

Health and Social Care Committee

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

Tuesday 19 January 2021

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

Questions 207 - 269

Witnesses

I: Charlie Massey, Chief Executive and Registrar, General Medical Council; Andrea Sutcliffe CBE, Chief Executive and Registrar, Nursing and Midwifery Council; and Professor James Walker, Clinical Director of Maternity Investigation Programme, Healthcare Safety Investigation Branch.

II: Sara Ledger, Head of Research, Baby Lifeline; Niamh Maguire, Obstetric Clinical Lead, Sussex Local Maternity System; Dr Daghni Rajasingam, The Shelford Group; Jo Mountfield, Vice President for Workforce and Professionalism, Royal College of Obstetricians; and Gill Adgie, Regional Head, Royal College of Midwives.

Examination of witnesses

Witnesses: Charlie Massey, Andrea Sutcliffe and Professor Walker.

Q207 Chair: Welcome to this morning's session of the House of Commons Health and Social Care Committee. This morning, we continue our inquiry into the safety of NHS maternity units following the very severe problems that we have had at Shrewsbury and Telford and East Kent trusts, both of which have big inquiries in progress at the moment.

We have some very important witnesses this morning. On our first panel, I welcome Andrea Sutcliffe, who is chief executive of the Nursing and Midwifery Council; Charlie Massey, chief executive of the General Medical Council; and Dr Jimmy Walker, who heads the maternity programme at the Healthcare Safety Investigation Branch. Thank you all very much for joining us.

I want, if I may, to start with an issue that has come up very frequently in our inquiry, which is what many NHS staff describe as a blame culture in maternity units. Actually, it is not just in maternity units, but we are looking at maternity safety at the moment for this inquiry. That blame culture, as it is described, can make it very difficult for doctors, nurses and midwives to speak openly after a tragedy, basically because they worry that they might lose their job if they are open about having made a mistake. What that means, of course, is that vital lessons are not then learnt, and mistakes and tragedies end up being repeated.

This morning, we have the two regulatory bodies that are the people who have the power to strike doctors, nurses and midwives from the register. That means that they cannot practise in the future, which is probably the thing they are more afraid of than anything else. I would like to ask both of you about how you deal with that blame culture so that proper learning happens. Then we will come on to Jimmy Walker from HSIB.

Andrea Sutcliffe, I know that you have long experience of this with your background in the CQC as chief inspector for adult social care, where I was delighted to work closely with you in both of our previous incarnations. One of the reasons people say that they are worried about speaking out is that they might end up facing a fitness to practise hearing and being struck off. How much of a problem do you think that is, and what is the NMC doing to encourage openness and transparency?

Andrea Sutcliffe: Thank you very much, Chair, for the opportunity to be here this morning as part of your incredibly important inquiry. You are absolutely right; that blame culture exists, and it is harmful. It is harmful because, as you rightly say, people feel that they are not able to speak up. They do not learn from things that go wrong. They do not have a supportive way of looking at them. They do not listen to women and their families, and the failures continue to happen. System failures are potentially endemic if that is not addressed.



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As a regulator, we obviously have a very important role to address that. My personal view is that while we are here to protect the public—that is absolutely the core of what the Nursing and Midwifery Council is for—I do not think that we protect the public by making nearly 725,000 nurses, midwives and nursing associates afraid of their regulator. Unfortunately, some of them are, because of things that have happened in the past and the myths that are perpetuated about what the NMC is for.

We have been doing a lot of work to try to address that. First of all, we are focusing on our core regulatory role. That starts with setting standards. We have recently established new standards for midwifery: the future midwife standards. They are absolutely clear about our expectations of midwives in their training and in their practice. They sit alongside the code, which is also very clear, about our expectations that midwives, along with nurses and nursing associates, are empowered and enabled to speak up, and that we expect them to do so.

Q208 **Chair:** Andrea, before you go on, I want to drill down a bit. Does a midwife who works extremely hard, and is totally committed to his or her role, know the difference absolutely clearly between the kind of ordinary human error that we can all make in the course of our work, which is regrettable and that we try not to repeat, but is ultimately forgivable, and gross errors that could lead to being struck off? When we see at places like Morecambe Bay notes being “mislaid” but possibly deliberately destroyed, what we worry about is that people think they will lose their right to practise if they make an ordinary human mistake.

Andrea Sutcliffe: What the evidence shows is that very few people are actually struck off in the end, although obviously that potential outcome is there for every referral that is made. We look at referrals and we make sure that if there are issues of dishonesty or of covering up, as you quite rightly say, they will be addressed.

We want to make sure that people understand that we understand the context in which they are working. They are working in high-pressurised environments where a woman’s pregnancy and birth can go catastrophically wrong very quickly. We need to make sure that we understand that and that we respond appropriately by encouraging people to have reflective practice, to understand what happened, to focus on that and to learn from it, not to cover it up, because that does not help anybody.

Q209 **Chair:** We have looked closely at what happens in Sweden, where families who have a disabled child do not have to prove clinical negligence in order to get compensation. Some of the experts in Sweden said that that led to a much less confrontational culture. Do you think that a change in the law on eligibility for compensation could help build a more constructive relationship and a better learning culture when things go wrong?



Andrea Sutcliffe: It is not my position to comment on that aspect, because that is not our locus. What I would say is that there are very many aspects of the way the law around this works that create an adversarial culture. As you rightly say, in terms of compensation there is the need to prove clinical negligence. In the fitness to practise process, we have a regulatory regime that encourages an adversarial approach; for example, our legislation says that we need to call those things allegations, which immediately puts people on the defensive, when, actually, what we want is to have a meaningful conversation about what has gone wrong and how we can put it right.

One of the things that we are looking for is reform of our own regulation, so that we can resolve things earlier, encourage insight and remediation, and move away from the adversarial process that causes harm for our registrants and has a deep impact on the women and families who go through the process. They have to constantly repeat what was the worst time of their lives by giving us evidence on all of those sorts of things. If we were able to do things in a much less adversarial way, it would be of benefit to everybody. I hope that the Committee will be able to put weight behind our regulatory reform ambitions.

Q210 **Chair:** Can I bring in Charlie Massey from the GMC to comment on those thoughts?

Charlie Massey: Thank you, Chair, and good morning everybody. I completely agree with Andrea's last point about regulatory reform. You asked about fear culture and blame. Undoubtedly, there is a degree of fear of professional regulators out there. I do not believe that the facts always bear that out. If you look at our own processes, in the last full year when we closed cases, only five of the 257 cases that we took to our tribunal were for clinical failings alone. The vast majority of things that lead to doctors losing their licence or having their licence suspended are issues around behaviour, things like sexual misconduct, criminality and substance misuse.

One of our long-standing ambitions is to spend more of our time and effort getting upstream. One of the things that I know Andrea and I feel very strongly about is that we want to use more of our regulatory resource to anticipate mistakes and get ahead of that curve, and support improvement among our registrants.

Legislative reform has a really important part to play in that. Frankly, we investigate doctors because the law tells us to, when we know that it is very unlikely to lead to us using the most serious sanctions. While we have introduced some workarounds—we have used something that avoids about 500 cases each year turning into full investigations—actually it is important that we focus our energies on cases where there is a professional regulatory case to answer.

Another point is that it is really important that we take a systems view in looking at registrants who come to us. The law asks us to consider the



question of accountability in individual cases when we are considering our fitness to practise processes. One of the things that we have been doing over recent years is to make sure that all our decision makers are trained in human factors and techniques. That means we make sure that we ask ourselves questions about system learnings as well.

My last point is that education and guidance has a really important part to play in making sure that our registrants understand the importance of openness and candour, and not only speaking up themselves but supporting colleagues to speak up as well. Regulators have an important role to play as part of the solution rather than as part of the problem in relation to the fear culture.

Q211 Chair: You and I were both involved in the Bawa-Garba case when it happened. This is not an inquiry into that, but I have one question on it. What has the GMC learnt from that whole incident?

Charlie Massey: We have learnt a great deal. The issues around human practice techniques came directly out of that case. My deepest learning has been about the role that we, as a professional regulator, need to play in driving improvements in workplace culture and supporting wellbeing.

There were three important reports that we commissioned on the back of that case. One was about the fact that BAME doctors are so much more likely to be referred to us than white doctors. Another one was about understanding what drives positive wellbeing and thinking about how we can work with Governments, arm's length bodies and providers to promote it. That case has taken us much more directly into thinking about the role we can play in creating more sustainable, supportive and inclusive workplaces for doctors and other healthcare professionals.

Q212 Laura Trott: Ms Sutcliffe, I want to pick you up on a couple of comments that you just made to the Chair. In response to discussing whether something is covered up, you said it should be openly talked about because, if not, that does not help anyone. I understand the balance you are trying to strike between understanding and the fear culture that we just talked about, but is there also a line about making it very clear that unacceptable practices will result in people being struck off, and that the regulator will be very firm in that regard?

Andrea Sutcliffe: We are very clear in the standards that we set in the code of conduct for all nurses, midwives and nursing associates: we expect people to be candid and honest, and to speak up when they see poor practice. As Charlie said from the GMC point of view, some of the things that we look at, and where people experience the toughest sanctions that we have, are around those aspects of behaviour. This is something where the GMC and the NMC are very closely aligned. Our duty of candour guidance is jointly written by the pair of us—the two regulatory bodies—and we support it in practice, and expect it to be what happens.



