HOUSE OF COMMONS

Health and Social Care Committee

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

Tuesday 2 February 2021

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Watch the meeting

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

Questions 270 - 325

Witnesses

I: Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care; William Vineall, Director of NHS Quality, Safety and Investigations, Department of Health and Social Care; Sarah-Jane Marsh, Chief Executive, Birmingham Women's and Children's Hospital, and Chair, NHS England Maternity Transformation and Children and Young People Transformation programmes; Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health, NHS England; and Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer, NHS England and Improvement.

Examination of witnesses

Witnesses: Nadine Dorries MP, William Vineall, Sarah-Jane Marsh, Dr Jolly and Professor Dunkley-Bent.

Q270 **Chair:** Welcome to this morning's Health and Social Care Select Committee, where we are looking into the issue of maternity safety in NHS maternity units, following some big issues uncovered at the Shrewsbury and Telford and East Kent trusts.

We have a fantastic panel of people here who know a huge amount about this, led by our Minister of State, Nadine Dorries. Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent lead the NHS's maternity transformation programme, which aims to halve baby deaths and baby injuries by 2025. Sarah-Jane Marsh heads Birmingham Women's and Children's Hospital, which is one of the safest and most successful maternity units in the whole of our NHS. From the Department of Health and Social Care we have William Vineall, who had the dubious privilege of being in charge of patient safety during my time. Thank you all very much indeed for joining us this morning.

I start by thanking you on behalf of all of us for your incredible hard work during the pandemic. People do not stop having babies during a period like this, and we all understand what a huge task it has been to keep the show on the road during such a very difficult period. We would be grateful if you could pass that on to your teams.

Let me start by inviting the Minister of State, Nadine Dorries, to make a few opening comments. We will then move on to some questions.

Nadine Dorries: Thank you very much, Chair. We will indeed take back your thanks to the Department. I would also like to thank you and members of your Committee for your work on this inquiry. Safety of maternity services is an extremely important issue. It is a priority for me, so I very much welcome the Committee's interest.

I would like to give an example to demonstrate how much of a priority it is for me. When I first arrived in the Department of Health and Social Care as an Under-Secretary 18 months ago, I set myself five targets. No. 1 on that list of targets was to introduce national screening for group B strep, which is the UK's most common cause of life-threatening infection in new-born babies. It most often causes sepsis, pneumonia and meningitis, and is the leading cause of meningitis in children under five.

On average in the UK, at least one baby a week dies from GBS infection, and 70 a year are left with lifelong disabilities as a result of contracting meningitis or sepsis in their first days of life. I urge that we all take note of that devastating infection. I note the hugely important work undertaken by the charity Group B Strep Support, who have worked tirelessly for 25 years to try to improve the UK policy on group B strep. Their campaigning saves vital lives. It is a major issue for me, and one that I continue to work on.

I believe that all pregnant women should receive testing for group B strep, using the gold standard enriched culture medium test, at 35 weeks' gestation. That is why, campaigning on it within the Department, within months we managed to launch the universal screening trial to compare group B strep with the usual risk-based care that is used in the NHS at the moment. As a result of that screening, the UK National Screening Committee will review its recommendations in light of the evidence and the trial after it reports. While women are being tested for group B strep, I am keen that the opportunity is used to scan them at 35 weeks' gestation so that breech babies are picked up early. I am aware that that is also being considered in the March proposal.

I will stop there, Chair, because I do not want to take up additional time on opening remarks. I am sure there will be lots of questions.

Q271 **Chair:** You mentioned the charity Group B Strep Support. In some research that was published yesterday, they found that only 13% of trusts are conducting tests in line with PHE and royal college guidelines. I know that you have written to all trusts asking them to make sure that they are doing that. Is there a deadline by which you are expecting all trusts to comply with those royal college and PHE guidelines?

Nadine Dorries: Yes. We were aware of that a short time ago, but obviously Covid has impacted on all areas in the NHS, including maternity. I wrote to all CEOs of trusts last week. The deadline is the day they received the letter, and it should be on every CEO's desk now. There is absolutely no reason why the £11 test, using the enriched culture medium, which grows the bacteria overnight, cannot be used in place of other tests that give an immediate result but may not be as accurate. I have asked all of the trusts to ensure that they are using the ECM testing as of the moment they receive the letter.

Q272 **Chair:** Thank you very much. Let's move to broader questions. I want to start with something that probably shocked a lot of people more than anything else about the Shrewsbury and Telford issues that Donna Ockenden is looking into, and that is just how far back those issues appear to go. When I launched that inquiry, we knew that some of the issues went back as far as 2008-09. It now looks like some families were affected in the 1990s. I want to ask you a general question. Why do you think our national systems have not been as good as they need to be at spotting these issues earlier?

Nadine Dorries: I will try to keep my answer as succinct as possible because there are many areas of that issue that I hope we can cover during the morning.

I would like to begin by saying that, yes, that did happen, along with the fact that, when incidents took place that were avoidable harms to babies or mothers in maternity units, it took parents a very long time to get to the point of having those investigations looked into, issues considered or even getting an apology from a trust.

You are absolutely right. The Ockenden report has gone back over many cases where the parents probably did not get any resolution even when they made a complaint. I do not think that would happen today. We can look at East Kent and the systems in place now, such as HSIB, CQC and others, that have demonstrated that we can move very quickly.

I think culture is at the heart of many of the problems that we face in maternity. You mentioned staff. I had both a visual and an oral demonstration of just how entrenched that culture can be. Obviously, I went to visit SaTH myself to look at the maternity unit and to speak to the midwives, the clinical lead and the obstetricians. That was after the board had very much changed. There was a new CEO in place, and they were very much under way with a new programme of support, amelioration and training. A huge amount had taken place, but as I arrived at the hospital I was told immediately, "We are going to take you to the midwife unit first and then we're going to take you to the obstetrician-led unit."

