohort starts in the year 2000, and our cases run up to 2019. Basically, bereaved parents pushed for the original 23 cohort to be instigated, and it was their efforts, working with you, that led to that. Within that cohort and earlier than that, we have come across a lot of families who tried really hard to get the system and the trust to listen to them. They carry on their shoulders a huge amount of guilt because they feel that they failed to get the system to listen to them.

Q147 **Chair:** I am trying to get a sense of scale. You have looked at 250 cases so far. How many preventable baby deaths do you think there were? You cannot give an exact number, but what sort of scale are we talking about?

Donna Ockenden: I can only comment on the 250 cases that my independent clinical review team has looked at to date. Those findings are very clear in our first report. We have an awful lot more work to do, so I would ask you to bear with us while we complete that. The focus should be on the learning that already comes out of the first report.

Q148 **Chair:** But of those 250 cases, were there 250 preventable baby deaths?

Donna Ockenden: No. The 250 cases are a selection across the cohort, from 2000 to 2019. They must not be treated as more than an indication. As you will remember from the original Secretary of State cohort, there are five key categories: stillbirths, neonatal deaths, maternal deaths, brain damage, and a category that we call severe harm to mothers or babies.

Shropshire is a small population, and everyone knows each other. We have been very careful not to say that there are X baby deaths, X of this and Y of that. Until we publish the final report, what we should acknowledge is that those five key categories are very serious indeed.

Q149 **Chair:** I understand your reluctance, when you are still in the middle of the inquiry, but I want to ask about the culture in the trust. You talked about the continual changes of leadership; I think there were eight chief executives in the last 10 years. You talked about not listening to mothers.

Are you saying that the tragedies would not have been noticed by the trust? Obviously, if they had listened to the mothers they would have reacted differently, but are you saying that they really did not know what was happening, or that they knew but they chose not to take action?

Donna Ockenden: I cannot stress enough that listening or not listening to families is absolutely key. We know that many families tried over many years to get the trust structure—midwifery, obstetrics, general management and executive level—to listen. We have seen lots of examples already in the 250 of really dismissive letters, very unkind letters. What was picked up very accurately in the media and by the families themselves, who said it from Thursday onwards, was that there was a culture of saying to the mother, "Well, this is your fault. If you had not done X, then your baby may have lived." That is one key issue. It is not only not listening, but blaming mothers. Again, mothers and fathers will tell you that they have carried that guilt for years.

There was also a tendency not to investigate. I have been a head of midwifery since 1999. I clearly remember the start of an incident review process in the very early 2000s, in 2001 when I joined Portsmouth. We were absolutely starting to investigate when things did not go as they should have.

For a very long time, the trust had its own mechanism. It called them HRCRs, which I have never come across anywhere else in the country—high risk case reviews. They did not follow national guidance. Bear in mind that my team are almost all entirely clinical. Most of the week they are doing shifts on labour wards or in antenatal clinics or whatever. What we found was that when the trust investigated—if they investigated—they often hung their hat on the wrong hook, so to speak. They picked something that certainly was not the root cause and they got diverted, so they failed to learn.

The trust has now shared with us a vast amount of documentation. They have been really helpful in that. We noticed that until a complaint came in, or until litigation was commenced, the initial trust review simply did not happen. It is not one issue. It is not that they tried to sweep things under the carpet. It is not that they just did not listen to families. There were multifaceted things going on, I have to say, across all professions.

Q150 **Chair:** What was very striking for me is that you made recommendations at this very early stage, not just for the trust but for the whole of the NHS. What is your basis for thinking that it is not a one-off issue, but that there are lessons immediately that need to be learned right away for maternity services across the NHS?

Donna Ockenden: We were tasked by the Minister of State, back in the summer, to get out some early learning. She personally asked me, "By the end of this calendar year, if it is available, please can you get out learning for the trust, and please look to see if there is potential learning for the wider system?"

As we were doing our work over the summer and in the autumn, we clearly identified 27 local actions for learning for the trust itself. Taking into account that my team is entirely clinically focused—they are there day in, day out in their trusts and clinics—there started to be a realisation that, although this was a review of the Shrewsbury and Telford Hospital NHS Trust, it would make good sense for other trusts to start looking at issues to ensure that what was happening at Shrewsbury and Telford was not happening in their own trust. Think of it as preventive action: "Go away and look at the way you run your labour wards. Go away and look at the systems that you might have in place for risk assessment." It was a preventive issue. "Go away, please, and examine and consider what we are saying."

You may be aware that a letter went out late last night to all trust chief executives, chairs and CCGs, reminding them about our immediate essential actions and asking for some pretty immediate action on those by 21 December. We are really pleased about that.

Q151 **Laura Trott:** Thank you, Ms Ockenden, for the incredibly important review. One of the things we have been covering, and that has come up as part of this inquiry, is the prevalence of ideology in views on how women should give birth and the impact that has had on maternity safety.

I note that part of your interim review findings was that the caesarean section rate in the Shrewsbury and Telford NHS Trust was much lower than the rest of the country. Can you give your insights on the impact that that had on maternity safety, and some of the drivers behind it that you found from your initial findings?

Donna Ockenden: It is very clear from our report that, yes, caesarean section rates were considerably lower at Shrewsbury and Telford hospital

when compared to trusts locally, trusts in the region and trusts across England. That is clear from NHS statistics.

This is a multi-professional issue. We have spoken to hundreds of women who said to us that they felt pressured to have a normal birth. My clinical team said they have seen examples, even in situations where a normal birth in their own hospital would be contraindicated, of women being pressured to have normal births. I need to be really clear. This came from across the professions. It came from obstetricians and from midwives. It was not solely a midwifery issue.

We will be writing more about it in our next report because it is something we need to explore, but the issues at the Shrewsbury and Telford trust were multi-professional in nature. It was not one profession battling against another; it was across those key professions.

Q152 **Laura Trott:** You used the term "normal birth". Is that something that is now outdated and needs to be changed? Obviously, the right choice for women is the safest choice. Do you think we need to look again at whether we should be using the terminology normal birth at all?

Donna Ockenden: I would base everything I say and do on what families have told me. I have met hundreds of families face to face in Shrewsbury, and the very clear steer from those mothers and their extended families is safe birth. They want a birth that is safe, and that at the end of it they are well and in good health, and their baby is well and in good health. For me and my team, and for the mothers and fathers who have contributed to the review to date, it is about a safe birth.

Q153 **Laura Trott:** This might be something that you are covering as part of your forthcoming further review. Do you think there is more that the NHS needs to do in looking at C-section rates and how it monitors them overall? In the information that women are given about the safety of various choices—I know this is something you covered as part of your interim review—are there specific recommendations that you would like to discuss with the Committee?

Donna Ockenden: What we raised in our first report, in both the local actions for learning and the immediate and essential actions, is the issue of truly informed choice, so that when women are making choices about place and mode of birth, they make the decision based on accurate information. That is something we know the trust is going to be working hard on because they have given us the commitment that they will be actioning the 27 local actions for learning, plus what will happen in the system as a result of the letter to chief execs and chairs last night.

Q154 **Laura Trott:** Do you think there is a problem more broadly for the NHS in the information that women are given about their birth choices and the safety of the various options?

Donna Ockenden: What we asked for in the immediate and essential actions is that all trusts go away and look at that. In the letter that was

sent last night, I think they cite the Chelsea and Westminster trust as an example of good practice. We need to stress that there are trusts that are doing incredibly well on the safety and quality of maternity services. We must not lose sight of that. The whole thrust around immediate and essential actions was, "Please, can all trusts look at the report and make sure that their services are as safe as they should be?"