Q213 Laura Trott: Over a number of years we have seen significant failures in the Morecambe Bay and East Kent trusts. Those situations involve specific criticisms about the NMC. What confidence can people have that the NMC has changed and that the culture of defensiveness that James Titcombe talked about in his evidence is different?

Andrea Sutcliffe: As Charlie has already said, we always learn from these cases and the situations that we face. Certainly, from Morecambe Bay onwards, we have been very focused on making sure that we address some of the problems that were identified. What happened at Morecambe Bay was absolutely awful, and we know that we made the situation for those families worse by the way we handled those cases. I am profoundly sorry that my organisation prioritised process over people, and that the process was not brilliant, and really compounded their distress.

There are lots of things that we have done, but there are three key areas that I think it would be helpful for the Committee to hear about. The first is about how we work with families and the public; the second is our fitness to practise process; and the third is the way we are changing as an organisation.

On the way that we are working with families and the public, I have spoken to James myself about the experience that he had and the experience of others who have gone through our fitness to practise process; it has a real impact on them. One of the things we have done is to establish a public support service that provides somebody within the NMC who works with the families and supports them all the way through the process, even sitting with them at hearings if that is what they want.

We have also established a telephone support line so that there is emotional support available for families who are going through the process. We have given training to our colleagues and our panel members so that they can respond better, so that some of the things that James described as his experience with the NMC should not happen again, but I know that we have more to do. I would not want to tell you that it is all sorted because that would be foolish.

There are other things that we are trying to do. We are doing some work on how we can support witnesses better in vulnerable circumstances so that they can be enabled to give their best evidence, and not feel that it is them under scrutiny, which I know some of them feel it is like at the moment. The other aspect of working with the public is that we want to engage much more with them in shaping what we do, so that they have confidence in the organisation as a whole, not just when they are involved in fitness to practise processes with us.

Thinking specifically about what we have done about the fitness to practise process, there is a whole host of issues. We are working better with employers through our employer liaison service. We are making sure that we use information better; we have created a regulatory intelligence



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unit, for example. We are providing more accessible clinical advice for our own investigation teams and those sorts of things.

Again, as I explained to Jeremy, regulatory reform will help us to move things more upstream to focus more on having a less adversarial approach to all of this. I think that will help. It is also around helping employers to focus on what they can do better at local level. In February, we are going to launch some new materials on how they can do better investigations at the first stage, which will help us and them. It will also help our registrants and families.

Finally—

Q214 Laura Trott: I am sorry. We have lots to fit in today, so I have to cut you off, but I think you have given a comprehensive answer to that question.

I want to pick up on something else that we have been talking about a lot in this inquiry, which is the concept of normal birth, and its being prioritised in some cases over what is safest for women. Is there a clear message from the NMC that safety needs to be absolutely prioritised above any kind of ideology?

Andrea Sutcliffe: Absolutely. One of the things that I really hope comes through in my evidence today is the importance of our future midwife standards, which we developed based on the evidence of what is safe. Working with midwives, and with women and their families, we have created a set of standards that I think, once they are fully embedded in education and in practice across the country, will be the cornerstone of safe care.

We do not use the phrase normal birth anywhere in those standards. What we talk about is making sure that midwives understand the normal physiological process. Giving birth is a natural event, but they must recognise, when there are signs that things are going wrong, that they have a responsibility to recognise that, assess it, escalate and then continue to work with the multidisciplinary team to assist in whatever intervention is needed. Those future midwife standards will be a really important thing for us. We must make sure that they are embedded across the country because that will help us to deliver the safe outcomes that we want, and a positive experience for women and their families.

Q215 Laura Trott: Thank you; that is very welcome. I have two very quick questions for Professor Walker. HSIB's inquiries are a very good innovation to make sure that we have an independent look at what, on occasion, goes wrong in our health service. Do you think, Professor Walker, that your recommendations are adequately picked up on by trusts?

Professor Walker: Thank you, and the Chair of the Committee, for allowing us to answer for the work we are doing.



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We work closely with trusts, and I think the recommendations we give are taken up, if they can be, within trusts. In many situations, they need help from outside to develop training programmes and the changes required to improve the level of safety in their practice.

What is true is that the implementation of recommendations, not just from us but from others, was always the next point of failure in the system we had for trying to improve patient safety. A lot of the work we have done, working closely with trusts, has helped on that, but another stage is required.

Q216 Laura Trott: Do you think that the Department of Health and Social Care more centrally should be involved in making sure that your recommendations are implemented?

Professor Walker: Central support in encouraging implementation is important, but it probably has to be done at a more local level. We are working closely with regional chief midwives and the LMSs on giving them the information that we have, to help them develop the local structures that will put the changes into place.

Everyone needs to take responsibility for the things that have gone wrong up to now and for how things can improve. It goes back to what was talked about on the blame culture. The main problem with blame culture is that the people who are blaming do not take responsibility for the incidents that have occurred. That goes through the system all the way up, so the more responsibility people take for things that have occurred, and the more responsibility they take for the implementation of change, the more likely those things are to occur.

Q217 Laura Trott: Obviously, it is very important that your inspectors are independent. Do you ever take your inspectors from within trusts, and have you ever seen any conflict of interest arise between the two?

Professor Walker: They are investigators rather than inspectors; that is the correct terminology. They are not within a trust. None of our inspectors investigates cases in the region where they originally worked. They are always outwith that region so that there is no conflict of interest. In any case that is brought up, the individual investigator is asked if there is a conflict of interest because someone they know may be working there or a family member. So, no, we go to great lengths to make sure that there is no conflict of interest.

Chair: I would like to come back to Professor Walker in a moment, but before that I will bring in Luke Evans and Barbara Keeley.

Q218 Dr Evans: Charlie, picking up on the culture, you mentioned that the perception is different from reality when you look at the number of cases that have gone through. What work have you done on the perception of the GMC by doctors?



Charlie Massey: We regularly do perception surveys of doctors, which tell us that there are still some myths that we need to bust. The statistic I use, that just five in 257 cases are for clinical failings alone, is not borne out in what many doctors on the frontline feel. Many doctors on the frontline feel that if they make an innocent, everyday mistake, it is likely to lead to the GMC taking serious action against them.

I know that we have a lot more work to do. We are trying to do that. We are also trying to work through clinical governance systems locally. Responsible officers have a really important role to play. Our engagement with responsible officers tells us that that is hugely valued. Ultimately, we are trying to become a much more upstream regulator. We sit on a huge amount of data, and we should be using that data, and are increasingly using it, to try to drive improvements in practice, rather than waiting until something tragic has happened to, in this instance, a mother or baby, and then acting after the event. We should be using our energies to be better at anticipating where things might be going wrong, and then working with Andrea, the CQC and others to take earlier and better action.

Q219 **Dr Evans:** That is really helpful; thank you. Perception is reality, in essence, when it comes to culture. Doctors pay individually themselves to be involved in the GMC. Is that the right model?

Charlie Massey: I believe that independent regulation is really important. We cut the annual registrant fee for doctors and only increased it in line with inflation. I come back to the point that, in the history of the GMC so far, we have spent over half the money that we receive from doctors on our fitness to practise processes. I want to get to a place where we are spending the bulk of that resource in thinking about how we can support doctors to be better doctors. We should not be focusing all our efforts at the far left-hand end of the bell curve. We should be thinking about how we can move the whole curve to the right to improve care for patients.

Q220 **Dr Evans:** Isn't there some kind of conflict of interest, in essence? You are there to regulate doctors and protect the public, yet doctors pay the GMC. You are encouraged to give them pastoral support, yet report to the GMC when there are problems. Isn't that a vicious cycle which means that there is always going to be a conflict of interest? Doctors and professionals do not quite know what to do, which leads to a perception that becomes reality.

Charlie Massey: I do not see it like that. We have important responsibilities that are not just about investigating doctors when bad things have happened. We have important responsibilities, for example, in overseeing undergraduate education and approving curricula for postgraduate training. Through that, we set the standards that we want to see embodied in education.



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It is very relevant to the world of maternity that over recent years we have beefed up our emphasis on things like leadership, team working and communication in the capabilities that are embedded in all postgraduate curricula. I do not see a conflict in that activity with the work we do around fitness to practise, but what we need is more freedom to decide who we investigate and how we investigate them. That is going to be the key, through legislative reform, to ensure that we can spend far more of our resources on supporting doctors.

Q221 Dr Evans: Do you think the model is correct at the moment?

Charlie Massey: I think independent regulation is the correct model. As soon as we become funded through Government, for example, that independence of view will not be perceived as such out there. That would be a very dangerous road to go down.

Q222 Barbara Keeley: I have a couple of questions to put to Charlie Massey and to Andrea Sutcliffe. On bullying, you say that obstetrics and gynaecology training have the highest rates of bullying, together with high dropout rates and high burnout risk. Can you tell us why that is and how you think it should be addressed?

Charlie Massey: In our data, we see some quite troubling data around bullying. For obstetrics or gynaecology trainees, we see in our national training survey each year that some 14% report that they have experienced bullying. That is against an average for all trainees of 6%, so we see more than double the rate of bullying in obstetrics and gynaecology. We also see it in other grades of doctor. We recently conducted a survey of SAS middle-grade doctors who are not on a formal training pathway; 40% of them reported experience of bullying compared with 30% for the generality of that type of doctor.

There is definitely something worrying going on in relation to bullying. I think the causes are quite complex. A lot of the work we have done over the last few years has pointed to workplace culture being a real driver for it. There are some things that all the reviews that the Committee has been looking at have pointed to in terms of challenges in relation to leadership and board oversight. They are all things that have been borne out in our own work as being really important.