I was shocked by those words in my introduction. Surely, the core problem that we identified was lack of collegiate working. The old days of the midwife putting her foot on the door to stop an obstetrician coming into the room, and saying to the mother, "Come on, don't let the doctors get this," have surely gone. It appeared to me that, although we may not be at that stage, there was still a visual and cultural separation of the midwifery unit and the obstetrician-led unit. Therefore, we are not at the place where we should be. It should be the safe birthing unit, or the delivery unit. The fact that that culture is still there means that we still have issues to address. I hope that we and some of the team can have the chance to explain to you some of the measures that are in place. I am very confident that we are well on the way to resolving that.

Q273 **Chair:** Thank you. We will come back to you on that, but I want to bring in Sarah-Jane Marsh on this point. Do you agree that we are much better now at picking up these issues more quickly and that the reporting culture has changed? Why do you think, none the less, that it took us over 20 years to uncover some of those issues in one NHS trust?

Sarah-Jane Marsh: Thank you, and good morning everybody.

It is tragic and terrible, and our failure to be able to pick this up over many years has no doubt led to avoidable harm. That is devastating to all of us involved in maternity transformation because it is the absolute opposite of what we are trying to achieve. We came into the picture in 2015 with the publication of "Better Births". There were so many different things that we knew we needed to bring together, essentially, to reverse that.

Some of it is about culture, as the Minister was just saying. We have to have transparency of data, and staff willingness to engage, and be open to things that go wrong and to change in the units themselves. That is the absolute priority. Everything that we layer on top of that is

important—I will talk about that in a minute—but we know that the safest organisations are the ones where the teams themselves review the data and look at what has been proved. Through maternity transformation, we have been encouraging that, with the training we have done and with the development work we have done with individual units.

Over the last few years, we have moved towards safeguards for places where things are going wrong. We have a whole variety of mechanisms to review the data, both at the local maternity system level—everybody in a local area delivering maternity services—and at the regional level, where we now have chief midwives embedded in all the NHS regions. We also have it at the national level, where we have a national oversight committee that can look at not just the data but the intelligence that all the different stakeholders have, for example, from CQC reports, HSIB investigations and the information that the colleges and Health Education England might hold. We have that hard and soft information coming together in one place.

I feel a lot more confident that, if there were similar issues now in an NHS trust in England, we would, first of all, have a culture where trusts themselves would address them, and then we would have safeguards at the regional and national level. Could I tell you that they are 100% foolproof? I have yet to find any quality surveillance system, based on data and intelligence together, where you can absolutely guarantee every time that you will know of every unit. That is why we are never complacent about what is next. We are scanning for best practice, not just in this country but across the world. If there is anything else that anybody else is doing, we will do that.

We have come a very long way over the last four to five years. We almost celebrate now when we find that there are difficult issues. We celebrate that we have found them and that we can address them quite quickly with that level of transparency. We have come a long way, but, as I say, I would not want to tell you it was perfect.

Q274 **Chair:** Let us drill down into the issue of transparency and how easy it is for staff to speak out if they have concerns. We have been looking, in this inquiry, at what happens in Sweden, which has about half our neonatal death rate. If we had the Swedish neonatal death rate here, about 1,000 more babies would live every year.

The evidence we had from one of the people responsible for the Swedish system was that one element that was very helpful in Sweden in getting the patient safety level so high was their no-fault compensation. In England, you have to prove clinical negligence before a family gets compensation if a child is born disabled, but in Sweden you just have to prove avoidability. You just have to prove that something went wrong. Minister of State, do you think we should look at doing the same thing here?

Nadine Dorries: We are always looking at other countries, to see what we can learn from what they are doing. There is some evidence that Sweden's harm rates in maternity are lower than ours, but there could be a number of reasons for that. The evidence that the Swedish compensation system necessarily makes their system safer is patchy and difficult for us to get a handle on. The insurance agency in Sweden that runs the safety programmes has not yet been fully evaluated.

What I will say, and I cannot be drawn on the detail, is that we are looking across the NHS in the round, not just in maternity, at how issues of no-blame, no-fault compensation and clinical negligence are treated, how they are dealt with, how we look at them and how we administer them. There is a review taking place. It was discussed as part of the spending review that we look into that. Work is under way. I cannot be drawn on the detail at the present moment, but we are evaluating it. I do not want you to think that we are complacent and not having regard to what is happening in other countries; we really are. I do not know if William Vineall wants to say something.

William Vineall: Do you want me to add a few points, Jeremy?

Chair: Please do, William.

William Vineall: As the Minister said, at the spending review we committed to improve patient safety and tackle the rising costs of clinical negligence by publishing a consultation this year. Work is hard under way on that. As Nadine said, we are looking at all drivers of costs and aspects of the current process in that work. Costs have quadrupled in 15 years from £0.6 billion to £2.3 billion. Obviously, that is money that comes from the patient care budget, so it is important that we address those issues.

To your point about Sweden, and looking at openness and transparency—linking that, in a sense, to the earlier question on culture—we have the "saying sorry" approach, which stresses to clinicians that saying sorry is not an admission of liability. The number of cases that actually come to court each year is pretty small—fewer than 50—and within the current tort-based legal system that we have, we have tried to do as much as possible to resolve concerns earlier. In a sense, it is, in a slightly different way, what they are trying to do in Sweden. NHS Resolution stresses the mediation approach and has used mediation to settle 1,000 claims—400 in 2019-20. It has shortened the time to resolution by nearly four weeks. It has the early notification scheme, which is a way of alerting at pace where you have the difficult brain-injured babies.