Q155 **Neale Hanvey:** Ms Ockenden, thank you for your report and your input so far. I want to begin to explore some of the recommendations that you have put forward. Before I do that, I am interested in some of the comments you just made, particularly about risk management and reporting mechanisms. Those are pretty fundamental tools to monitor and manage clinical safety in a whole range of settings. Am I correct in understanding that you found that those systems were either not in place or were not used effectively?

Donna Ockenden: You are absolutely correct. In a number of the 250 cases that we have looked at so far, my doctors and midwives—everyday doctors and midwives in 12 trusts across England—picked up quite quickly that the root cause in a particular case simply had not been picked up by the local system in Shrewsbury and Telford.

Q156 **Neale Hanvey:** From that I assume that, if risks are not being reported, there is no observation of patterns that begin to emerge. Was there not concern at board level that those data, which are fundamental to any NHS organisation, were not being generated?

Donna Ockenden: If you remember, in chapter 3 of the report—bearing in mind that this is the first report and we still have more to do—we draw attention to the turnover, the churn at board level, at chief exec level and non-exec director level. That is something we need to look at in the second report. It may well have been a factor.

Q157 **Neale Hanvey:** I want to ask you a bit about what you envisage as the managing complex pregnancy aspect of the report. How are organisations going to start to work collectively? Do you see it as a clinical network-type model, and how will peer review and the like happen within those networks?

Donna Ockenden: The first thing we say is that all complex women should have a consultant lead. In our review of the 250 cases, we found a number of cases where women either remained under midwifery care or were referred to a consultant specialist, perhaps in cardiology or epilepsy, and were then seen by junior doctors, so there was a failure of consultant oversight. When women should have been referred to regional centres, they were kept in-house at the trust. There were a number of failings that my clinical team picked up on.

We are saying that, first, there needs to be local action. Trusts need to be assured that women who are complex get the right oversight within a trust, whether that is a consultant obstetrician leading their plan of care or an anaesthetist—a really important member of the maternity team—

involved at the right time. They should not be walking in during an emergency, when there has never been an anaesthetic plan for a lady.

London is making really good progress on the ability for trusts to work as part of a network of maternal medicine centres. You would not expect in a district general hospital all of the specialties that women in our population might need. We are all talking virtually today. Ordinarily, I would have been sitting with you in London, but we have got much better at virtual consultations. It should be relatively easy for that kind of arrangement to be put in place. As I said in the report, we think it is an urgent national priority for all women to be able to access the help they need from the specialists who are out there.

Q158 **Neale Hanvey:** Do you see the risk assessment that you envisage happening throughout pregnancy as a vehicle to drive higher-risk women into the specialist centres? Do you see it being able to facilitate that?

Donna Ockenden: Yes; it could work both ways. An antenatal check-up should be a risk assessment. Every antenatal contact, whether with a community midwife, a hospital midwife, an obstetrician or a GP—whoever in the maternity team sees the woman—should monitor risk. It may well be that the care plan stays exactly the same, and that the woman remains low risk, or the medical condition that she may have come into pregnancy with is well managed. That is fine. That is reassurance, but equally there needs to be a decision as to whether the woman's care needs to be escalated to a consultant obstetrician, or whether she needs to see a consultant anaesthetist in her pregnancy, or indeed whether the skills are not present in that hospital and specialist help needs to be sought from the region.

Q159 **Neale Hanvey:** What barriers do you envisage to making your recommendations a reality? If you had a wish list of two or three particular aspects of support, what would they be?

Donna Ockenden: I was up very late last night, and I am pleased and delighted that the national system has now written to all chief executives, chairs and CCGs highlighting the key issues. There are the seven immediate and essential actions. What has been highlighted within them, because there are subsections, are the key issues that could be acted on now. Risk assessment is one of them. Listening to women's voices is another one. It is only Tuesday, and I am speaking to this Committee and giving evidence to this Committee. A letter has already gone out across the system. I feel confident at this stage that everyone has understood both the seriousness of the issues raised in Shrewsbury and Telford and the absolute need for the wider system to look at everything we are saying.

Neale Hanvey: Thank you so much for all the fantastic work you are doing. Well done.

Q160 **Rosie Cooper:** Thank you for all the valuable work you are doing, Ms Ockenden. On the point you have just made about confidence that the

system is listening, Robert Francis and the eons of people who have made recommendations following inquiries always hoped that things would improve. We have not really seen the generation of improvement that we needed.

You have seven immediate actions and key recommendations. They are really common sense; they are not earth shattering. They should have been happening anyway. You indicated that the board oversight was not good. The board and management were not listening to patients. My question relates to the higher deafness—the deafness of regulators who, I would say, were missing in action in most of these inquiries. There is the CQC, the Department of Health itself, and NHSEI, as it is now, or the TDA as it was.

What is the point of staff and patient surveys? We have invested a lot of time and money in getting these things on the table from previous inquiries, yet they have all failed again. How can you feel more confident that we can wake up the regulators, which cost us a lot of money, and make this work for patients?

Donna Ockenden: That is a really good question. Essentially, the first report is about immediate actions for learning, and you can see in chapter 3 of the report that there is a brief outline—only a few pages—of things that we will consider in more detail. We talk about the role of the CCGs, the board, the CQC, and the statutory supervision of midwifery that was around until 2017. Please be assured that we will leave no stone unturned in assessing the role of all of those systems, but getting real clinical actions out on to the ground before Christmas was our main focus in the first report. Please be assured that all of it is under way, and we will not shirk from our responsibilities in calling things out, if needed.

Q161 **Rosie Cooper:** That is really good news. Bill Kirkup is doing another inquiry, so, between you, I hope and pray that we have a major influence on the system.

I have a clinical question. We hear a lot that a team of the right midwives will make a huge difference to the care of mothers. It is very appealing. I was chair of a Liverpool women's hospital in the late 1990s. I did not manage to get to ask Professor Knight whether the model had been costed. It is not a new idea, because Baroness Cumberlege promoted it in the 1990s. My belief is that due to the huge extra costs—I do not mean a few thousand or a few hundred thousand; we are talking millions—and the lack of staffing it never got off the ground. Do you think that the model has been costed and that it could work today? Do we have the money and the staffing to do it?

Donna Ockenden: That is not something we have focused on in the report so far. Obviously, we have looked at the 250 cases, and the issue of continuity of carer that I think you are describing, which we used to call team midwifery in former times, 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."

I was head of midwifery from 1999 until 2014, a long time, and I recognise the workforce constraints and difficulties. If I was to ask for two things, it would be multi-professional working and continual risk assessment of women throughout pregnancy, rather than hanging my hat on one particular model.

Q162 **Sarah Owen:** Ms Ockenden, you have talked a lot about enabling women to make informed choices, and women needing to be informed free from ideological bias. When discussing my mode of birth earlier this year, I was given a list of risks when it came to a C-section, but I had to push and question what the risks were for a vaginal birth. Why do you think there is an ideological preference for non-assisted vaginal births from some maternity teams? How ingrained do you think that ideology is?

Donna Ockenden: We saw, and it is very clear in our report, a very big difference in the C-section rate between the Shrewsbury and Telford trust and other local and regional trusts across England. We need to look at it in more detail in our second report, but it was very clear that it was a multi-professional effort.

We know that obstetricians were very much leading the way in Shrewsbury and Telford in the push for normal birth. A number of my obstetricians have commented that, in some of the scenarios where normal birth, if you can call it that, was achieved, they would have said, "Absolutely not." I have very experienced obstetricians on my team, and they said, "Under my watch, on my shift and in my labour ward that would not have happened."

It is important to say that at that trust there was a multi-professional, not just midwifery-led, focus on normal birth at pretty much any cost. It is very clear in our report that there were times, occasions and cases, when had a baby been delivered by a caesarean section the outcome may well have been better, and almost certainly would have been safer.