There is more work to be done to understand what is driving it. Combining our data with that of the NMC and the CQC, my aspiration is that we will be able to triangulate it to derive some insight, so that we can, collectively, take earlier action. There are loads of examples of great practice in maternity provision. One of our challenges as regulators is how we replicate that best practice and bring support to those who face a lot more challenges.

Q223 Barbara Keeley: As a follow-up, before I talk to Andrea about midwifery, have you any ideas about specific support we should be giving trainees? That burnout is very costly to the workforce. People are leaving,



and more obs and gynae trainees work less than full time. There is clearly quite a hit to the workforce, and that causes another problem in itself. What support could we give to trainees to help them?

Charlie Massey: The burnout is problematic not just in the impact on training itself; we also know that doctors under stress are much more likely to make mistakes, so it is a bottom-line issue in patient care as well.

Some of the things that we need to be doing are pushing still further around some of the multidisciplinary training. You have already heard evidence in previous hearings around cultures of tribalism sometimes between doctors and midwives. There are lots of really good things going on to improve that. I think all of the inquiries talk about the importance of doing things together.

I come back to the question about leadership and about ensuring that maternity services are well led. Well-led workplaces create more of a culture where people can speak up and feel able to speak up. One of the really worrying things we see in some of our data is that, when people are asked why they do not speak up, they say it is because they fear that either they are not going to be heard or, worse, that they will be blamed for raising concerns. That is ultimately a function of culture and leadership. It does not change overnight, but it is something where the combined efforts of ourselves and others have a really important role to play.

Q224 **Barbara Keeley:** Andrea, could I ask you the same about midwifery? Do you see similar patterns, and what are your views about the specific support we could give to help with burnout and those issues for the workforce?

Andrea Sutcliffe: As Charlie said, we see those issues similarly in midwifery. We run a survey of people who leave the register each year. Midwives say that too much pressure is one of the reasons why they leave, and not having access to meaningful continuing professional development is another reason. We can see that. We also see that student midwives are more likely to experience or witness bullying behaviours. We know from the evidence that, if you witness that, it has a profound effect on you as well. There is a chilling effect: "I am not going to go there, am I?" We know that that is a concern.

In terms of what we can do to address those issues, our code of conduct and the future midwife standards are absolutely clear about our expectations for midwives themselves, and about how they should conduct themselves and contribute positively to creating an environment where bullying is not tolerated and undermining behaviours are challenged when they are seen. There are some very specific things. For newly qualified midwives, it is a scary place to be. One of the things that we want to see is that what is called preceptorship—support—is really good for newly qualified midwives when they start their registered career.



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Last year, we set out some principles of preceptorship for employers to put in place. I want to make sure that that is what happens, because the immediate support they get is important.

The second area is around continuing professional development, and making sure that there is sufficient funding and time for midwives to have continuing professional development, so that they can keep their skills up to date and feel confident and capable in the work they are doing. It is such a responsibility, and we need to make sure that we support them in that.

We also need to make sure that we have enough midwives and that they have good leaders. Charlie has already mentioned leadership. I could not agree with him more. It is so important that there is good direction and support. As Charlie has already said, we must do that jointly, so that the midwife, the obstetrician and the wider multidisciplinary team work well together. If they train together, they are much more likely to be able to do that, particularly when they are under pressure.

Q225 Barbara Keeley: Before we leave training—I think this is important—you focused on midwives leaving because of a lack of focus on development and career progression, but are there any specific training areas that you feel are not being given the importance they should be, leading to services being less safe than they could be? From the safety point of view, is there anything missing in training?

Andrea Sutcliffe: One of the things we need to look at are the issues that have been raised in the thematic reviews that come through from the HSIB work. A particular issue is around assessing foetal heart monitoring and making sure that people keep up to date with those skills. That is absolutely critical in recognising when things are going wrong and making sure that they are assessed properly and escalated appropriately. Making sure that people are up to date with that, and are confident around it, is absolutely critical.

Q226 Barbara Keeley: Charlie, on the training point, you reported doctors feeling “forced to cope with clinical problems beyond their competence or experience.” That clearly has a link to safety. Do you have any points to add on training needs?

Charlie Massey: I agree with Andrea. I was talking earlier about the training pathways and our oversight of postgraduate curricula and undergraduate education, and the point that Andrea made about ongoing learning and development is really important. The fact is that only a decade ago the majority of doctors did not have an annual appraisal. Now, nearly 100% of them do, and that means that questions about what should be embedded in continual learning and development are much more ingrained in the way doctors work. That is really important.

I cannot put enough emphasis on the multi-professional training point. While we will be very focused, through our responsibilities, on what that



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means for nurses and midwives on the one hand, and doctors on the other, some of the work that trusts have been doing to try to bring midwives and doctors together in training is fundamentally important. Ultimately, to provide the best care to women, we need teams that work effectively together, where leadership is shared, where there is a clear purpose and where responsibilities are understood. That is the area where reviews and inquiries have repeatedly pointed to there being a gap.

Q227 Chair: I have a couple of questions for Charlie Massey before I move on to the HSIB side of things. We all make mistakes; it is part of human nature. Doctors happen to have chosen a profession where the price of an ordinary human mistake is sometimes a tragedy, even someone dying.

Do you think doctors are clear enough about the distinction between the ordinary human error that we can all make, where the right reaction is to learn from it and try to design it out of the system, and the kind of egregious errors that the GMC ends up striking people off the register for?

Charlie Massey: Generally, yes, doctors are, but there is still further to go. Obviously, every doctor, nurse and midwife gets out of bed in the morning intending to do a fantastic job looking after their patients. In the vast majority of circumstances, that is exactly what happens. Sadly, as with any sector, people make mistakes, and sometimes those mistakes can lead to tragic outcomes. The fact that there is a tragic outcome does not mean that the GMC recalibrates and says that therefore if, tragically somebody has died, the only solution is for a doctor to be struck off or suspended. Indeed, there are many cases where that does not happen.

You asked me about the Dr Bawa-Garba case earlier. At the same time as that was happening, the other half of my postbox was full because there was a very tragic incident where a GP in Wales had not seen a little girl who tragically died from an asthma attack later that night. In that instance, because the doctor understood that she had made a mistake and undertook training, and there was insight, remorse and remediation, we took the view that it was not even a case we wanted to take to our tribunal. The learning was in place and we could satisfy ourselves that those problems were not going to occur in the future.

Of course, it is one thing for me to say that and it is another thing for doctors on the ground to believe it. That is why we cannot communicate enough to doctors about where the GMC sees its responsibilities beginning and ending. It is also why local clinical governance systems are so important. Tragically, when things go wrong, too often local clinical governance and investigation systems fail. It becomes a battle, as you have heard from various people with losses, in the course of the work of this Committee, and things become intractable and often get thrown into the world of professional regulation.



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We need to redouble our efforts to support local systems to be better at learning and understanding, and having early conversations. What people want when things go wrong is learning and understanding, and to feel that the same mistake will not happen again. I think that is something where we can never do enough.

Q228 Chair: Could you comment on something that I asked Andrea about earlier? If we had the same maternity safety rates and the same neonatal death rates as Sweden, we know that 1,000 more babies would live every year. In some of our inquiry to date, we have been very struck by the fact that they have a much less adversarial system in Sweden, which is partly because families do not have to prove clinical negligence in order to get compensation if, for example, a child is born disabled. They have a much more constructive process, and that has enabled a lot more learning to happen in the system. That is the argument for the Swedish system.

When I was Health Secretary, you used to advise me on patient safety. If you had your old hat back on, would you be asking the Secretary of State to look at the Swedish system as a way of bringing down our neonatal death rates?

Charlie Massey: If I put my old hat on, I think I would advise any Minister always to make sure that we learn lessons from anywhere in the world, but to be cognisant of the fact that there are different contexts in play. It is not necessarily easy to transplant a system from one country, and simply lift and shift it into another.

From a GMC perspective, we do not have a particular position on litigation. I was listening to some of the testimony, particularly from Darren Smith, and it was clear that the process of litigation had led to real barriers and a real struggle to get information. You had a lot of evidence about how adversarial that can become. The litigation system is a part of that. The role of the criminal law in medicine plays a role. Certainly, some of the fear culture you asked us about earlier has a role to play.

For our part, we need to promote openness, honesty and learning, and support local decision making and clinical governance, which I was talking about earlier. If we are doing our job well, we should reduce the need for medical litigation, for people to go through those processes in the ways you heard about. Being open and honest about incidents is absolutely key to creating the learning culture that we all want.

Q229 Chair: Thank you. Let me turn to Dr Jimmy Walker from the Healthcare Safety Investigation Branch. What HSIB does in terms of your investigations into serious maternity incidents is relatively new. Could you explain to the Committee what you do, and how well you think it is going?

Professor Walker: HSIB investigates incidents occurring with certain criteria, called Each Baby Counts. It is certain types of problem that occur



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in women at term who end up with stillbirth, neonatal death or babies with potential brain damage. It is a very focused group of babies. There are about 1,000 cases a year.

We have now been in position for just over two and a half years. We have the whole programme rolled out throughout the country. Investigators who have been trained professionally for the investigation of healthcare incidents are now all in place. The families are involved from almost day one of the incident because we contact them for permission to access their case records. They are then ongoingly involved throughout the investigation process.