Q275 **Chair:** What happened to the rapid results and redress scheme that you and I got approval and funding for three years ago? Has that not yet been implemented?

William Vineall: The situation with the rapid resolution and review is that, as you say, we consulted in 2017, but we decided in 2019 that we

were not going to pursue that programme, partly because we felt we had put in place planks of it through the work on HSIB to do maternity investigations and the work through the early notification scheme. We felt that they were effective ways of delivering the objectives in RRR.

In addition, going back to my earlier point, we are going to consult this year on the wider issue of clinical negligence, cost reduction and different approaches that you can take to compensate people through different mechanisms.

Q276 **Chair:** I want to bring in Matthew Jolly and Jacqueline Dunkley-Bent on the issue of the blame culture and how we make it easier for people to speak out.

Minister of State, I appreciate that you cannot be drawn on the review that you are doing on clinical negligence, but can I ask a couple of questions about our current system? At the moment, the compensation that people get takes account of loss of earnings. The practical impact of that is that the disabled child of a banker gets much more compensation than the disabled child of a cleaner. Do you think that is morally justifiable?

Nadine Dorries: No, it is absolutely wrong. It is also based on the fact that any injury requires care from the private healthcare system going forward for the rest of that individual's life. These are outdated practices. It is an outdated system. As I have said, I cannot be drawn, but that whole system is under review at the moment. As William elaborated further, work is under way. It is not just a workstream; it is intensive work with meetings at a very high level.

You cannot amend or modify a system of clinical negligence or compensation without, hand in hand, having a robust system of patient safety. You cannot have one without the other. We need patient safety to be in a much better place than it is today. We need to do work on both, hand in hand, to make the system that you have just articulated, which is so unfair, fair and equitable for all. There is much work to do, but I do not want you to think, "This is something that I'll call the Minister back on in a year." We are working at pace on this.

Chair: Excellent.

William Vineall: It is important to stress the fact that when the NAO reported on clinical negligence cost reduction, they said there was not a causal link between safety and the amount of clinical negligence. As the Minister said, we are saying that we have to improve patient safety anyway for all the patently obvious reasons, not least the damage it does to the people who suffer harm. In addition, we need to look at the way we structure our systems for compensation payments. That is why, in the spending review, we said that we were going to do further work on patient safety alongside the work on clinical negligence cost reduction. They are two drivers. They are not an either/or.

Q277 **Chair:** I would like to bring in Dr Matthew Jolly. You and Professor Dunkley-Bent head the programme charged with trying to halve baby deaths, and severe baby injury maternal deaths and stillbirths. I want to drill down on the point about blame culture.

It is only one aspect of it, but, in your experience across the whole NHS, does the fact that sometimes families have to involve lawyers very early in the process to get compensation mean that you get an adversarial start in investigations as to what went wrong, rather than a collaborative start where proper learning can happen?

Dr Jolly: That was definitely the case in the past, but it feels very different now. We have duty of candour; when you are a clinician and you feel that harm has happened to someone you are caring for, you explain and acknowledge that.

The way we run our investigations, with the perinatal mortality review tool and with HSIB, means that there is a much more objective process. It is about how the whole system works. It is no longer about an individual making a mistake; it is understanding all the reasons why an individual was put in the position where they could make a mistake or do something that led to the bad outcome of a pregnancy.

When staff go to work in the morning, they intend to give the very best care they can. When something goes wrong, it is obviously devastating for the parents and for the family, but it is also devastating for the staff. It is easy for someone to slip into being defensive if they are not in a supportive environment where they feel safe to discuss what went wrong and to generate the learning to make sure that it does not happen again. That has changed. It may not have changed completely yet in every unit, but it is dramatically different from how it used to be. That has to be a great improvement.

Q278 **Chair:** Thank you very much. Professor Dunkley-Bent, you will be very well aware of the story of Joshua Titcombe. Joshua's father, James, wrote a book in which he described how the notes on Joshua's care were lost. James thinks they were deliberately lost.

None of us knows exactly what happened in that situation, but are there situations where midwives are so scared of the consequences that they do completely egregious and unacceptable things, such as tampering with or mislaying notes, because they just feel that, if they speak out openly about something that went wrong, they are not going to get supported in any way at all and will find that their world crashes down on top of them?

Professor Dunkley-Bent: First of all, it is very sad to reflect on the book that James Titcombe wrote and, indeed, the sad passing of Joshua. I cannot necessarily comment on that case, but as a midwife of 30 years' experience what I will say is that a culture where there is openness and transparency is very much better than a culture that is defensive and where there are barriers to exposing problems.

We all want to ensure that there is rapid learning. The best way to do that is to value and build a culture that is open. I agree with Matthew that we have made huge strides towards building and developing that culture. It takes time. It is time we do not have, but none the less it takes time.

As a result of the Morecambe Bay inquiry and the Kirkup report, statutory supervision was dissolved. What replaced it was a model of supervision that supports and enables midwives. There is an element of restorative clinical supervision that helps them to think about quality improvement and to think about why we are all here. First of all, it is to serve mums and babies and then to ensure that, where there is avoidable harm, we have rapid learning. I think that the culture is changing, but I appreciate that we have a long way to go.

Q279 **Dr Evans:** My first question is to Dr Matthew Jolly. Who is responsible for setting the culture? We have heard a lot about it, but whose job is it to set that culture?