Q163 **Sarah Owen:** I want to dig a little deeper, because that does not come about organically. Why do you think the ideological bias towards vaginal birth was so embedded and widespread?

Donna Ockenden: We still have an awful lot of evidence to review, which will be part of the second report. What we have managed to say to date in the first report is that there were a number of cases where caesarean section should have been used earlier, and had it been used earlier the outcome for mothers and babies would have been better and safer. The trust has worked really hard to amass a vast amount of documentation, which we received in early November. We have been making our way through it, and we can promise you that we will be looking at that in much greater depth in the second report later in 2021.

Q164 **Barbara Keeley:** Following on from what Sarah has just been asking, do you believe it is possible to change the deeply ingrained culture across professions, where the view is that they know more than the woman

giving birth about how she should give birth, as indicated by the use of the term we have been discussing, "normal birth"? Clearly, you can point to trusts where it is being done well, but how possible do you think it is to change that?

We heard earlier, when we were looking at the example of black mothers, where maternal mortality and baby deaths are much higher, that a mother felt she had let the midwife down. Where are we with care when somebody feels that they have let the midwife down through having a C-section rather than a vaginal delivery?

Donna Ockenden: I caught the tail end of that conversation. Having been in and around maternity services and women and children's divisions for over 30 years, that was such a sad story to hear.

To my mind, it has to be about women being equal partners in their care. There are a lot of trusts doing that very well. We need to call it out for what it is; it is unacceptable if women and their families feel that. I have met countless husbands and partners in tears because they felt they let the system down as well by not playing a strong enough role. We need to call it out for what it is. Childbirth and the arrival of a new baby should be the most joyous event in a family's life. It is simply unacceptable if what we leave along the way are, instead, broken families, and women who carry guilt on their shoulders for many, many years.

I will be the strongest advocate for women that I can be, and as I hope I have been throughout my career. I will continue to speak out on this for as long as is necessary.

Q165 **Chair:** How much would it have helped the families you have spoken to if their child's death had been investigated independently right from the outset?

Donna Ockenden: Again, I refer to the fact that I have been in and around maternity services for about 30 years. I have clear memories of very effective investigations done locally with external expertise called in as required. Certainly, in my days in Portsmouth we were doing that from the early 2000s onwards.

It is about leadership. I absolutely treasured my role as head of midwifery divisional director, and I took huge personal responsibility in ensuring that if things went wrong—they can go wrong sometimes in the very best of services—families felt satisfied that any review or investigation was of the highest standard. It all goes back to leadership locally within the trust and the ability of the head of service—the head of midwifery—to talk to and interact with the board on an as required basis. I never came across any barriers to talking to my boards and getting them to listen.

It is really important that, if something goes wrong, families should have the confidence to be able to go back to their local services and continue to receive healthcare. There has to be something about skilling local and

regional services to make sure that they investigate appropriately, and then build relationships with families.

Chair: Thank you very much. That concludes this panel. Donna Ockenden, thank you very much for joining us. Thank you again for the hard work that you and your team have done to get to the very important interim report that you published last week. As you say, it is very encouraging that the message has now gone out to the whole NHS about lessons that need to be learned immediately. Thank you very much indeed for joining us; it is enormously appreciated.

Examination of witnesses

Witnesses: Professor Smith, Dr Morris and Gill Walton.

Q166 **Chair:** For our final panel this morning, I welcome Dr Edward Morris, president of the Royal College of Obstetricians and Gynaecologists, and Gill Walton, chief executive of the Royal College of Midwives. Alongside them is Professor Gordon Smith from the University of Cambridge, who has been doing important research into whether we should be doing additional ultrasound screening to check for breech births when babies' heads are in the wrong position.

I want to start by asking Dr Morris and Gill Walton about the Government's target to halve neonatal injury and death by 2025. It is a very important target, and I would like to get a sense as to whether you think we are on track. As I understand the latest figures, we have reduced stillbirths by a quarter and neonatal deaths by 23% from 2010 levels, but there is still a long way to go. Dr Morris, are you optimistic that we can get there, or are there things we should be doing but are not?

Dr Morris: I completely agree with you that we have made progress, and it is great news that that has happened. However, I feel, as does the profession, that there is much more work to be done. To do that, we need to address a lot of what we have talked about this morning so far. There are areas where significant improvement can be made. It needs a team approach, supported by the Government, to invest more in safe maternity care. That is where I would start my answer, but I am very happy to continue after Gill.

Gill Walton: Progress has been made and there is a long way to go. The Ockenden report has shown us that we should speed up and develop system changes at pace, which include the most important softer stuff about behaviours, listening to women and focusing on the things that make the biggest difference. That has to be multi-professional working, learning and training together, based fundamentally on enough money to support maternity services.

We have been saying for a long time that maternity services are underfunded. They are underfunded, yet they are still subject to cuts

every year, so some of the things that we believe are the essential components of safe maternity care are affected year after year. There is still a long way to go, and the report we have just heard about needs to make all of us step up and gather pace to make the changes much more quickly than they have been happening.

You will see an array of things that have been done over the past three to five years. For health professionals in maternity services, some of those things are very confusing. There is a lot of action. The trouble is that that sometimes leads to lack of focus about the things that work. We should be clear about what works, and pull all those things together so that it is really clear and supportive for leaders in maternity services and systems to implement changes more quickly.

Q167 **Chair:** I want to dig a bit deeper into what needs to happen on staffing levels. You talked about cuts. There are people who still feel that there are shortages of the necessary skilled people. One suggestion is that we should specify nationally the workforce requirements necessary to deliver a safe birth, and make sure that every single maternity unit has those numbers. Is that an approach you would take?

Gill Walton: It is an approach we should take. Birthrate Plus is a midwifery tool you may have heard of. We have just done further analysis with Birthrate Plus at 50 trusts. Sadly, we are still 3,000 midwives short. Some of that is because women's needs are more complicated. More midwives are definitely needed, but it is not just about midwives; it is also about maternity support workers, who are an essential part of the maternity team, and obstetricians, anaesthetists and neonatal and perinatal health teams. The whole workforce required to deliver care safely to women needs to be appropriately funded.

We carried out a survey to ask midwives how safe they felt in delivering care. It was during the pandemic, during Covid, but 80% said that currently they do not feel safe in terms of the right numbers of staff to deliver safe care all the time. That is shocking. It is not right for women to have a maternity service that does not have an appropriately funded workforce.

I always add the good things. We have seen an increase in the number of midwifery training places. That was to try to catch up with the 3,000 shortfall we had three years ago, but we have to keep on top of that. While there may be smaller numbers of vacancies in maternity services at the moment, the funded establishment for those services is not right. I welcome the letter that came out last night from NHSE to trusts to look very carefully at their workforce numbers, with a tight timescale. The Royal College of Midwives would absolutely support trusts to do that piece of work.

Q168 **Chair:** Thank you. Ed Morris?

Dr Morris: I completely agree with everything Gill said. When we look at obstetrics as part of the multi-professional team that we have heard so much about this morning from Clo, Tinuke and Donna, it is vital that we have the right numbers of doctors and midwives working side by side.

If we look at the training grades in obstetrics, at the moment we know that 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. We do not know yet exactly how many more consultant obstetricians we need, but if we are to expand the work consultants do, along the lines of Donna's recommendations in the letter last night, which we welcome, we may well need an expansion in our consultant workforce of about 20%. That would need training and considerable effort to encourage more doctors into the specialty. I think expanding staff in obstetrics is where we need to go, but the team goes wider than that. As Gill said of midwives, it is working day by day as a team.