Over the last year, we have developed a process of putting back into trusts, so that trusts now do their own 72-hour review to look at acute problems that might need immediate action. They also do the duty of candour. In general, they link with us, and we escalate any problems we see as we go through with the investigation report.

We have mechanisms for escalation to the head of midwifery by communications that occur every two weeks. Every three months, we give that information back to the trust by what are called quarterly review meetings, where we go through the themes that they have in their trust, but also national themes and anything we have picked up in other hospitals. It is the old "it happens in Newcastle and there is learning in Penzance" approach. If something happens in one place, we describe that to hospitals all over the country. Within four months of an incident occurring, the trust has the first draft of a report for factual accuracy. The families also review it at that time, and it is published within six months. Over 90% of our case reports are published within a six-month timescale.

We developed the QRM—the quarterly review meeting—because initially we found that we saw the head of midwifery or the safety manager and fed back to them, but nobody else. We discovered that other people within the trust did not know what we were doing. They did not know us and they never saw the reports. What we have now encouraged is who should get that information within the trust. It goes to the director of nursing; it goes to the safety champions. At the quarterly review meetings, we now have consultant obstetricians and their junior staff, paediatricians and their junior staff, and anaesthetists, as well as midwives, in a group discussing what is happening.

It comes back to what I said earlier. You need common ownership of incidents that have occurred. If you do not have common ownership, you do not then have common ownership of the solutions that are required to be put into place to prevent them from happening again. I think we have been very successful in achieving what we have done to date.

Q230 Chair: We had some feedback about the HSIB reports from the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. To summarise, they basically said that having those independent reports is a very welcome development, but sometimes



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trusts feel cut out of the investigations because of very limited local involvement from the outset. I think they feel that the investigations are being done to them rather than with them. Is that a fair criticism? Is there something you could do to avoid that feeling?

Professor Walker: I think initially, when we were first set up, there was a certain degree of confusion over exactly where we sat. Trusts did not know whether to trust us in what we were actually doing. I think that has largely gone. We still investigate the incident. The trust is not involved in the investigation, but we keep them involved in what we are finding. They know the findings as quickly as we know them. From the point of view of learning from the incident, the trusts are now learning just as fast, if not faster than they did before.

The advantage that we bring is that we have a far broader base of investigation. Staff find it a far more comfortable investigation, because they feel people are listening to them and they can describe things that previously they never got the opportunity to do in incidents in the hospital. We can do a wider investigation into not only the maternity unit but the accident and emergency unit, if the patient came through there, the ambulance service, the GPs and other medical areas in the hospital that the mother may have come into contact with. We can look at a far bigger picture of why things happened, unlike previously when the trust did not have the ability to do that.

The other thing is that, because we are in there all the time, we pick up the progress of change but also progress of no change. We can tell the trust that there are themes, and that this incident happening now is the same as the one they had four months ago, so therefore they should be looking at that and why it happens. There is a lot more cumulative information that we can give back to trusts now, which they did not have before. With the best will in the world, they just did not have the approach or the capability to do it. I think we give a far richer return to trusts about their incidents and about what then could happen and how things could change. Then we try to help to implement that change as best we can in the circumstances.

Q231 **Chair:** I have a final question before we move on to our next panel. The Government have committed to putting HSIB on a statutory footing. How much difference will that make to your work? As I understand it, one of the benefits of a statutory footing is that there will be some legal protection for doctors and nurses who give evidence to HSIB investigations; basically, any evidence they gave would be anonymous, absent a court order to the contrary. Could you tell me what difference it would make to your work if HSIB had that statutory backing?

Professor Walker: It would make a lot of difference across the board. The first thing is that over the period of us being in existence we have integrated fully into the national programme. There is a very good interchange of expertise and help between the national programme that existed before and the maternity programmes. We are not two separate



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entities. We are one entity and we learn from each other. A lot of what we learn we can feed back into the national programme. What we are learning is not purely about maternity problems. There are often problems within the trust in general. That is one thing.

The idea of safe space and protection is interesting; we do not work under safe space at the moment, and in general we have not found that to be a problem. The one value of safe space is not that it allows people who have made an error to admit it; it is about allowing people to discuss what is going on in their trust in such a way that they do not feel that they are going to be blamed or punished for whistleblowing, in a way—for describing what goes on. Safe space allows people to describe things that they would not necessarily have described before. I think it will improve that.

Thirdly, people criticise us because they do not see us as really independent. At the moment we are hosted by NHSI, so they see us still as a Government agency to a degree. The problem is that people are not necessarily convinced that we will still exist in a year's time. That was the problem we had initially. A lot of people would not engage with us and would not support us; they felt, "We'll just ignore you and you'll go away." Being established as a statutory body would allow us to have permanency, or reasonable permanency, to allow the development of our role in the patient safety networks that we are developing at the moment with the other agencies.

Chair: Thank you very much indeed. Thank you, Andrea Sutcliffe and Charlie Massey as well for joining us. Best of luck to you and all your organisations in these very challenging times. We really appreciate all the excellent work you are doing.

Examination of witnesses

Witnesses: Sara Ledger, Niamh Maguire, Dr Rajasingam, Jo Mountfield and Gill Adgie.

Q232 **Chair:** I welcome our second panel. Sara Ledger is head of research at a charity called Baby Lifeline, which does an enormous amount of highly respected training in maternity safety. Niamh Maguire is the obstetric clinical lead at the Sussex local maternity system, one of the many local organisations charged with implementing all the improvements that are being asked of maternity units across the country to improve our safety levels. Dr Daghni Rajasingam is an obstetrician at Tommy's and represents the Shelford Group of large teaching hospitals. Thank you for joining us. Jo Mountfield is vice-president for workforce and professionalism at the Royal College of Obstetricians and Gynaecologists. Gill Adgie is the regional lead for the Royal College of Midwives. We have a large and illustrious second panel, and we are very grateful to all of you for joining us at such a busy and stressful time for everyone associated with the NHS.



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I want to start with an issue that has already come up this morning and seems to be one of the fundamental blocks around improving our maternity safety rate—the simple issue of just having enough staff. We have a NICE standard for the number of midwives needed, but not yet one on the number of doctors needed. Let me bring in Gill Adgie from the Royal College of Midwives. Is it enough to have a NICE standard? How do you make sure that maternity units really implement what is required?

Gill Adgie: Thank you for inviting us this morning. It is important to understand that maternity care is complex and unpredictable. Having safe staffing levels for maternity services and a ratio for staffing maternity services is difficult. Perhaps rather than a ratio, maternity services should be seeking to make sure, and trust boards should be making sure, that there are sufficient midwives to provide care for women when they are in established labour. That is one-to-one care in labour, so that each woman has one midwife looking after her. Some women need more than one midwife to look after them in labour because of the complexities of their case.

The NICE guidance was published in 2015. Provider organisations should definitely continue to adhere to and implement the recommendations in the NICE safe staffing guidance.

Q233 **Chair:** How many are? Are most trusts implementing the guidance? What is the picture?

Gill Adgie: To be absolutely honest, that is a question I cannot answer. We did a freedom of information a while back around the NICE guidance, and whether trust boards were having sight of maternity staffing figures on a six-monthly basis, which is what is written in the guidance, to ensure that midwifery staffing levels support women and babies receiving care. That may be a question that NHS England needs to answer: how do they make sure that trust boards are actually looking at maternity services?

A number of the people on the earlier panel this morning talked about leadership in maternity services. It is really important that we have good, strong leaders in maternity services. That also includes, as far as the RCM is concerned, a director of midwifery who reports directly to the trust board. A director of midwifery should be sitting side by side with the director of nursing at trust board meetings to report on maternity safety issues and issues in maternity. Those issues should not be reported on behalf of maternity services by the director of nursing.

Q234 **Chair:** Thank you. We are currently training an extra 3,000 midwives, which is a 25% uplift on the number we were previously training. Do we know yet whether maternity units are going to have sufficient funding to actually employ those additional midwives?

Gill Adgie: No, we do not. We are not actually training 3,000 extra student midwives yet. It is a four-year plan. In 2019-20, the maternity expansion for student midwives set by Health Education England was



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650. In the next three years, it is an extra thousand. This year has been pretty difficult because of Covid, so they came in under 690 but they were very close to 690, which is really good.

It comes with challenges for the system. Obviously, there need to be sufficient midwives to train and support student midwives in practice. If they get a job at the end of their training, as Andrea said, they have to have strong preceptorship and support in the first year. We know that, quite often, when they come in as newly qualified midwives, the gap between the realisation of being a student and now a qualified midwife is really quite difficult and causes some fear for newly qualified midwives.

We believe that Health Education England is taking the right steps, but you absolutely hit the nail on the head by asking the question about funded establishments. Based on Birthrate Plus, at the moment our assessment would be that the NHS in England is 2,069 midwives short. Obviously, there is a programme for maternity expansion, but before Christmas NHS England said that there were 800 vacancies. We are not really sure, and NHS England is not sure, what the demand is. We do not know what the funded establishments are and whether there needs to be an increase in those funded establishments.

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

Q235 Chair: Basically, there is no national picture that says for every maternity unit in the country, "This is the number of midwives they need to have employed in order to look after pregnant mothers safely. This is the number they have, and this is the shortfall." That is what we do not have at the moment. Is that what you are saying?

Gill Adgie: If organisations all undertook a Birthrate Plus assessment, that would give them the number of midwives that they need to be able to provide safe care. Maternity services are complex. Birthrate Plus is based on one-to-one care in labour, but it also looks at antenatal and postnatal care, parent education, and antenatal clinic and day assessment. It looks at labour and birth. As I said before, sometimes more complex women, with more complex needs, need more midwife time.