Dr Jolly: Everyone. From the chief executive to all the clinical staff and our secretaries and support staff, it is something that should run through the very core of an organisation. It is set by the way you treat your colleagues as well as how you treat the people visiting the hospital in maternity and the women we care for. There has to be a culture of honesty, integrity, kindness and respect. If that is not set from the very top of the organisation, and reinforced by all of us working in the organisation, there is a problem.

Q280 **Dr Evans:** What factors lead to failure in the culture?

Dr Jolly: There is a complex range of reasons. I am wary of pointing fingers at direct individuals, but you sometimes see it in the leadership of organisations. Sometimes you see it in individual clinicians' behaviours. Sometimes it is important to understand what lies behind that. We are all human beings. Someone could be ill. They may be frightened or they may have marital problems. There may be all sorts of things going on that affect their behaviour at work. Kindness and understanding about when people are doing the wrong things that lead to poor culture is important.

There are things we can do to equip people to recognise when they are not performing well or to help them be more effective leaders in affecting culture. I am pleased that funding has been put in place to help to try to address some of that clinical leadership and the way people set culture within organisations.

Q281 **Dr Evans:** A supportive culture is so important, as you have emphasised. The flip side is that we have to remember it is patients' safety, and every incident that goes wrong may well be a mother or baby having an adverse outcome. At what point should we jump in to prevent the culture from getting worse, and what mechanisms should be used? When is

enough enough?

Dr Jolly: We should be doing something about it now, and we are doing something about it now. I would like to have the resources to do even more. It is great that we are now being given some resources to do more. It is something we should be working on every day through our behaviours. At the moment, we are looking to commission some additional support and expertise in how we build the right expertise to change culture within organisations.

Q282 **Dr Evans:** That is really helpful. William Vineall, with regard to that, your aim is to drive down by half the number of incidents. How many incidents are there that should not have happened in the last year?

William Vineall: I don't have that piece of information to hand, I am afraid, but I can write to you.

Q283 **Dr Evans:** Do you have a feel of the percentage of reduction that has happened in the last year?

William Vineall: I cannot give you a percentage reduction in the last year, but obviously we know, overall, that on some of our objectives on the 2020 ambition for reduction of stillbirth rate and neonatal mortality rate we are on track. We are not yet on track for maternal mortality, brain injury and pre-term birth rate. That is part of the reason why we made the announcement, which the Minister may want to say more about, of the £9.4 million in the spending review to do additional work to look at brain injury so that we can try to catch up progress on that objective.

Q284 **Dr Evans:** That is a fantastic objective. Having a baby can be dangerous. It always has been historically, and we need to do as much as we can to reduce that risk.

When Boeing had a problem, a plane fell out of the sky and 200 people died, the entire world banned that Boeing aircraft from the sky. If we look at a nation, the same principle is more difficult, because people have babies, but the same culture fits. What do we accept is enough, and how can we really push that forward? Do you believe you have enough tools, if you see a problem, to stop a hospital or midwife unit and say, "Look, there's a real problem here"?

William Vineall: As Sarah-Jane said, you cannot say hand on heart that you have an absolutely safe system. Compared with five years ago, and certainly compared with 20 years ago, we have many more mechanisms in place that can react more quickly.

To give you one specific example from East Kent, the situation was that Harry Richford started the campaign about the untoward deaths there in 2017. We, through HSIB, went in and started doing maternity investigations, as we go through all the hospitals, in 2018. Going back to what Matthew said, they recognised that there was a structural problem in that trust. It was not just one incident, so they referred to the CQC.

The CQC did unannounced inspections this time last year. That begat the investigation that is soon to begin.

Clearly, it would be much better if you never had to go through that cycle, but at least we are going through the cycle much faster now, in comparison with an equivalent situation at Shrewsbury and Telford where, as Jeremy said at the start, these things were happening 20 years ago and they came to light a couple of years ago. We are trying to put more structures in place. The CQC goes in.

I think one of the things that we are going to have to look at more carefully in the future is that, even if you take the statistically very important improvements in maternity care that I have just mentioned, we should not blind ourselves to the fact that there are at the moment, unfortunately, some places where the overall quality of care is not good. You can both make population-based improvements and, at the same time, go in faster in the places where you have problems. Obviously, the reason why we set up the HSIB maternity investigations was to get ahead of that process rather than just be reactive.

Q285 **Dr Evans:** Following on from that question, Dr Jolly, we have heard quite a lot in this inquiry that units are understaffed and that there are not enough staff in the profession. In the airline industry, if you had a tired pilot, you would not let them fly longer than 11 or 12 hours, or whatever it is. Should we be cementing in place a structure that says, "This is what a midwife or obstetrician should be doing, and that's it"? What would the consequences of such an approach be from your perspective?

Dr Jolly: There is a balance to be had between how hard you work, how much experience you get and how much you maintain your skills. Right-sizing is a challenge. We do not have the workforce completely right yet; you are correct about that. There is further work under way. You heard evidence in previous hearings from RCOG and RCM about that. I know that there is a real push to use the Birthrate Plus methodology for trying to get the midwifery staffing correct.

RCOG is doing a lot of work at the moment looking into how best to implement the Ockenden recommendations, and whether we should be changing the thresholds for when a consultant attends and which units are sufficiently busy that we need to think more about consultant hours and presence. It is quite a complex area. I am delighted that RCOG is looking into it in so much detail at the moment.

There is definitely a need for more resource. We can do better. It is not going to be one size fits all. What you do in a small unit of 1,500 deliveries and what you do in a unit of 10,000 deliveries will be different. There are some subtleties about how we right-size it.

Q286 **Chair:** Dr Jolly, could I ask you to go back to Luke Evans's question? You and Professor Dunkley-Bent are the people who are scanning all the NHS maternity units. Do you have the ability, the support and the resources

that you need, as well as the data you need, to zoom in quickly if another Shrewsbury and Telford or East Kent happens? Are you confident that that very important horizon-scanning can happen?