When teams work under pressure, they are less able to work efficiently. Loads of research studies demonstrate that teams under pressure do not have time to do a high-quality level of work, but importantly they do not have enough time to take time off work to train. They are trying to fill the rota day in, day out; they do not get time to go away from their unit and do team training. Obstetrics, midwifery and maternity is a very high-pressure specialty. Quite often, an emergency will happen quickly and unpredictably, and the survival of the woman or the baby will depend on a team being able to get into gear quickly and recognise how to manage that. There are practice drills. It sounds very military. That is because in some cases it needs to be; people need to be able to respond extremely quickly. If units are under pressure and understaffed, teams do not get time to train properly. That is one of the areas where we feel that, steadily over the years, team identity and the ability of a team to work together has been lost.

Q169 **Chair:** We have just heard Donna Ockenden describe a culture at Shrewsbury and Telford as "normal births at any cost". Do you accept that that was a serious cultural problem at Shrewsbury and Telford, and do we still have that problem in other parts of the NHS?

Gill Walton: I also heard Donna's answer about those cases being a wider problem across the whole multi-professional team. Normal birth at any cost ideology is a complex issue. Understanding the physiology of normal birth is really important. For me, the important thing is that it is not about promoting normal birth as the best outcome. It is important to understand the woman's values and needs, and how she understands the evidence underpinning the care and the choices she has.

Q170 **Chair:** Do you accept that normal birth was promoted like an ideology at Shrewsbury and Telford? That was what Donna Ockenden said. Do you accept what she said, which is that that was an issue?

Gill Walton: I agree that it sounds like it was.

Q171 **Chair:** Do you think there may be a problem in other parts of the NHS as well?

Gill Walton: I think it is changing. It is important that all teams work together with women at the centre of care and do not promote one type of birth over another. One of the things Eddie and I are talking about a lot is how the two colleges come together with one voice in supporting good birth—good birth through the eyes of women. It is moving on from that that is really important.

Q172 **Chair:** Thank you. Let me turn to Ed Morris on that.

Dr Morris: From what Donna was talking about, it certainly seems that in Shrewsbury and Telford a culture like that existed. Do we know that that is happening around the country completely? I don't think we do.

There are some excellent units around the country that have extremely good rates of intervention, satisfaction and safe deliveries. Obstetricians are part of a team that supports women to have a birth that is safe for them and their baby. In the UK, only about 40% of women give birth without any form of intervention, mainly because birth is unpredictable; complications can arise and any decisions should be made with the complete involvement of the mother. She should feel fully informed and very definitely part of the process, so that she feels comfortable about the choices she has made.

As Gill said, our role as the colleges, working with the right partners, is to make sure that that culture, if it exists, is wiped out. As Donna said in her answer, a lot of it stems from leadership. If the leaders stand side by side and do not tolerate cultures like that, it can only filter down through the system. One of the frequent concerns Gill and I have had about centres that do not seem to be working well, or are in difficulty, is the fact that they do not necessarily seem to have the right support at board level, which one of the members of the Committee concentrated on earlier. That is really important. Gill and I feel very strongly that maternity needs to be represented at the board, and to have a sound voice on the board, so that it is not ignored.

Q173 **Chair:** We heard a lot this morning about how difficult it was for families to speak out. They were not listened to at crucial moments. According to Donna Ockenden, that was at the heart of the problem. Can I ask you as representatives of your respective professions whether sometimes it is too hard for people inside a maternity unit to speak out when something goes wrong because they are worried about recriminations, and that people might not understand the difference between an ordinary human mistake and clinical negligence? Are there things we can do? Do the HSIB investigations help? Is there more we can do to make it easier for people to speak openly when tragedies happen?

Gill Walton: It is absolutely true that staff are not working in a blame-free environment, and we have a lot to do to create transparent cultures where people feel well supported to speak up when things are not right. Listening to everybody—women and staff—and having high-level representation at board level is absolutely key. For senior leaders to be able to go to the board and into the system to speak truthfully about what is going on is really important.

HSIB was a good idea. Having a consistent system of investigation across the country, and showing the way by involving women and their families in that process, was excellent, because some services were doing it well and some were not. It has been good in providing a level playing field across maternity services, but we have had concerns about the speed of some investigations, and maybe the quality of the thematic reports that have come out. Our members have told us that when an external team comes in as part of the investigation process, you lose some of the local learning. That is key because systems and services are all slightly different, so some local learning has been lost.

Before HSIB, good services had already started to involve neighbouring trusts in reviewing and looking at some of the very serious incidents, so that they were not marking their own homework. That is quite a good model and is one of the things Donna is suggesting. It is not just learning from the local maternity service; learning from across the system is important. On balance, HSIB has some good things, but I am not sure it is the answer.

Dr Morris: I agree. There is more to do to enable staff to listen more. To give an example, you will recall the RCOG project, Each Baby Counts. That was run as a confidential inquiry, so trusts were able to give us information about every brain-damaged baby or stillbirth towards term pregnancy. We got every single detail about those cases from 100% of the trusts in the UK. That enabled us to delve deeply. It shows that, if you are able to get the full information, you can learn an awful lot more.

In her evidence this morning, Donna described where she works. She works in a unit where there is high-quality local investigation and people really learn from what happened. There is true value in a local unit doing an internal investigation to look into what went wrong. If you do that regularly, and listen to people and value them, but still have the mother at the centre of the investigation, you end up with a very high-quality look into what went wrong and the learning from it.

HSIB has worked extremely well in some areas, as Gill said. We largely agree on that. It has investigated over 1,000 cases and published thematic reports on just over 300 in the time since it has existed. Its independence has been very much valued, certainly by families. Family involvement and listening to families has been critical to the success of HSIB, but we feel there has been some loss of focus in its output. The output needs to be refocused to allow trusts some ownership of what

went wrong, but it still needs some national oversight, with a strong family focus, so that issues can be addressed.

Chair: James Davies is going to ask a few questions of Professor Gordon Smith, who is joining us to talk about the issue of scans.

Q174 **Dr Davies:** Professor Smith, I understand that you have an interest in novel approaches to preventing adverse outcomes, in particular the idea of a third scan beyond the 20-week anatomy scan. Could you outline the findings of your research in that area?

Professor Smith: A number of things can be assessed in a late pregnancy scan. One of the things we have focused on is a scan near term. The due date is 40 weeks, and we are thinking about a scan at 36 weeks to try to stratify women for risk as they are making plans around location and type of birth. We evaluated over 4,000 women having first pregnancies. We performed ultrasound scans and followed the natural history of the pregnancy. We have combined that with some health economic analysis.

One open goal at the moment is the presentation of the baby. Midwives routinely perform palpation to determine whether the baby is head first or otherwise, but we know from research that anybody doing palpation detects about 50% to 70% of non-cephalic presentation and misses the remainder. In cases where the diagnosis is not made, the woman loses the opportunity to have interventions. You can attempt to turn the baby using external cephalic version, or have a discussion around a planned caesarean section or a planned vaginal breech birth.

You really want to know the information before you go into that situation, but what happens is that quite large numbers of women go into labour with a non-head-first presentation and the diagnosis is made at some point during the labour. Often, those women end up with an emergency caesarean section or take the risks of an unplanned breech, which can sometimes lead to the death of the baby. Since we published our research, we have been contacted by mothers who had had undiagnosed breeches and complications during labour with bad outcomes. Uniformly, they were positive about the idea of a presentation scan. It seems almost self-evident that it would be beneficial.