We need to understand that the Birthrate Plus calculation makes a calculation around specialist midwives. We know that over recent years the demand for specialist midwives, for women with complex needs, such as diabetes, substance misuse and issues around FGM, has increased. We need more specialised midwives in services. That is a calculation that Birthrate Plus will give us as well. It is the gap, Jeremy, between what Birthrate Plus says and the funded establishments. What we know from



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our DOMs is that if a head of midwifery needs 30 more midwives in a service based on Birthrate Plus, when she goes to the trust board with a business case, it is quite often knocked back.

Q236 Chair: Gill, perhaps you could write to the Committee and give us some details as to what needs to happen on Birthrate Plus, what is not happening and what your recommendation would be. We would like to look at that very carefully, if we may.

Could I bring in Jo Mountfield on the point about staffing levels? What is happening well? What isn't happening, and what would you like to see happening?

Jo Mountfield: In terms of the workforce?

Chair: Yes.

Jo Mountfield: I would like to start by reiterating what Gill said. It is complex. If it was easy, we would have sorted it out by now. We have a very complex system of maternity units. Each maternity unit is somewhat different. What you have to remember is that the medical workforce are not just delivering on maternity. They also have gynaecology. What gynaecology and maternity undertake can be different in many different units, so working out what you need in terms of your medical staff is really complicated. If it was easy, we would have done it quickly and we would have sorted it by now, but we have not.

We absolutely have to bear in mind that we need to establish what the safe staffing levels are for the right outcomes for women, and for the right experience for women. We started some work in the royal college. What are we doing well? We set up a workforce group, but it has been a bit slow getting going because we have had other things to keep us busy for the last year, sadly. It is looking at the fact that we know we don't have enough workforce. We do not have enough doctors doing obstetrics and gynaecology. Even in our last workforce survey, in 2018, nine out of 10 trainees told us that there were gaps in their rotas at every level. We have a significant shortfall in the number of doctors that we need to run our service safely. We do not have accurate figures on what that looks like because we have not been able to do the work that can actually give us that information.

We have to be focused on safety. We think that is absolutely paramount. Soon we will be producing guidance on the responsibilities of consultants, which is key. We need to work out what we want people to do. We want to work out what they need in order to be able to do that. We can do this piece of work, and we could do it at pace, but it needs proper funding for us to do it properly so that we can work through the complexities of what is going on in the system. That would be my key recommendation, quite honestly.

Q237 Chair: Do we have a NICE standard at the moment for the number of doctors?



Jo Mountfield: No.

Q238 **Chair:** Is that work in hand?

Jo Mountfield: No, it is not. It is because it is so complex. The last piece of work that the colleges produced, about 10 years ago, was "Safer Childbirth". That was about the number of consultants needed to cover labour wards. It gave a standard that, if you had more than 5,000 births, you needed to provide 24-hour cover on a labour ward with consultants.

That has never been implemented. It has not been implemented for two reasons. First, the number of births is not an accurate way of working out what you need to do in a maternity service, because there are different complexities and different services. Some units that have 5,000 births will have tertiary foetal medicine units, which do complex referrals in, and others will not. They will be running district general hospital-type services. It changes from unit to unit. We did not have evidence that putting consultants on call 24 hours a day significantly improves safety. In order to fund that—it comes back to money again—you need to have 9,000 or 10,000 births in your centre to be able to put 24-hour cover on a labour ward.

We have pushed that. The presence of consultants on the labour ward has gone up significantly in the last 20 years. Consultants are needed there to oversee what is going on, but we need to do the piece of work that works out how we can give sensible recommendations that take into account the differences in maternity units, but allow people to understand what their shortfall is, and then to go back and say, "Do we have the money to do this?" Simplistically speaking, I do not think we have enough trainees coming through to give us the numbers we need. I do not think there is enough money within the—

Q239 **Chair:** But that is a job for NICE to do, is it?

Jo Mountfield: I think it is a job for the professions to do. Yes, it is for NICE, but we have to be front and centre. The obstetricians, gynaecologists and midwives and the people who run the MDT absolutely need to be front and centre of that to give the right information, so that we can make it happen. We could do it at pace, but we would need some funding to do it. That is what I am saying. We do not have that ability. Most of the work at the college is on the back of people who are doing it on a voluntary basis, as well as their clinical jobs, to try to move the profession forward. That is how it happens.

Q240 **Chair:** Colleagues want to come in, but we have a couple of other areas that we must cover this morning. First of all, I want to bring in a couple of people who are responsible for trying to improve maternity safety at the coalface.

Niamh Maguire and Daghni Rajasingam, I want to ask you this simple question. Since 2010, the objective is to halve baby death rates, stillbirths, maternal deaths and severe injuries. If we look at stillbirths,



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we have done very well. They are down by about a quarter. But if we look at neonatal death rates, they do not seem to have moved very much over the last decade.

What do you feel is actually happening? Are we making good progress on maternity safety, or has it stagnated? What are the challenges that you see? We will start with Niamh Maguire, who is the clinical lead at the Sussex local maternity system.

Niamh Maguire: Thank you for giving me the opportunity to represent the views of our local maternity system, which is on the south coast and covers a number of smaller units as well as tertiary centres.

To answer your question, we are continuing to make progress. I have to say that initially I was somewhat sceptical about our ability to make the changes that we have made, but I very much welcome the progress that has been made to date.

My understanding of the progress with respect to neonatal deaths is that some of these deaths are being recorded very early in pregnancy. We need to find a measure of which of these babies who are dying are at the limits of viability. Obviously, we have had some changes in guidance about that with the BAPM toolkit for babies from 22 weeks' gestation, which resulted from attempting to save babies at the very limits of viability. That is even more of a challenge if you are in a unit that does not have neonatal intensive care.

Data is key, as has been mentioned by a number of the previous speakers, including Jo. If we are working with inadequate data, we cannot necessarily answer the questions. That is my understanding of where the issues are. With respect to term babies, we continue to make progress.

Q241 **Chair:** Thank you very much indeed. Can I bring in Daghni Rajasingam, who is representing the Shelford Group, which are large teaching hospitals, for your perspective on whether we really are making progress and, if not, why not?

Dr Rajasingam: I want to take a minute to step back to think about what we are talking about. In maternity services, as obstetricians, midwives and clinicians, we are dealing with the extremes of human joy and tragedy. It is easy to forget that in the systems, processes and organisations that we have for trying to improve services.

You wanted to know what it was like to be at the frontline, the front face, of a big organisation, trying to deliver safe services in the best possible way that we can. For me, there are several things that are difficult. We have made absolute progress from 2010. The focus that you gave as Health Secretary has put maternity services under the limelight for the right reasons—to try to make positive change.



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However, there are some things that we have chosen not to address because they are difficult and complex, and they take time. We talk a lot about culture. What does it actually mean at the front face? If you ask a clinician what they understand by culture, they will give you 1,000 different answers. Do we break it down? Do we make it easy for people to understand how to improve culture? Do we focus on what is good? How do we learn together?

We have talked a lot about education, but we focus on postgraduate training. The way we are trained as clinicians at medical school and nursing school impacts hugely on how we see the world as we enter the world of providing care, and often dealing with the emotional burden of suffering. Thankfully, in our profession, we also have extreme joy. How do you marry those two, and how do you therefore make the best decisions that you can, not just for yourself as a clinician but within the team and the system?

Learning together is not just about individuals. We focus a lot on individual learning. We focus on the regulators who regulate us as individuals, but I see it more as a team sport and very much more around systems. How much systems learning do we have in our education? How much of it do we incorporate in postgraduate education? Almost nothing.

Quality improvement, for me, is around three key bits of culture: clinical excellence, operational excellence and the environment in which we function. Quality improvement capabilities, to enable the competency of staff and teams dealing with women and their families, are absolutely key.

Chair: Sorry Daghni, could you wrap up, because we want to ask some questions?

Dr Rajasingam: It is incredibly difficult to do what we need to be doing because of the burnout rates that we have, because of resilience and because of chronic understaffing.

Q242 **Chair:** For you, staffing is the key issue. Is that right?

Dr Rajasingam: Staffing is the key issue. Where we have staff, we can streamline the data provision that we have to give various different people. Something that came out clearly from the Shelford Group is that the burden of providing data in different formats to different organisations for different reasons, and not having the feedback looped to us, to enable us therefore to understand that data meaningfully, is a real issue.

Chair: Thank you very much indeed.

Q243 **Dr Davies:** Continuing on the topic of staffing, Jo Mountfield, you talked about the complexity of requirements for staffing. For clarity, it is not just consultants, is it? It is also midwives, and paediatricians presumably. Do



you have a list of all the professions that you think might be considered?

Jo Mountfield: A list of all the professions? In the acute labour ward setting, who do we have there? We have midwives; healthcare support workers; theatre staff; theatre practitioners; anaesthetists, who are a really important part of the multidisciplinary team; paediatricians; and advanced nurse practitioners working in the paediatric team. I could go on and on. It is a wide, multidisciplinary team that deals with many aspects of looking after women, right from the moment they get pregnant to the minute they leave our service. It includes physiotherapists.

A huge number of different people provide that service. It is complex. It is not just about doctors. It is about the whole team coming together and providing a seamless service. I can give you a list. I can write it down for you.

Q244 **Dr Davies:** I have worked in a labour ward myself, so I have a rough idea.