Dr Jolly: I am confident that we have moved to a totally different level of sophistication in how we do horizon-scanning. It is relatively early days. Jacqui and I chair the maternity safety and surveillance concerns group, which is where we bring together Health Education England, the royal colleges, HSIB, NHS Resolution, the GMC, the NMC, and so on, to get those early warning signs.

Have we got it exactly right yet? I doubt it. I fully expect us to be able to do even better, but this is a big step from where we were before. There is real determination from all those organisations to make it work even better. I am delighted with our progress, and I aspire to do even better.

Q287 **Dr Evans:** My final question is to the professor. We have talked a lot about the staffing culture in the NHS, but I am interested in your perception about the culture of the people who use the NHS. Has the expectation gone up? Has it changed? Are people looking for litigation too quickly when things go wrong?

Professor Dunkley-Bent: Are you referring to staff members?

Dr Evans: No, patients, the users of the service; mums and families. I am keen to know if you think, in your career, that there has been a change of emphasis. In my clinical career, I personally feel that there has been. That is both good and bad. People are much more aware of what is out there and what is going on. They are able to check guidance. At the same time, that can mean quite an aggressive front: people come up and immediately jump in and say there is something wrong, and there isn't the understanding behind the case and the difficulties associated with something like giving birth. I wondered if you have a feel of the public's perception of the culture. Does that have a knock-on for both the NHS and you in your safety role?

Professor Dunkley-Bent: Absolutely. From the objective data, if I may refer to the CQC survey, we know from the last survey that was undertaken, which involved a cohort of 17,000 women across England, that we definitely majored in women feeling confident that they were listened to about their maternity experiences and maternity decisions. We learn an awful lot from those surveys. From the softer intelligence, I would say, for midwives and obstetricians, we recognise that it is a unique privilege to support a woman and her family through the maternity journey. Of course, I would expect any woman to think, "This is my unique time and I want the very best." Every health professional gets that.

Our ambition is to ensure that women get the very best. It is important that the public should feel that they are entering a one-time life opportunity. You never get a first time to have a second baby—you get

my point. Therefore, it is good to have those expectations. Every maternity provider—in fact, every NHS trust—runs a patient survey. The most common is the Friends and Family test; for every service, the key is constantly hearing feedback and learning from what women are experiencing and how we can put it right.

In summary, it is good that the bar is set high. It is a special and unique time. What we do in maternity ripples for generations, so it is really significant. The bar should be high.

Q288 **Chair:** I want to come to an issue that has recurred throughout this inquiry, which is the question of staffing, and whether we currently staff our maternity units at safe levels. I want to ask the Minister of State about that. Dr Jolly just talked about a tool called Birthrate Plus, which is a very detailed tool to tell you whether you have enough midwives in a unit. It currently shows that we are short of about 3,000 midwives across England. Are we planning to fill that gap?

Nadine Dorries: Chair, we know that there has been an increase in the number of obstetricians and gynaecologists since 2019. I think it equates to 4.8%, with 113 more obstetricians and gynaecologists on maternity units than there were in 2019. We also have an increase in the number of midwives. You, yourself, increased the number of midwives who were in training. Health Education England is, at this moment, undertaking work to evaluate future demand on maternity wards going forward, over a projected period of time. What we know is that, of the midwives we have in training at the moment, 80% of them will go into full-time work in maternity units.

One of the problems is that not everybody who trains decides, at the end of their training, that they want to go into midwifery, or even work in an NHS hospital. That is one of the issues. The work that Health Education England is undertaking is to evaluate that in terms of attrition and what we need moving forward. We are on target to deliver 3,650 more midwifery training placements by the end of next year, 2022-23. In September 2020, there were 2,480. That 4.8% increase, the 113 doctors, now means that we have 2,480 full-time obstetricians and gynaecologists working on maternity units.

It is all going in the right direction. We are getting more midwives and obstetricians and gynaecologists through. I think that is a very important point. We focus on midwives, but reading the Ockenden report—and given the conversation we have just had around culture and collegiate working between doctors and midwives working as a team, and about reducing and minimising cultural differences—it is important that we have more doctors as well as more midwives.

Q289 **Chair:** I am going to come on to doctors. I just want to establish the position on midwives, because I am not quite sure I understood your answer. Birthrate Plus says we are short of 3,000 midwives. Do we agree with that and, if so, are we going to fill that gap? Is it going to be part of

the NHS mandate, for example, that that gap must be filled?

Nadine Dorries: Identifying that gap, and knowing how many midwives we need to work within the NHS on maternity units moving forward, is, as you know, the work of Health Education England. We have asked them to evaluate what that gap is and how many midwives we need to move forward. We have extra midwives in training who are coming out this year. As I said, we hope that 80% of those will go into full-time posts.

Q290 **Chair:** Could you write to us when that work is done? Are you expecting that work to be done soon?

Nadine Dorries: Absolutely. We will send you a note when we know what the Health Education England findings are on anticipated need and numbers moving forward. We will write and let you know what that is.

Q291 **Chair:** Could we ask you to do it by Easter, just to give them time to complete the work? It is really important that we have on record what you think the gap is, and what your plans are to fill it. Would that be possible?

Nadine Dorries: I will try my very best.

Q292 **Chair:** Thank you. Let us move on to doctors because that is very important. Dr Jolly said that work is ongoing. At the moment, all we have is the "Safer Births" document, which was produced by the royal colleges in 2007. That only talks about the number of doctors needed for a certain volume of births. It does not account for the complexity of births, which is what Birthrate Plus does for midwives. Will DHSC fund the necessary work so that the royal colleges can establish a very detailed tool that will say exactly how many obstetricians you need in every unit?