We caution that there are lots of other things you can do. When you do a scan, you can assess the size of the baby. Is it small or large? You can look at the blood flow. The clinical usefulness of those is a little less certain because there is the potential for false positive results. We might think the baby is small or large and it leads to intervention that turns out to be unnecessary because the scan was a false positive, but in the case of presentation it is a binary thing. Midwives currently try to palpate; the scan tells us for sure.

Q175 **Dr Davies:** You would say that for breech presentation alone there is sufficient evidence to warrant a third scan at 36 weeks or so.

Professor Smith: My assessment would be that there isn't a research question left, other than the best way to implement it. Would you have midwives with hand-held scanners? Would you have women attending hospital to be seen by a trained sonographer? The outstanding research question is principally around how you implement it.

Q176 **Dr Davies:** Do you think it is practical in terms of the investment of manpower, given the number of ultra-sonographers required, bearing in mind that there has been difficulty in recruiting simply for what the current provision requires?

Professor Smith: When you teach junior doctors in a delivery unit, any one of them would learn the basic skills to assess presentation out of hours as an emergency. Ultrasound assessment of presentation falls into the category of see one, do one, teach one. It does not require advanced levels of ultrasound skills, and it seems to me to be feasible. There are now point of care ultrasound devices, and staff could be trained to do it fairly simply.

You have to set the cost of time in making the diagnosis versus the cost of failing to make it, and making a diagnosis in labour in the middle of the night, having staff devoted to doing a caesarean section and resuscitating the baby, and the whole delivery unit's emergency theatre being occupied for something that was potentially avoidable. All out-of-hours work creates risk, so the investment of time to make the diagnosis antenatally seems to me potentially very worth while.

Q177 **Dr Davies:** In other words, you are suggesting a basic ultrasound scan to look at presentation of the baby, as opposed to one that perhaps is looking at foetal abnormalities as well.

Professor Smith: Yes, particularly growth abnormalities at that stage in pregnancy. There is scope for a late pregnancy assessment of wellbeing to try to pick up risk factors for stillbirth. That is a major focus of our research. What can we do at the point just prior to term to have better risk stratification?

I liaise very closely with Sands, the stillbirth and neonatal death charity. It carried out a survey of bereaved parents; 60% of its survey respondents had been told they were low risk and went on to have a stillborn baby. That is a manifestation of the fact that we are not good with our existing tools at identifying risk factors for things like stillbirth. The danger is that, in our attempt to try to do something about stillbirth, we create lots of unnecessary intervention without preventing stillbirth. For me, the stillbirth prevention side is very much about developing new knowledge. For breech presentation, it is a question of how you implement it.

Q178 **Dr Davies:** Do our representatives from the royal colleges have any views on the deliverability of what is suggested?

Dr Morris: Gordon's suggestions are extremely good. Point of care scanning for presentation is in play in several units around the country and is very successfully in play in my own unit here in Norwich. That certainly has efficiencies.

The assessment of a small or an extra-large baby or potential risk factors for stillbirth opens up quite a hornet's nest to try to work out whether it is appropriate. As Gordon says, a lot of effort needs to go into researching the area, so that we can get the right answers about whether we can do it. Fundamentally, it would need significant investment in sonographer time. Sonography for maternity and pregnancy is a specialist area. We feel that, if we were to add another scan, it would put significant pressure on the system we have now to look at the details of that scan and the risks of stillbirth, and whether it is a large or small baby.

Overall, at the moment I am not sure the system could cope with that in terms of staff numbers. It would need to be thought out very carefully. In my view, research to get the most efficient way of learning from those scans would probably be the way to go.

Q179 **Dr Davies:** Gill, do you have anything to add?

Gill Walton: Building on what Eddie has just said, sonographers are a part of the workforce where there are huge shortages. It comes back to women's choices as well. If there is evidence that having a third scan will give them a better outcome if they have a breech birth, the women should be part of the decision about whether or not to have that third scan. Women have very clear views about whether or not they like scanning, so at the end of the day it is about all those things, plus the women's views, which is the bit we have not mentioned.

As for preventing stillbirths, we have opportunities to do that other than through scanning. I am surprised that Eddie did not talk about the Tommy's funded programme between the RCM and RCOG—the National Centre for Maternity Improvement. At the moment, they are doing a huge piece of work on placental function with an app. There will, hopefully, be an opportunity to talk about that. All these things link together to help all of us work with women to look at their risk of poorer outcomes. We all need to work together in trying to do that well.

Q180 **Dr Davies:** Professor Smith, do you have any feedback in response to that?

Professor Smith: When we did our research study, we went back to talk to the women years after the birth. We imagined they might say to us, "What study are you talking about?" We interviewed 20 women who had had a breech identified by the research scan and then subsequent intervention. The midwife went to their houses and interviewed them. It was universally positive and in a way quite moving. Women said, "I sometimes wonder what would have happened if I hadn't recruited to your research study because nobody told me my baby was breech until I

turned up for that scan." I agree 100%. Everything we do in maternity is driven by the women who come to us looking for care, and our experience with the women we diagnosed with breech presentation was uniformly positive.

Q181 **Dr Evans:** My first question is to Gill Walton to pick up the idea about the stress staff are under. One of the concerns that clinicians often work under is the idea of defensive medicine, doing things to make sure they do not get sued. How does that fit in for midwives? Given the concerns and pressures you have mentioned, is there a delineation of added pressure in trying to make sure you will not come a cropper?

Gill Walton: I am not sure that midwives go to work in the morning practising so that they are not sued; they go to work in the morning to make sure that they provide the best care they can to women.

It is much more about midwifery leaders trying to manage the complexities of a service that is never the same day to day. Women do not go into labour at guaranteed times. Some days, you are extremely busy; at other times, you are not. It is about maternity services and maternity leaders looking at the whole, and worrying about not having enough staff at a period of time that eventually leads to a poor outcome, and then going through the whole process of whether somebody has been at fault. Has the system been at fault? Have I raised the issues with my maternity staff often enough? Have people listened to me? It is a collective issue rather than an individual one. Every maternity leader thinks all the time about whether we are doing the right things to make sure that the best outcomes will happen. As individuals, being sued is probably furthest from their mind.

Q182 **Dr Evans:** Some of the happiest and scariest times I had in my training were in the labour suite and the neonatal part. That said, do you think more can be done to prepare for the emergency moments? We heard from Dr Morris particularly about the team-building side. Do you think more could be done to link doctors and midwives so that they are prepared and fully drilled? If you take the comparison with A&E dealing with a resus, is there parity? Is there any research on joining up those two thoughts?

Gill Walton: Yes. On multidisciplinary training, there is a lot of research and lots of good programmes are doing that, and most services have to do it. The question is whether they have time to do it consistently. Is it funded appropriately? Are the workforce funded appropriately to release staff to have the time to do that training and often enough so that they absolutely have it? The most important thing about multi-professional training is that it is multi-professional; everybody does it.

One of the things we are picking up, from today and various things, is the issue of culture. Midwives, obstetricians and the wider team must work together, respect each other and understand what they all do, because they are all different and do slightly different things, so that women are

in the centre of care. That multidisciplinary training, not just on the skills stuff or the emergencies, but on all the things around the softer side of behaviour—how to talk to each other—that make a difference to the culture, has to be funded appropriately so that every maternity service in the country is doing it.

Q183 **Dr Evans:** Dr Morris, you mentioned trying to encourage people to join the workforce and that being an issue. What steps are you taking to encourage F1s and F2s to choose obs and gynae? As you rightly pointed out, there are holes in every post, particularly in obs and gynae. What steps do you think you could take, and what steps could the Government take, to encourage people to choose your profession?