Jo Mountfield: Very good. I hope it was a positive experience.

Q245 **Dr Davies:** From what you are saying, now is not the time for national mandatory staffing levels to be imposed, because we simply do not know what those should be, and there is so much variation between units.

Jo Mountfield: Yes. You cannot come up with a simple figure: "If you have this many babies, you need this many obstetricians." That is not the right way to go about it. There is a way of going about it, and we are really happy to be involved in that, but it has to be done properly. The danger of not doing it properly and just coming up with sweeping generalisations is that people focus all their attention on meeting the national standard because we have been told we have to meet it, and then something else is lost; you are losing another vital bit of the service because we do not have enough staff to do other bits as well.

If we are going to do it, let's do it properly and get some real nuance around it, and support our multidisciplinary teams to get the right workforce, so that we have the right staff in the right place doing the right things to make the safest service we possibly can. That is what we are all in it for. Absolutely.

Q246 **Dr Davies:** Great. Do you think there are any learnings from other professions in the UK in terms of minimum staffing guidance, or from abroad when looking at obstetrics?

Jo Mountfield: There is not an awful lot abroad. There is some interesting data from the American College around what maternity units can provide. They have different tiers of maternity units. There may be something for us to look at there, but we run a different service from other countries. That comes back to the point about the clinical negligence scheme not being exactly the same. We have to do something



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that is bespoke for us. That is not to say we should not look abroad for ideas to being back.

Within our own community and within doctors in this country, yes, of course other people have done some work around staffing levels. That has tended to be in less complicated areas of work. It is much easier if you are doing one job. If you are an ED consultant, you go and do ED. You do not do colposcopy, the labour ward one day and then an antenatal clinic, and so on. It is more complex.

Q247 **Dr Davies:** Gill, I see you nodding. Do you have anything to add?

Gill Adgie: Just that I agree with Jo. One of the things that she missed off her list was ultrasonographers. They are obviously important in maternity services, supporting the multidisciplinary team. There is a shortage of sonographers. Health Education England, through workstream five, has been doing some work trying to increase those numbers, but I think there is still a way to go to support all the services that are required.

Q248 **Dr Davies:** In terms of this Committee making recommendations, would you suggest that we need to encourage Government to provide funding for studies to take place to look at staffing?

Gill Adgie: Yes.

Jo Mountfield: Definitely.

Dr Davies: Thank you.

Q249 **Taiwo Owatemi:** My first question is to Jo. It is around the role that technology can play in addressing workforce shortages as well as reducing the current workforce load. We have seen the benefits of technology, especially during the Covid crisis. Do you have any thoughts on using further technology, particularly AI, in addressing some of the challenges around workforce shortages?

Jo Mountfield: Was the question about cyber-technology? I missed the word.

Taiwo Owatemi: It is around AI and any role that technology can play in addressing the issue of workforce shortage and workload.

Jo Mountfield: Technology can help us, certainly, as we look towards how we train people in future. There is certainly more work that we can do to look at that. One of our real anxieties at the moment is the lack of training that our trainees have had in gynaecology, which is going to stop them becoming consultants in a timely way and will have knock-on effects for the workforce.

From the training perspective, yes, definitely I think it is going to help. We are looking at ways in which we can deliver our services differently. Remote consultations, of course, have taken off astronomically over the last few months. We need to look at where that is the right thing to do



and where it is not the right thing to do in terms of streamlining. It works well for some women, but it may not be the answer for all. There is work going on to look at that.

Decision-making tools and those sorts of ideas are all things that can help us to move the profession forward. We need to be looking for that support, but fundamentally for me—I will say this—obstetrics is an art form. It is less of a science and much more of an art form. That may sound strange, but it is about putting women at the centre of their care. It is about personalising it for the individual woman, and you can only do that if you have human interaction.

Yes, there is a place for those innovations, and we need to be looking for them. We need to use our workforce so that they are working at the top of their licence, if you want to call it that. Let's use their skills in the best possible way. Artificial intelligence may well be able to help us with that.

Q250 Taiwo Owatemi: My next question is directed at Dr Rajasingam. It is about something that has been covered already—complexity with regard to addressing the cultural problems within maternity services. What factors do you think contribute to the culture that prevents learning?

Dr Rajasingam: I think it is multifactorial. As Jo alluded to, obstetrics has always been a bit of an art form. That is not to say that there is not a lot of science and that we cannot reduce the variation with which we do certain things. It is the additional bit around personalising care and understanding the situation that surrounds a woman and her family. It is understanding why she is asking for certain things, although they may not be what we, as a system, think would be safest for her.

I think our basic understanding of the drivers of culture is not there. We have not explored them appropriately in maternity services because we are very reactive in our response. When bad things happen, they tend to be tragedies. Our instant reaction to that is to sort it out and to have a here and now solution. That does not work for culture change.

Each time we do that, we impact hugely on the workforce, the resilience of the workforce and the resilience of teams. We are not paying enough attention to that.

Q251 Taiwo Owatemi: Do you have any examples of where a team or service has been able to nurture a culture that avoids blame and creates a safe learning environment for the delivery of the service?

Dr Rajasingam: In my organisation, speaking from a Guy's and St Thomas's point of view, one of our key values is respecting others within a just culture, so there is a lot of work going on across the organisation to try to get people to understand what we do as a team. It is a team sport. We make mistakes, but when we make mistakes we have the onus to learn from them. Are we learning at an individual level? Are we learning at a team level? Are we learning at a directorate, a service, level?



The reports that HSIB provide give us an overview. I can look within my own service at how we are trying to implement a just culture. I have external bodies; for example, HSIB might give me information on whether I am doing it well, or whether or not there is an issue. It is critically important. We have talked about the complexity of delivering services. In maternity services, we have a huge amount of social complexity. At Guy's and St Thomas', 25% of women who book with us have significant social complexity, and that plays into how we can keep them and their babies safe.

Then there is the issue of diversity. There is diversity in how we deliver stuff. There is diversity in the patient population that we choose to serve. There is diversity in our staffing groups, but there is a lack of diversity in the leadership of maternity services. When we have the disparate outcomes that we know about—I know that you as a Committee have heard from BAME women—in this country where we have free care for all women, we need to address those. We need to make services safer for that very vulnerable group of women initially. Then I am sure that we will start learning systems issues and will make services safer for all women and their babies.

Q252 Taiwo Owatemi: My last question is about maternity voice partnerships. Much of the evidence submitted by the local maternity systems emphasises the importance of having diversity with regard to BAME women, as well as patients from lower economic backgrounds, within the maternity voice partnership. What do you think are the barriers preventing that? What do you think can be done to address those barriers?

Dr Rajasingam: That is an absolutely key issue. Whose voices we hear, and how we hear them, is really important. We are not very good at co-producing and co-creating solutions and designing services. It is not inherent in the way our system has been set up.

What are the biggest barriers? One of the biggest barriers is not just providing creche facilities, so that all sorts of women can take part in a maternity voice partnership, but remunerating women for their effort, treating it as a job, valuing it and therefore paying for it. We do not have any set systems across the country. You will know that my area of south-east London is one of the most deprived boroughs. We have a lot of women from diverse backgrounds who are keen to be involved but do not know how to make their voices heard. Some work around that is absolutely critical.

Taiwo Owatemi: I agree that there has to be more information available to inform them about how they can join and be involved in being maternity voice partners. Thank you so much for your time.

Chair: Thank you. Gill Adgie wants to come in, and I will bring you in, Gill, but I want to bring in Paul Bristow. We have not forgotten Sara Ledger, who is going to give us some very important insights into training



in particular and, I am sure, other things too.

Q253 Paul Bristow: I want to return to Jo and Gill, and talk about workforce and service reconfiguration. When other clinical areas have undergone that type of review, it has typically led to fewer but larger centres doing more work. Instinctively, do you think that is what will happen with this if there was a service reconfiguration?

Jo Mountfield: There has already been some reconfiguration in parts of the country. If you look at the Greater Manchester area, they have done a big reconfiguration of services that has worked really successfully because it was done in partnership with the public and they have taken the public with them. That is not the case in all parts of the country.

As we know, generally the public want to keep their services local, in the same way as they have done before, yet we know that we do not have enough resources in the workforce to service that. If we want to provide safe, high-quality care, we have to be able to explain to the public that moving maternity services will still give people options. If you are somebody who has had a straightforward pregnancy with no factors, you can have a choice of birthplace, from home right the way through to the tertiary referral centre.

We have to talk to women and give them the information to make an informed choice about where they want to have their babies and where they want to have their care. I very much back up Daghni on this. We really need to take account of diversity and where we have inequalities. We should be focusing our efforts and putting our services where we are going to make the most difference.

You are right; that means we may have to think about rationalisation. As you approach that, it is always a very long, very complicated and very difficult thing to do, because generally people do not want to change the services they have locally. They perceive them as being the best and easily accessible. It is a difficult one to square.

Q254 Paul Bristow: It certainly is. Do you want to comment on that as well, Gill?

Gill Adgie: I don't disagree with Jo. It is very difficult. Big is not always best, and we have to look at the service as a whole. It is really important that women's choices and what women want is central to whatever we do. It is important that there is communication with women. When you are pregnant, you are just interested in maternity services at that point in time. You might come along and have another baby in two years' time, and you think you are going to go to your local hospital, where you went last time, only to find that actually you now have to go 10 miles down the road to a much bigger unit. You are quite often only really interested in maternity services when you are actually pregnant.