Nadine Dorries: I think that comes under the same workstream. Health Education England, as you may be aware, have funded a fellow post at the RCOG to focus on improving both retention and the overall quality of training for obstetricians and gynaecologists—

Q293 **Chair:** I am sorry to interrupt. I completely understand that, but before you do that, you have to know the numbers that you need. By Easter, can we know what we think the gap is for the number of doctors and the number of midwives, and the plan to fill that gap? Ahead of our report coming out and the Ockenden review coming out, it would be incredibly helpful to know exactly what the Government think the gap is, and what the plans are to fill it.

Nadine Dorries: I completely agree with the premise of your request. I will go to Health Education England and ask them if we can have that data. I just want to end on a positive note. I think it is really good news that we have seen a 4.8% increase in the number of obstetricians and gynaecologists on our maternity units in just over a year.

Chair: Thank you very much indeed. Let me bring in Barbara Keeley, who wants to talk about training.

Q294 **Barbara Keeley:** I want to ask some questions about whether midwives' and doctors' training is sufficient and whether there are any improvements. In 2018, Baby Lifeline published a report identifying serious gaps in training for the frontline and "little/no standardisation in the way maternity training is prioritised, provided, funded, assessed or attended." Could you comment on that, and what improvements still need to be made?

Nadine Dorries: Training is vitally important. Core competencies in training are important so that everyone is trained to the same level. That is one way that we can prevent problems arising in different areas of the country or in different units, where maybe training in particular areas is lacking. Donna Ockenden identified that in her interim report on SaTH. What we need is a core competency so that we have everyone trained to the same level at the same time.

William spoke earlier about the £9.4 million fund we have put in for brain injury training. I have also had allocated in the spending review £500,000 for leadership training. I think Matthew Jolly alluded to this: leadership training is incredibly important. Having the right working environment, in which people can identify their own training gaps and ask for help and support, and where there is an open atmosphere where that can take place, and an environment where training and professional development is encouraged among the staff, with everybody being trained in core competencies to the same degree, is one of the—

Q295 **Barbara Keeley:** Could I stop you there, Minister? Currently, only 8% of NHS trusts are delivering all the training required in the "Saving Babies' Lives" care bundle. That clearly is not good enough. You are talking in general terms. What is being done to ensure that all staff get the training that you talked about and that the NHS nationally has said they need to have? Eight per cent. is a pretty dire level to reach, isn't it? You are talking about the same core competencies, but it is clearly not happening.

Nadine Dorries: The £8.1 million that we allocated to the maternity safety training fund delivered more than 30,000 training places in 2017-18 across multi-professional and multidisciplinary working teams. Throughout the maternity incentive scheme, we know that more than 90% of NHS maternity services are already delivering multidisciplinary maternity emergency training. There may be some issue on the figures. We are very much on to this. Training is incredibly important.

NHS England and Improvement are working with local NHSs to understand and overcome barriers, such as enabling staff to be released for training. For professional development in-service training, we want to make sure that there aren't barriers in maternity units to prevent midwives, obstetricians and others working within the units to—

Q296 **Barbara Keeley:** But there clearly are barriers. If only 8% of trusts are delivering all the training required in that care bundle, there clearly are

problems, because 92% are not.

Nadine Dorries: NHS England and Improvement are putting in place what they need to put in place to make sure that there are no barriers to that training. Perhaps Sarah-Jane Marsh, who is also a provider of maternity services, could elaborate on that question. She knows her unit and other units, and whether there are barriers to midwives' continuing professional development and training.

Sarah-Jane Marsh: Thanks, Minister. The Saving Babies' Lives care bundle training is pointing to a very specific set of things. It is the platinum standard of training. It is really important that we progressively get better with that, but I would not want you to think that only 8% of units are doing any form of multidisciplinary training, because we know that is not the case. We know that it is progressively getting better over time.

It very much links back to the issues we were talking about to do with staffing. When you have staffing challenges, training is often the first thing that goes. That is not right for all the reasons that we know. We have worked really hard to protect that time. We have used things like the CNST standards so that trust boards have awareness of those percentages as well, and can see the consequences of that training not happening, and raise awareness in the agenda.

Like so many things in maternity, it is so much better than it was a few years ago, but we know that it needs continually to improve. We have talked a lot about obstetricians and midwives, but if you look at the HSIB reports about the root causes of some of the things that go tragically wrong for babies, it is also about obstetric anaesthetists or about neonatologists. It is about the broader support team.

The gold standard that we strive for in maternity is having all the people from the maternity team together, receiving the training, doing simulation training and other things, to ensure that the team looking after the mother and baby are the team that also trained together.

Q297 **Barbara Keeley:** Let me ask you about funding, where there seem to be a number of barriers. Training is not being prioritised or provided, or attended, which is of serious concern. The Minister talked about funding in 2017-18, but how long would the benefit from that last? We are in 2021. Surely, we should be talking about a situation where there is a flow of continued funding, which would clearly help with that. One-off funding is going to fade over time.

Sarah-Jane Marsh: The more certainty we have around the funds that are available for training year on year, the better it is for those of us who provide maternity services to be able to plan forwards, and make sure that people have the dedicated time and everything else. In and of itself, the money is not the only issue, as we have said. It is about having—

Q298 **Barbara Keeley:** It is one of the issues though, isn't it?

Sarah-Jane Marsh: Of course. You want to be able to plan the whole year as well. It is great to get funding, but if it comes late or with only a little bit of time to spend it, it is more problematic in terms of making sure that everybody gets access. If you know you can organise training on a year cycle, it is much easier for everybody to be able to plan that training.