Dr Morris: That is a really good question and something we regularly have to address in careers fairs in regions, as I am sure you are aware. It is about making the specialty as attractive as it can be. It is the most amazing specialty. We are part of the incredible teams we have heard about this morning that bring new life into the world, but we also look after women throughout the whole of their life; it is a full life-course approach. There is no other specialty that offers those opportunities. I believe that is what drives a lot of people into the specialty. As a college, we have an excellent training programme, and trainees are supported throughout the programme, so it is all about making it accessible to the trainees.

Perhaps I could return to the question you asked Gill with regard to stress in the workplace and team working. A thing that happens in medicine, as you know, Dr Evans, is that, when you come on to do a shift, you very rarely work with the same team. Every day, you are making a new team to work on that shift. That depends on teams working together no matter what level they are at. In our project, Each Baby Counts, we looked a lot at human factors and how those influence outcomes, and the ability of teams to work together on a day-to-day basis. As Gill said, if teams practise together and work together, when they form a team each day it helps with the culture in the system and reduces the stress on the output of the teams.

Q184 **Dr Evans:** Is that an argument to say that, in particular, trainee registrars and SHOs should have longer in post than four or six months, certainly at SHO level, at registrar level? Is that an argument to say they should spend more time in a particular venue?

Dr Morris: When the training posts for those who were getting experience to become general practitioners went down to four months, it had pressures on the system, but year-long posts are usually enough to get experience in a particular unit. Every unit is different. During the course of a trainee's career they often go to large teaching hospitals; they also go to more rural or district general hospitals to get a breadth of experience, so that they can see which would be the best career choices for them in the future.

Q185 **Dr Evans:** That is really helpful. On that basis, are you aware of any evidence that points to a rota pattern that causes those kinds of problems? For example, is it the length of time a trainee spends in a particular hospital? As far as you are aware, has a link with four months, six months, a year or two years been explored, that could be detrimental to care?

Dr Morris: The short answer is that I do not think that research has been done. It is a very interesting area. At the moment, we are doing a lot of work looking at the workforce. We have a vice-president for workforce and professionalism who is digging deep to try to understand the complexities of the obstetrics side of the maternity workforce, but, as Gill said, that involves looking at how teams work together. I am hopeful that we will get more information.

During the pandemic, our teams were massively disrupted not just by people who were unwell and off sick, but by redeployment of junior doctors to other areas of the hospital where it was felt they were needed. Doctors were taken from a pressurised area of the hospital—from something you cannot stop—to work in another area. You cannot stop pregnancy. Pregnant women will keep coming and they will continue to need the right care at the right time. In our survey, 53% of units reported redeployment away from maternity, so that made us able to create a very strong recommendation that, if there was to be a second wave and, heaven forfend, a third wave, there should be no redeployment of under-pressure trainees or maternity staff away from the delivery unit.

Q186 **Barbara Keeley:** I want to return to the question of normal births. We heard the terms "good birth" and "safe birth" used today. In an earlier session we heard from bereaved parent James Titcombe in relation to the Morecambe Bay tragedies. He told the Committee we needed to change the very term "normal childbirth".

When the Chair touched on that earlier, Dr Morris said we should ensure that the culture around normal births is wiped out, but is it possible to change that? From various reports, it seems to be a deeply ingrained culture across the professions that your colleges represent that they know more than the woman giving birth about how she should give birth, as indicated by the use of that term? We never want to end up again hearing from people like James Titcombe, but we heard earlier about a mother who felt she had let the midwife down by having a C-section. Can you both answer the question about normal births and how we end that culture?

Gill Walton: I was really saddened when I heard the story of the mother who said she had let down her midwife. I cannot comment on that case, but there is something about the relationship between midwives and women when they work together. It might be that the mother had said to the midwife, "At all costs I want to have a vaginal birth, at home, in a

pool, and I want you to help me do that to the best of your ability." It is something about maybe them both feeling—

Q187 **Barbara Keeley:** Could I stop you there? I don't think that was what we were hearing. I do not know whether you heard all the earlier evidence. We heard from a group of black mothers who are now campaigning because they did not even have the options explained to them, so it definitely was not the case. They did not have the information, and the midwife was pushing for normal childbirth.

Gill Walton: Sorry. I misunderstood that part of the question. You are absolutely right that it is about making sure that women have the right information. That is what I mean by good birth. The most important thing is that women are helped to understand the evidence behind all the choices they have, that it is clearly explained to them, and that it is documented and checked that they understand.

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. When women make those choices, and understand the risks and benefits, the health professionals, midwives and obstetricians, should respect that choice. Part of Donna's report is also about checking all the time what is going on in a pregnancy or during a birth to make sure that, if the risk changes, it is picked up, and another decision is made about the next choice.

The most important thing is that women are at the centre of that decision making and are listened to by everybody involved in their care, so that at the end of the whole experience, whatever has happened, the woman can report, "I was listened to. I was involved in decisions about my care. I understood and I had a good birth." That is what all of us want.

Q188 **Barbara Keeley:** I understand that, but you are talking about a pretty much idealised situation, compared with what we have heard from bereaved parents and the campaigning black mothers group. They did not have that experience. They were pushed around by an ideology, across your profession and the obstetrics profession, that forced them into a situation where they felt they had to have what is called normal childbirth. How on earth do we do what Edward Morris said earlier and ensure that that culture is wiped out, because it seems very damaging?

Gill Walton: I think we are already on track to change the culture. Some of that is about the professions working together. In the RCOG and the RCM, working with other royal colleges and women's groups, we have something called One Voice, which is how we look at all of those issues, to make sure that we are all saying and doing the same things, and that we are on the same focused track to move away from what you have just described, because that is not helpful and keeps damaging not just women's thoughts and experiences of maternity services but the

professions that are trying to come together to change the culture of childbirth in this country.

Q189 **Barbara Keeley:** In terms of maternal and baby deaths, it is more than damaging; it is completely detrimental to care. Dr Morris, do you want to add to that?

Dr Morris: Gill has said a lot of what I was going to say. I was going to bring up One Voice, where the professions work together to try to address the issues. Gill talked about the fact that the woman needs to be at the centre. It is all about correct and proper personalisation of the care that the woman and her family get, and what they want and is their right.

We need to help women make choices based on the right information. It goes back to what Gill gave you a lead-in for earlier. We can do it with technology and the right data. A lot of data is collected in the maternity system during antenatal visits and a woman's labour. That needs to be harnessed to help the woman make choices during her pregnancy.

One of the projects under way, and funded by the charity Tommy's, is producing an app that collects data about the woman's pregnancy as she goes through, to help her make decisions based on her risk as it changes during the pregnancy. It is in the evaluation phase at the moment, and it certainly does not replace the proper antenatal care and risk assessment that Donna so carefully delineated earlier. It is one area for the use of technology and I think it will be important.

The holy grail for a lot of obstetricians and midwives is that, when a woman comes to labour, she is fully informed and the information is accessible. You are quite right that one of the problems we have with the system is that there are bits of information for pregnant women all over the place; nothing is centralised and easy to access, whether you are in a disadvantaged group or a different ethnic group. We heard about the difficulties with that earlier this morning.

Another area that I want briefly to cover is intrapartum care. What happens during labour? How is the woman put at the centre of her care, so that she feels involved in the right decision about her mode of delivery? Those of you who saw the previous evidence given by James about the sad loss of his child will understand that the decision-making processes there were not right. We highlighted in our project, Each Baby Counts, that during labour the monitoring of the foetus has been a particular problem. I have long argued that it is not just the way we look at foetal monitoring that is the issue; it is looking at the whole woman regularly during labour.

In a big project with the RCOG, the Royal College of Midwives, some leading academics and some families, we have been looking at ways of improving how we assess a woman during labour regularly every hour, so that we can understand what is happening to her, so that she feels fully informed and part of the process. We hope we can roll that out. We are

waiting to hear whether the project has funding, but it definitely will be one of the ways of making sure that we stamp out the culture and improve the way the woman feels involved in the decision making and can look back on her birth as being the best she could have had in the circumstances.