Daghni talked about MVPs. MVPs are really important, and it is important that they are diverse so that we reach all parts of our communities and



give all women choice and information about maternity services. There is an issue around remuneration. Chairs in many of the MVPs get remuneration for that role, but in others they do not. That is really important and may be something that the Committee could recommend.

Q255 Paul Bristow: Thank you. I agree with you in the sense that, if services are rationalised at fewer centres, it is going to require a lot of very sensitive communication.

I was perturbed to hear—I think Jo said this—that 10 years ago you made some recommendations about 24-hour centres and 5,000-birth centres, but that they were not implemented. You said that one of the reasons was that it was a complex picture, and I get that, but would you explain a little bit more about why those recommendations were not adopted by trusts, and what needs to happen to ensure that any future recommendations you make are implemented?

Jo Mountfield: There needs to be money to fund it. It is as simple as that. It really is as simple as that. It was unaffordable for most services of 5,000 births to put consultants on labour wards for 24 hours a day because it is very expensive. We are expensive as consultants, and putting people on for night shifts is a really expensive way to do it. We have very reasonably priced doctors, called trainees, and locally employed doctors, for whom it is much cheaper to work out of hours. That is what it boils down to. We do not have the money in maternity services to implement that.

That was one reason, but there is a second reason as well. We did not have evidence that 24-hour cover in all those units was going to significantly improve safety. Was it going to absolutely improve the quality of what was going on? Was that the best use of their time? We still do not have evidence about a 24-hour consultant presence.

There are two reasons. There wasn't sign-up from the profession, in the sense that there wasn't the evidence. They did not see it as absolutely essential that we move to that. Interestingly, some units tried it and then moved back again, away from it, because they found that the whole process of trying to move to it undermined the culture in their department, and the sense of equality around the consultant body.

There were some real issues around that particular thing. To me, it comes down to being much more nuanced about it. We have to look at what the safest staffing is to get us the best outcomes. That was too simplistic. We do not know what the answer to that question is. We have to answer the question, and then we can put in the recommendations. But they need to be funded.

Q256 Chair: We still have a couple of other members of the Committee who want to come in. Gill, do you want to say something?

Gill Adgie: On the question of funding, it is important that funding for maternity services actually reaches maternity. Our directors of midwifery



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tell us that funding for maternity services is quite often siphoned off by directors of finance to help and support other services in big trusts. It is important, and may be a recommendation for this Committee, that maternity funding actually gets to maternity services, to improve maternity care and to improve safety.

Q257 Chair: Funnily enough, that is something we may be about to hear a bit more on from Sara Ledger, who is head of research at Baby Lifeline, which is a charity that did a lot of training under the previously existing maternity safety training fund that has now been wound up.

Sara, from your involvement with that fund, what insights did you get about how training can work, how it can work well and how, sometimes, maybe things go wrong?

Sara Ledger: Thank you so much for having us on the panel today. What everyone has said so far completely mirrors what I am about to say.

As you rightly said, we were one of the leading providers of training from that fund. We found that a lot of the money that went out for training did not actually go to the teams and was not providing training. Some hospitals used it for other things. I completely agree with what Gill said about making sure that funding that goes towards training is actually spent on training.

What Professor Walker said earlier about implementation is absolutely accurate as well. We found from our own research, "Mind the Gap", that there are a lot of national recommendations at the moment about improving care—for example, the Saving Babies' Lives care bundle, which is evidence-based best practice in trying to reduce stillbirths, neonatal deaths and brain injuries. Pre-term birth is the new addition to that.

We found that fewer than 8% of trusts were providing the training elements of that bundle. What we try to say is that, if you want to develop and change practice, you need to make sure that the frontline who are delivering care to women actually have training in what they need to be doing. The MBRRACE report that came out last week showed once again that around half the deaths of mothers and babies could have been prevented with different care. When you drill down into what that looked like, again national guidance had not been implemented at the frontline.

We are saying that you need funding for training to happen. The main barriers to providing and attending training for the frontline are funding related, staff related and resource related. It is even as simple as just accessing rooms on site so that professionals can attend the training. It is as simple as that.

Q258 Chair: Baby Lifeline has huge experience over many years with the very sad and complex issues that happen when you lose babies. What would be top of your list if we were really going to crack this problem and have



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Swedish levels of safety in our NHS maternity units?

Sara Ledger: I don't think it is as simple as one topic. We heard earlier about foetal monitoring, and obviously that is really important, and a lot more work needs to go into what good foetal monitoring looks like.

I actually think it is lack of standardisation. What we found from our research was that trusts provide various things in various content. For example, the leading cause of death in mothers is heart disease, but fewer than a third of trusts provide training in heart disease. There are trusts that have the memo on that and are providing the training, and then there are trusts that have not.

We have to be mindful of making sure that the training that is provided is meaningful and impactful. Fewer than 9% of trusts told us that they assess all the training that they do. When we drilled down to look at what that assessment looked like, it was at a very basic level. That is not because they do not want to assess it. It is probably because they need support in what assessment looks like.

We have had a few professionals come up to us and say, "Could we look at how you assess your training so we can do that in our own trust?" We have to make sure that we constantly keep on top of that, and that professionals are being released for training, which they absolutely should be, and their time should be protected. It should be a meaningful use of their time and they should gain something from it. Anecdotally, we have heard some of our professionals say that they attended training in adult resuscitation, where there were mannequins on the floor and there was a video playing. There was no one assessing it, and no one there to overlook what they were doing. Why are they there if there is no meaningful assessment of what they are doing?

Q259 **Chair:** That is very helpful. Niamh Maguire, do you have some comments on what you have been hearing?

Niamh Maguire: It is really valuable to hear Sara's evidence about training. I agree with a huge amount of that. There are all sorts of things. It is not just money. It is staffing, which we have all talked about; it is time, space and job planning time. Money is enormously important, but it is not the whole story.

Getting to the complexity of training with human factors, we talked about standardisation, which is really important; we have noticed huge variation across our local maternity system, which is a relatively small area. There are differences in funding for training and differences in content. Sometimes that is reactive.

It goes to a larger point that we see with all of the reports and recommendations. They are welcome, and the scrutiny, attention, energy and passion is very welcome, but it puts a huge burden on the trust. What we would like is fewer but more focused recommendations that perhaps have been tried out in practice before they are implemented



nationwide. Jo and Daghni talked about evidence. Perhaps we could see evidence that these things are going to cause improvements. That would be helpful, so that we had a little bit more focus.

The other thing I would like to mention is what Taiwo brought up about complexity. Given the FIVEXMORE and MBRRACE findings, we want to focus on the women and babies who are at highest risk. We have already heard from Charlie and others about our staff being potentially at risk as well in lots of different ways.

One of the things that we need to acknowledge is that sometimes things have perverse incentives. A well-intentioned initiative like focusing on continuity of carer with midwives can result in those brand-new midwives, who we are so proud we are training, being pushed out into the community and given enormous responsibility at a very early stage in their career. That can result in them feeling unsupported.

I am not saying that labour wards are always a supportive environment. We have heard that that is not always the case, but we need to acknowledge that sometimes we are putting people under a lot of stress in these circumstances, with the best of intentions.

Q260 Rosie Cooper: I want to ask Gill and Jo a question relating to priorities. At the last Committee, I asked the panellists to indicate how they would see their priorities against the costs of them. For example, when I was chair of Liverpool Women's hospital, the cost of the CNST premium for each birth almost used up the whole NHS tariff. We were approaching an unsustainable situation.

Baroness Cumberlege comes along and talks about named midwives and teams. We tried to implement that. As your panellists suggested, the costs were difficult. We found that to implement it properly could cost us nearly £1 million per team, and we had nine, so that did not go ahead. You have talked about making sure that the costs are there to cover it, but we have huge competing ideas. For example, you have talked today about 24-hour consultant cover, appropriate staffing levels, named midwives and midwife care units. How would you see those priorities relative to the costs of implementing each one of them? What do you think we should do first?

Jo Mountfield: Fabulous question. The answer is that we need a wider view of what those priorities are. I can tell you what I think the priorities are, but it comes back to the idea of complexity. If we use continuity of carer, for example, of course having continuity of carer for every woman is a really good idea, but the reality of delivering that—I say this because I chair an LMS as well—is really challenging. It boils down to not just the cost but midwives wanting to work in that way.

We have to have a balance. We need to think about who really needs continuity of care. It comes back to the areas of deprivation, socioeconomics and social and mental health, and those from BAME



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backgrounds. Those are the women who really benefit from continuity of care. I do not say that everybody would not like to have it, but is it really achievable? There has to be more nuance around that.

In terms of obstetricians, we still do not have the best bang for our buck. There is work that we need to do to say, "Is every obstetrician doing what we need them to do in order to promote the best and safest service?" It goes back to my original plea: let's have a concerted piece of work to look at this and to come up with some meaningful recommendations that the profession can sit alongside us with and say, "Yes, we can sign up to this; this seems really sensible," because we have all been involved in producing them. We have to have women at the front and centre of that.

What are the priorities? Obviously, staffing labour wards adequately is a big priority for us. One-to-one care in labour for midwifery is important. Having the right cover on labour wards is important from the obstetric point of view, as is having the right anaesthetists and neonatologists to be able to deliver the service. Your focus has to be on the acute stuff, but if you do that at the expense of everything else, you will not get the outcomes that you are looking for. It goes back to my original point; we need to look at safer staffing for both outcomes and experience. I am not sure that we have those recommendations right yet.