We are incredibly grateful that money has been made available to us for training. We recognise that, compared with other specialities in the NHS, we are very fortunate in maternity to have that, but I concur with your hypothesis that the more of a forward look we have around training, the more we are able to maximise the percentages.

Q299 **Barbara Keeley:** I will come back to the Minister on the funding in a moment. Specifically thinking about the current cohort of medical and nursing students, are you satisfied that the additional frontline work they are carrying out during the pandemic will not lead to lower levels of skills in other areas, such as obstetrics and midwifery? Do we need steps to make sure that the current cohort all graduate with the skills they need?

Sarah-Jane Marsh: We have worked hard in maternity services, certainly in this current wave, to protect our staff from being redeployed or losing out on training opportunities because they find themselves working in other areas. If we are honest, that did happen a little in the first wave because we did not know what we were facing. It was there all of a sudden, and we had to be very pragmatic and make sure that we got all resources to those who were the sickest and most in need.

We recognise, with the information that we now have, that we did not get some of that right in some services. We did an instant learning exercise—a bit like we were talking about before—when the wave was over, to say that, if we should get another wave, what would we do? I feel a lot more confident this time around that we have protected training opportunities. I would not envisage that midwives and other students currently in training would need additional time in their training to compensate for lost opportunities. I defer to Professor Dunkley-Bent and her experience, just in case I have missed anything.

Professor Dunkley-Bent: I concur and totally agree with Sarah-Jane's comments. We have, as Sarah-Jane mentioned, worked hard to listen to the student voice and to midwives who supervise students in practice. This year's third years, who are due to graduate in the fall, were last year's second years. They were included in paid placements. We took the decision this year, along with the chief nursing officer for England, Ruth May, and colleagues, to ensure that our midwifery students who are due to qualify in September and October are not a part of paid placement. That means that they continue with their education and training as normal. It is really important that we safeguard and protect that, so that when they graduate, they are able to work autonomously. They have proficiencies and standards to meet. They have to complete all the NMC

competencies, and they have to be signed off. We need them in clinical practice.

The fundamental, significant difference between our nursing students and our midwifery students is that, on qualifying as a midwife, you are deemed an autonomous practitioner. We have worked hard. It has not been perfect. We are still learning, but none the less we stand by our decision to support them in their education and training, alongside the NMC and the Royal College of Midwives.

Q300 **Barbara Keeley:** I have a final question on the funding for training, Minister. We have heard that it is important. Will you commit to reinstating funding for maternity training? You mentioned the maternity safety training fund, but we are three years on from that now.

Nadine Dorries: We have actually allocated £9.4 million for brain injury, which includes multidisciplinary training, including foetal monitoring, in a number of areas within maternity, and £500,000 in the maternity leadership training fund. We have allocated new funding for additional training.

We are looking very carefully at the recommendations from the SaTH review. We have had Morecambe Bay; and we have SaTH and East Kent. Now is the time for change. One of the issues about constant inquiries is recommendations. We have reached a point now where we have allocated additional funding for additional multidisciplinary training. What we need is a core competency agenda across all maternity units, with the training funding allocated, to ensure that everybody works at the same level of competency so that we can minimise the number of instances of avoidable harm that occur.

There is £9.4 million, as William said earlier, which we have allocated to brain injury. That includes multidisciplinary training. Additional in the spending review was the £500,000 for the leadership training that I think is so important. That sets the culture, the environment and the tone of maternity units. It enables people to identify their own weaknesses, lack of skills or areas in which they think they need additional training. The money is there. As Sarah-Jane said, of course the objective is to ensure—we had that with the spending review—that money continues to move forward into that area. Reducing avoidable harms and maternal and neonatal deaths is the ultimate objective. To do that, we have to continue with multidisciplinary training across all disciplines.

Barbara Keeley: Thank you.

Q301 **Dean Russell:** Minister, one of the things that has been clear through the Covid crisis is the impact on staff at a human level, in terms of the stress that they have had, and particularly how the impact of Covid has affected their lives more broadly.

One of the things that occurs to me in this situation is that we have talked about culture, staffing numbers, leadership and so on, but are

there any plans, or are they in place, for mental health and, more so, mental wellbeing support for staff? They also have to go through the trauma of seeing somebody lose their child in front of them. That must have a massive impact on them. If you could elaborate on the mental health side, I would really appreciate it.

Nadine Dorries: Thank you, Dean. I know this is a huge interest of yours. I think you have established 1,000 mental health first aiders in your constituency.

Dean Russell: Yes. That is the training programme.

Nadine Dorries: That is incredible work on mental health, which is the other part of my portfolio. You are a trailblazer in terms of what can be done by individuals in their area, Dean. It is huge, both in suicide prevention and mental health.

You are absolutely right; it is fair to say that NHS staff are exhausted. They are used to dealing with patients who lose their life, sadly. Not every story is a success story, but the rate at which both nurses and doctors have had to experience young patients rapidly losing their lives, as well as the turnover and the barriers that Covid restrictions have put in place in the normal interactions between family, staff and patients, have all taken their toll.

The NHS has put in place a very robust wrap-around package of care and support for staff, which includes access to free counselling sessions, IAPT and one-to-one services. People like Sarah-Jane—CEOs of trusts—have also put in their own layers of additional measures. Each trust has done something different. I have spoken to a trust that has put in a standard debriefing and buddying time for staff at the end of the day. Funding has gone in to support the mental health of staff across the NHS.