Q190 **Barbara Keeley:** The developments you are talking about are good, but, where it has become ingrained, what possibility is there of stamping it out? It is good to say that we should ensure it is stamped out, but how plausible is it that that is going to happen, given that this ideology seemed to take hold and become ingrained in places like Morecambe Bay, and as we heard via the Ockenden report?

Dr Morris: I think you have heard today that Gill and I pretty much stand side by side on the issue. We are aware of cultural problems. We do not know where they are at the moment. We know there are units in trouble that may have those problems. The system, which is colleges, working with Government, NHS England and the devolved nations, needs greater understanding, starting with the units that appear to be in trouble.

The whole thing tends to be driven very much by the data we get through the current systems. That data comes through very slowly. It needs to be sped up. I am meeting the new head of NHSX for maternity, who, hopefully, will help us to speed up the information. Fundamentally, we need to listen to women and find reliable ways of capturing information from them and their families when they are having problems, so that we can find the units where the culture is a problem and assist the leadership there to make the changes.

Gill Walton: It is important that all of us—NHS England and the two colleges—work together on maternity improvement, with women at the centre of care. We have to go in with both eyes open to think about how we all work together to improve the culture. We can only do it together. I do not think it would be right for each college or just the NHS alone to go into services they are worried about. We absolutely must do it together. Eddie alluded to that. Maternity improvement at pace is the responsibility of all of us, and we are really signed up for that.

Q191 **Neale Hanvey:** I want to go back to some of the questions I asked earlier of Ms Ockenden about risk reporting and your view of how embedded it should be in clinical practice across all disciplines. Without putting words into your mouth, but going back to staffing issues and the chronically excessive workload that the King's Fund has spoken about, how much do you feel that influences clinicians to put to one side the importance of managing clinical risk in a positive way? Does that make sense? They have so much to deal with that perhaps they do not 'fess up when things have not gone as they should have done.

Gill Walton: On the risk assessment for each individual woman, you are absolutely right that, when workload is high, sometimes the time and

robustness for that risk assessment is lacking. Every point in the risk assessment—antenatal care, labour care and post-natal care—is key. Things can change very quickly. Things can be going absolutely fine, but it is really important to be able to do risk assessment so that there is escalation to another appropriate professional. There is also the risk assessment of the service itself. It is not just the individual risk assessment; it is the risk assessment of the entire service.

Q192 **Neale Hanvey:** That is exactly what I meant.

Gill Walton: That again leads to the leadership issue. Do we have the right numbers of midwifery and maternity service leaders, obstetricians as well, who understand the complexity of the service they work in? Remember that a lot of the service is delivered outside the hospital walls, in the community setting.

Do the people who are the leaders of the service understand the complexities and risks of their service today? Do they have the right mechanisms to raise those issues at an appropriate level, whether that is a board, across the local maternity system or even further? Are those mechanisms in place, and are they at the right level in the NHS to do that? Do they feel confident? Have they been trained and developed to work at that strategic level to be able to raise issues clearly and quickly, so that action is taken?

From a midwifery perspective, the RCM has been concerned for some time about the number of midwifery leaders who are not in the right place in the NHS, and have not had the training and leadership development, even at a level in the NHS trust, to be able to speak to the right people to help them, and unblock the way to create a safer service when they believe there is a risk. Obstetricians and midwives need to do that together.

There is another issue about the leadership development of obstetricians in leadership roles. Because of the current system, often a clinical director comes into post for just two or three years and disappears. That goes back to training together. Even at leadership level, in order to manage risk and constantly risk assess the service, teams need to be trained together and to be at the right place in the NHS system so that their voices are heard. That is what we want to see.

Q193 **Neale Hanvey:** I want to pick up a point you made earlier about the constant pressure of savings, having to find money where there is none, and the temptation to cut staffing budgets, which could drive all the things you have been speaking about. Do you think that one of the reasons why perhaps boards have such a churn is that they are not able to get on top of what needs to be done to improve when they have the pressure of being driven to cut services?

Gill Walton: I think that sometimes it is one size fits all under the pressure of cost improvements. I have worked in the NHS for a long

time. I have found myself on many occasions having to justify the different approach that maternity services should have in terms of funding and certainly cost improvement. There are still services today where midwifery vacancies have been difficult to fill, so those posts have disappeared. We have to look at maternity services as unique, because they are unique and complex. Trust boards manage complex hospital services, but the complexity of maternity services is sometimes hidden in all of that work, so a voice at the board is part of the solution, which is why we are pushing for that.

Neale Hanvey: Any other comments from the panel would be welcome, but that was what I expected to hear. It is very helpful to have that information.

Q194 **Laura Trott:** We have had a series of maternity scandals in this country, culminating most recently in the devastating Ockenden report about the Shrewsbury and Telford NHS Trust. In many of those cases, data came up beforehand that could have prompted early intervention but it did not happen. Too often, it was parents who pushed for scandals to be uncovered and interventions to be made.

What more can we do to act on early data on things like perinatal mortality, which we know in the Shrewsbury and Telford NHS Trust was 10% above the national average? What more can we do to act on such data early to prevent such tragedies happening? Dr Morris, in one of your earlier answers, you touched on the availability of data.

Dr Morris: Perhaps the key thing is having an early warning system, for want of a better phrase, to understand where units could be in trouble and, more importantly, where we need to focus and redouble our efforts. Whatever happens, the aim is to bring together the right people to go and help those units. I think very strongly that it should be data-driven. The two colleges have worked together on several projects over the years, such as Each Baby Counts, and the national maternity and perinatal audit. We also helped to shape the perinatal mortality review tool that Professor Kurinczuk talked about earlier. As you heard from her, that is starting to give data, but it still does not bring together enough information quickly enough to look at the units that are failing.

What are the next levels you could look at? You could look at HSIB, but I do not feel that is necessarily responsive enough. CQC is perhaps more real time. I understand from Professor Baker's submission to the Committee that there is evidence to support CQC trying to have a more frequent and lighter-touch look at systems within hospitals that could be failing. There is stuff going on, but it does not feel that well joined up.

Both colleges, and certainly the partners we work with, feel that something needs to be done to join it all together, whether it is a commission to look at the design of maternity services in the UK or a centre that monitors the data, collects it and comes up with an early warning system. We need something like that. As I said earlier, the speed

with which the data comes through at the moment is still not particularly quick. It can take at least nine months to get data, so it is very hard to base important decisions on it.

We would like a centralised data hub that is influenced by the professions, and by the women and families that are supposed to be looked after by the system. We do not feel that, if it was an entirely Government-run structure, it would necessarily be clinically applicable and as reactive as we think it would need to be.

Q195 **Laura Trott:** So that I understand it, what is the structure you are proposing? Is it one whereby you have the royal colleges, NHS leaders and Government? What do you suggest would be the make-up of that?

Dr Morris: The make-up of it is still very much in our thoughts at the moment. The data comes from maternity systems, but, increasingly, as with the Tommy's app, it comes from a woman's actual pregnancy journey. Every time she engages with the maternity system will generate a data point, be it blood pressure or scan results, and that will feed into her own risk profile. That data needs to be looked at and analysed.

It could easily be an early warning system, a bit like a dashboard, that takes not only the woman's individual data but the unit data—very simple measures such as their caesarean section rate or their vaginal birth rate—and merges data from inspections such as CQC. Those things together, followed maybe by a local visit to try to understand whether there are cultural problems in the unit, could help us to try to get to the bottom of units that are having problems.