Can I say one more thing about training? I was going to come back to it; it is a two-second point. We have a really good innovation in my LMS called the Wessex Maternity Academy. We have brought together all the training across the whole of our LMS and shared it. We have a website with everything on it. People from different organisations can access other people's training, so that there is a real standard that we are all working to, and everybody can access it around the patch. It is a good model that we could help roll out in other areas as well. I wanted to throw that in as an example of some good practice for you to be able to pick up on.

Q261 **Rosie Cooper:** Thank you. Does anyone else have any opinions? This will be very valuable when we try to weigh up the priorities. It is easy to pick choices such as named midwives, which we would say everybody would need, but I know how absolutely difficult that is to make work.

Chair: Shall we ask Gill Adgie to talk about that? She is waving her hand.

Gill Adgie: Thank you so much. It is important. Maternity services have made great progress in the last few years around better births and trying to implement continuity of carer, but it is only a small part of better births and how we make our maternity services safer. A lot of emphasis has been put on that. What we have to keep in mind is that obviously the very best outcomes and safe outcomes for women—going back to what Jo said—mean making sure that we staff our labour wards appropriately with the right staff in the right place at the right time. It means being



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able to give women choices, and focusing on women who would really benefit from continuity of carer.

It would be wrong of me, as the RCN, not to say that it is important that we consider the work/life balance of our members and everybody in maternity services. We have talked at great length this morning about cultures in maternity services. Midwives, obstetricians and anaesthetists feel quite burnt out at the moment. That is not just because of Covid. They have had the extra impact of Covid, and we are seeing it more in maternity this time around than we did in the first wave.

The health and wellbeing of our workforce across the board, not just in maternity services but across the NHS, is important. We need to tackle the issue around culture. We have tried to implement great change in maternity services, when actually we did not have enough staff. They are feeling demoralised and overworked. Eight out of 10 of our members told us in November that they did not believe that there were enough staff on their shift to be able to provide a safe service. That is 83% of our midwives that we surveyed.

It is important that you feel safe and secure in your job. I was a labour ward co-ordinator many years ago. It is a very stressful environment to work in.

Chair: Thank you. We are coming to the end, and we have some final wrap-up questions from Barbara Keeley and Laura Trott.

Q262 **Barbara Keeley:** I want to ask Sara to say some more about training. Clearly, the position is very uneven. Cardiovascular training is covered in less than a third of trusts. Emergency skill drills are only in 25% of trusts. There are fewer than 8% of trusts providing all the training set out in the Saving Babies' Lives care bundles. What changes do we need to standardise the content and quality of training? Clearly, it is happening in some places, as Jo referred to, but what can we do to do better than those figures, which look awful?

Sara Ledger: I agree that they look awful. It was quite surprising when I was conducting the research. I was constantly checking to make sure that it was accurate.

One thing that is happening at the moment, which we are really excited about, is that a core curriculum is being put out across maternity services. What we are quite worried about with the core curriculum is that it will not be funded. I said earlier that one of the main barriers to attending and providing training is having the funding to do it. If you are going to put this core curriculum out, fantastic, but make sure that there is funding to support people to attend. That means protecting their time. Many members of staff and professionals come on our training and are pulled away in the middle of the day because they have to go back on to a labour ward. That is one thing that is important.



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Another thing, which came across as Gill was speaking, was people feeling valued. What we found from the last fund was that people were coming up to us and saying, "It is so nice to be on a training course that is expert led and is not being paid for by me, and I am not attending it in my annual leave." We still have people all the time having to attend training in their annual leave and pay for it themselves. That is not a valued workforce. That is something else that we think needs to happen.

The work that Jo is doing in her LMS is amazing. That kind of communication between different trusts is really important. Another important area, which we find from our own training, is that you have expert-led national opinion as well, so that you have the people writing the guidelines delivering training to LMS leads or the frontline in general.

Q263 Barbara Keeley: Those are all important things. How can we ensure that training results in improvement to safety? You talked about the resus course that sounded hopeless, with mannequins and a video running. Nobody is going to be impressed by that. How can we link training more to safety, and make sure that we get the improvements we want?

Sara Ledger: Something that needs to happen is general quality assessment of training and making sure that people are learning, and that that knowledge is assessed, confidence is assessed and competency in general is assessed. Professionals who do not feel competent and confident in some things should not be doing them because that is where mistakes happen, and that is where tragedies happen. We think that generally assessment needs to be better and more wide-ranging across a number of topics.

The other thing that needs to happen is to look at the data. The hospitals we work with that do well on that look at where they might be slipping up or might need to improve something. They provide training, and then they look back at their data and decide whether it has got better or not. Simple quality improvement structures can tell you if it is working.

Q264 Laura Trott: In the course of this panel we have talked about the importance of making informed birth choices. I want to dig into that a little bit more, to see whether there is anything that the panel think can be done to improve the information that is given to mothers about what their birth choices are, and what more can be done centrally to help. I would like to direct that to Dr Rajasingam in the first instance.

Dr Rajasingam: Thank you; it is a key question. In giving a person choice, you are opening up a service to potential issues. I will give you the example of maternal request caesarean section, which is the one that everyone talks about.

I absolutely want to give every woman I look after the choice to have a caesarean section, if that is what she chooses, having all the information on board. That is on the one hand. On the other hand, as head of service in my directorate, I am penalised for allowing that woman to have a



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caesarean section. One of the key parameters and metrics that we look at is the caesarean section rate as a whole. That is not intelligent data.

We have the Robson criteria. We have caesarean sections in different groups. What we should be focusing on when we look at the organisation is, are you doing the right thing for that particular group of women, and can you show that you are doing the right thing for that woman and giving her the best choices? There is something about marrying up the way in which we measure our metrics of good and high-quality care and the way in which we offer choice. We need to—

Q265 **Laura Trott:** I do not want to interrupt you, but when we are thinking about recommendations from this Committee, what should we take forward? Should we remove the caesarean section rate as one of the things that we monitor trusts on? How do you think it should be changed?

Dr Rajasingam: We absolutely need to look at caesarean section rates but in a much more intelligent way, using the Robson criteria. If you remove the broad caesarean section rate, you enable clinicians to have a very different conversation with women wanting to explore that. My experience as a frontline clinician is that often women come in wanting an elective caesarean section, but what they actually want is a degree of control over their labour. They want a degree of assurance that, if things do not go according to plan, they will be able to bail out and that we will be supportive. That is a very different conversation from, "Yes, I want a caesarean section." "Okay, you can have it," or, "No, we do not do it in this organisation."

Q266 **Chair:** I am sorry to interrupt. Can you just explain what you mean when you say you are penalised by advising someone that they can have a C-section?

Dr Rajasingam: The penalty is for the service and the system. Every caesarean section that we do contributes to our caesarean section rate. Traditionally, one of the ways in which units were assessed was on their caesarean section rate. That is not the way forward, and many things are changing. Across our LMS, we now collect the data for the various Robson criteria, so that we are intelligent. We can say, "Well, in this group, with elective caesarean sections, we are expecting the group to expand a bit because we are giving women more choice." The difficulty is with informed choice. It is about shared decision making, giving the right information, and giving the right information to all sorts of women, across different social classes and across different educational attainments. The way in which we impart information is not always appropriate for the group.

Q267 **Laura Trott:** Gill, do you want to say something on that question?

Gill Adgie: Thank you, Laura. It is a really good question. It is important, because it is about workforce, which we have talked about a lot this morning. It is about having enough workforce, enough midwives and enough obstetricians to make sure that we can have conversations with



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women, from an early stage, around informed choice and what their options are.

We do not want a 10-minute appointment where women feel rushed, or they do not want to ask the question because they can see that the midwife is rushed. They come to antenatal clinic with 10 questions, but they can see how harassed and overworked the midwife is, so they just ask the three questions at the top of their list because they know they only have a 10-minute appointment. It is about having enough staff in the right places and enough time to be able to have those conversations with women.

Q268 **Laura Trott:** Thank you. Niamh?

Niamh Maguire: I want to ask very briefly whether Daghni, Gill and perhaps Jo feel that having a director of midwifery sitting on the board would put to bed once and for all this horrid question of being monitored, and having our feet held to the fire on caesarean section rates. That is not the measure we should be looking at.

There are some advantages in working in a smaller organisation. It is sometimes easier to have your voice heard, but maternity is always a small part of our constituent organisations and our voice is not necessarily heard. Having a voice on the board is really important.

Q269 **Chair:** Let us bring in Daghni on that one. I am afraid we will not have time to bring in everyone because we are coming to the end of the session. Daghni, do you want to comment on what Niamh said?

Dr Rajasingam: I do. Board representation is really important, but what is even more important is the data we are giving the board in order to make an accurate, meaningful assessment of whether services are good and safe, and delivering what women need.

Chair: Thank you very much indeed, everyone. That brings the session to a close. We have had an absolutely fascinating two panels. We thank both sets of panellists for their contributions today, but particularly on this panel, thank you, Sara Ledger, Niamh Maguire, Daghni Rajasingam, Jo Mountfield and Gill Adgie, for your excellent evidence.

I want to finish, if I may, by congratulating Baby Lifeline. It is your 40th anniversary this year and was set up by your mum, Sara. I am lucky enough to have met Judy; she is a real force of nature, and she set it up 40 years ago. Many congratulations on all the brilliant campaigning and on the babies' lives that you have saved in that period.

Thank you all for giving evidence this morning. That concludes this morning's session.