Q196 **Laura Trott:** Ms Walton, do you have any views on that?

Gill Walton: At the moment, if you are working in a maternity service, there is a very complicated system. Data comes from all over the place, as Eddie said: CQC, HSIB, NHSR, the NHS itself, and all the inquiries and reports. Somehow, we need to think of ways of simply pulling it back together, to make sense of it for the people who have to be trusted to make the difference. They are the people who are providing clinical care in services.

We are thinking about how to build on the work we have already done. How do we have a wider and bigger collaborative centre that helps bring in the data and looks at joint programmes and the research, and then goes to the health professionals working in services and supports them to start making a difference? The key still has to be that it is about putting women at the centre. In some of the work we have already done, we have made absolutely sure that women are central. For example, with Tommy's, we are working with women on that programme.

For a midwife working in a maternity service today it is complicated. Everybody is trying to find solutions and make a difference, but somehow that complication is halting the speed of improvement. The suggestion is to try to bring it all together. Both our colleges represent most of the

midwives and all the obstetricians who work in the services, so we are in a good place to do that. It is more bottom-up than top-down, and we think that could work.

Q197 **Laura Trott:** My final question is slightly different. In this session, we have talked a lot with various witnesses about the dangers of using the terminology "normal birth" and the implications that that can have for women's safety. Will both of you commit that your colleges will advise against using that terminology from now on?

Gill Walton: Personally, I have not used the terminology normal birth as an outcome for some time. I think it is through the lens of women's experience. It is a good birth for them when they have been very carefully involved in the decisions about their care. That is an approach that as a college we have been talking about for some time. We need to keep talking about it together; both colleges and both professions need to talk about that, but there is a policy lead as well. 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. We would like to see the right targets for maternity services, promoting a woman-centred approach that is about good birth.

Q198 **Chair:** I am sorry to interrupt, Laura. I want to go a little further, Gill. You obviously have a huge amount of influence on midwives up and down the country because you are chief executive of the royal college. Just saying that you will not use the term "normal birth" is not the same as saying that you will ask your members not to use it, to avoid some of the problems we are talking about. I think Laura was asking whether you would be willing to commit to that.

Gill Walton: I think it is about how we have those conversations in the education and training of our profession. I think we can do that, because we have all sorts of—

Q199 **Chair:** You can commit to not using the phrase "normal birth".

Gill Walton: There is a difference between normal birth as an ideology, which we do not support, and normal physiology, which I think we have to understand. There is a difference. The bit that is most important is understanding normal physiology and supporting women to make the choices that are right for them.

Q200 **Chair:** Everyone agrees that we want to support women to make the choices that are right for them. I am sorry not to let you get away with this, but it is very important. Many people who do not understand, particularly in the case of their first baby, will naturally gravitate towards something that is called "normal". That is human nature, so the question we are asking is whether you are willing to encourage your members not to use the phrase "normal birth", as the professional involved, because that could exert a hidden pressure on a woman to go for a certain type of birth when what matters is a safe birth.

Gill Walton: You are right; a safe birth is what is important, and I think we can support the concept of not pushing for normal birth. We should not be doing that. In the wrong hands, normal birth ideology has been shown to be unsafe, and we absolutely support the good birth concept, which is the right outcome for women.

Q201 **Laura Trott:** I guess the point is that when you use the phrase "normal birth", people will think that is what should happen. It is not just about the ideology; it is about that specific phrase, which can be so damaging and potentially dangerous for women. What we are trying to get out of you today is a commitment that as a college the phrase will not be used and promoted. It is important because it has a real impact on women.

Gill Walton: I absolutely agree. We have not promoted the phrase "normal birth" for three years. That is absolutely true. I cannot control every single midwife in the whole of the UK, but that is absolutely what the colleges centrally have been doing.

Q202 **Laura Trott:** Dr Morris?

Dr Morris: My answer is very similar to Gill's. As a college, we are not pushing for normal birth. We do not support the ideologies we have talked about at length this morning. What we support is the right birth and safe birth for a fully informed woman.

Q203 **Laura Trott:** You will commit that your college will not use terminology such as "normal birth" in the future.

Dr Morris: As Gill said, we will encourage people to use the correct language and not push for a normal birth and, therefore, I am sure they will avoid using that phrase. It is unavoidable sometimes; it comes up in conversation, but it should not be used to put pressure on women to go for a delivery that they feel is either not appropriate for them or is not perceived as the safe option. A woman needs to be fully informed as to the right way to have her baby, for both her and the carers giving her care at that time. It is all about giving the right advice.

Q204 **Laura Trott:** Gill mentioned the fact that maternity units are often monitored on the wrong things, for example caesarean section rates, which might be driving the wrong types of behaviour. Is that a view you share?

Dr Morris: Monitoring units is a complex thing. You cannot look at a unit's performance through one lens like caesarean sections. At the college, we have been performing an audit, commissioned by the Government indirectly; it is called the national maternity and perinatal audit. That looks at figures on the performance in units, such as pelvic floor damage rates, caesarean section rates, instrumental delivery or outcomes for babies. It is a very complex picture, which is one of the reasons why we are pushing for a way to join together all the data points that come out of the units before, during and after pregnancy, to make

sense of how units are working. You cannot look at those units through a single lens.

Q205 **Rosie Cooper:** Dr Morris, there are those who believe we do not have a proper or real complaints system in the NHS any more, which leads to trusts not learning. To deal with the problems we have talked about throughout today's hearing, you indicated that you would like a central data hub, as it does not feel joined up, but regulators cost the taxpayer billions and billions yet fail miserably. I am talking about CCG, NHSEI, Department of Health, the royal colleges of midwives and nurses, medical royal colleges, trust boards, medical staff committees, local medical committees, and staff and patient surveys.

Should we be adding yet another layer, or should we be making accountable people accountable? Are you suggesting that we should just add another layer, or reorganise the system as a whole? It is certainly not working, and it cannot go on failing and costing the taxpayer more, and possibly patients their lives?

Dr Morris: I understand your question. I am certain it is not about adding another layer; it is about using what we collect already but using it better and in a timely fashion that fits the need. We have all talked about the fact that things need to change at pace. As I infer from your question, I do not believe it is moving quickly enough at the moment. That is because the system at the moment is under-resourced. It does not move quickly.

While complaints are part of the metric that is collected, I would rather hear more from women about elements of their care in labour that we can improve, not just the awful disasters we have heard about today and in previous evidence sessions, but the near misses. There is so much to learn from those near misses, which may well be the subject of a complaint. A team that works well analyses near misses and feeds them into their governance sessions, so that they can learn from them. Systemwide, if there is a way of collecting that, along with whatever friends and family data there is, we can get even richer information as to how units perform.

Q206 **Rosie Cooper:** Absolutely, but I suppose the point I was trying to make is that all of that is there. Never mind doing it quickly, at pace or any other bit of modern parlance. These issues have been around and on the table for a long time in those organisations, from the trust right through to the Department of Health eventually. This has been going on for years, so never mind doing stuff at pace and learning quickly; you are not even learning slowly.

Dr Morris: For local units, their governance meetings in maternity departments always include a review of the complaints that have come through. In my unit, which I hope most people see as a good one, that is what happens. We sit down, go through the complaints and change the things relevant to those complaints that can be changed. Systemwide, I

agree with you; it is not moving quickly enough and we need to use taxpayers' money more effectively in that area.

Rosie Cooper: Absolutely.

Chair: Thank you very much indeed. That concludes this morning's session. A very big thank you, Dr Morris, Gill Walton and Professor Gordon Smith, and to the earlier witnesses, Donna Ockenden and the two witnesses from the FiveXMore campaign. It has been a very important session. Thank you all very much for your time.