In maternity—I do not know if Sarah-Jane will contradict me and say something different—my understanding is that no midwives have moved from maternity units. Babies did not stop coming. Full term was still full term. Babies arrived when they were supposed to arrive. No midwives were moved from maternity into red areas or into Covid areas in general hospitals to assist. They stayed in the maternity unit. Life continued for a while without birthing partners or even partners being present at scans. We changed that. We altered the guidance to allow both birthing partners and scan partners to accompany women on their pregnancy journey at the times when they needed that help and those partners the most.

In terms of the mental health impact, I do not want to say that it has been less prevalent in the maternity units because babies have continued to come, but everybody has had additional pressures going to work, delivering babies and dealing with Covid in their own lives and in their own hospitals. It has been a pressure on everybody, even those not working on the Covid frontline or in ICUs. Everybody has felt it.

NHS England and Improvement, Sir Simon Stevens himself, Claire Murdoch and Professor Tim Kendall were at the front of this, and ensured that very quickly they got a robust wrap-around package of mental health support in place for all NHS workers.

Q302 **Dean Russell:** Thank you. Thanks for your kind words as well; I appreciate them.

On a very different point, I spent some time volunteering in a maternity ward office. I have to say that I have never seen elastic bands quite so big, which were holding together many files of documents and paperwork. It seemed to me that an awful lot of time was being spent by back office staff. Often, when we talk about the NHS, we talk about nurses, doctors, obstetricians and so on, but there are an awful lot of amazing people who work behind the scenes.

What I found was the sheer amount of paperwork. Is there much work going on to digitise the NHS at that level? I know that in my local hospital they are doing an incredible job on that. Are there any plans on that, particularly around maternity, because that seems to be where the files are the biggest?

Nadine Dorries: NHSX is not in my portfolio, but Sarah-Jane might want to comment. You are quite right, Dean, to highlight all the people who contribute to the smooth working of a maternity unit. We focus on midwives, obstetricians and gynaecologists, but there is a whole back team supporting the work that takes place in the labour and delivery suites.

Sarah-Jane, I do not know what it is like in Birmingham. Would you like to say something about that?

Sarah-Jane Marsh: This is another part of the maternity transformation programme. It was embedded in "Better Births" that we needed to digitise maternity care records, not just for the staff using the elastic bands and, needless to say, occasionally a fax machine as well, but because we want to move ownership of the record to women themselves so that they feel it is their maternity record and that they own it, along with the clinicians leading their care. If it is digitised and people can have access, particularly on a smartphone, it becomes quite revolutionary in personalised and safe care, as well as moving something from paper to an electronic system.

Over 130,000 women now have access to their own digital care record. That is a fantastic achievement, but we know we still have quite a long way to go. We are working with our colleagues at NHSX and NHS Digital to deliver that because we recognise how important it is.

In my own organisation—Birmingham Women's and Children's—we actually moved over to a digital system. It was not just about making things more streamlined, with less paper around, but about a transformation in safety as well. I recall a lady on one of the in-patient

wards telling me that she had been taken ill while a very long way away from Birmingham. She was able to access her maternity care record on her phone and show it to the clinicians in an A&E department hundreds of miles away from Birmingham. They were able to use that to deliver safe care to her. It was a completely different outcome from what would have happened if there had been no access to the record.

We need to think about it as an important plank of safety as well. Huge progress has been made, but I would love to be back in two years' time telling you that it was now universal and that all units had an electronic patient record for women, and that all women who wanted to—not everybody does—had access to their record.

Dean Russell: Thank you. I notice that Dr Jolly has his hand up.

Dr Jolly: Sarah-Jane has given an excellent answer. The move to digitisation is under way. We have lots of support from NHSX on that. What is exciting is that there is also work under way to use the technology to improve safety. The Tommy's group, hosted at the Royal College of Obstetricians and Gynaecologists, is looking at how we use digital data to identify people who need extra intervention and support, and to implement best practice pathways.

As Sarah-Jane says, it is not universal yet. We are using the CNST maternity incentive scheme to encourage people to reach the level of digital maturity required to implement electronic patient records, but it is definitely the direction of travel.

Q303 **Sarah Owen:** Minister, a target was set for continuity of carer for 75% of black, Asian and minority ethnic women to be cared for under continuity models by 2024. Has the pandemic impacted that target at all, or are you on track?

Nadine Dorries: I will ask Professor Jacqui Dunkley-Bent to come in behind me on that. I would like to make a point, as you have mentioned that particular issue.

I have established an inequalities forum, which has met twice. Sadly, the work has been slightly delayed due to the pandemic. It looks at issues around why we have inequalities of outcomes in terms of births and avoidable harms due to being in the BAME community and other reasons. That work is under way.

Professor Jacqui Dunkley-Bent, do you want to come in on this?

Q304 **Sarah Owen:** Sorry, Minister, I asked you specifically whether you are on target to meet the targets that you have set yourself, or not.

Nadine Dorries: Yes, I believe we are. It is important to explain that there is an idea that continuity of carer means that you have the same midwife from the second that you either self-refer, or are referred by your GP to the maternity unit, until the point of birth. I think we can

understand, due to the working patterns of midwives, that that is not always possible. The objective is for continuity of carer, certainly through pre-delivery care, to remain with the same midwife.

I do not have the figures right in front of me at the moment, but I believe we are on course to meet those figures. Professor Dunkley-Bent can tell you more about it because it is something she is absolutely passionate about and works very hard on. I hope we are going to meet those figures.

I am sure Professor Dunkley-Bent will say this. Continuity of carer is a fantastic model. We know that it has a huge impact on the number of stillbirths. It works and, of course, if we could have continuity of carer, with the same midwife from the moment of referral to the moment of delivery for every woman in the country, we would. We would do it today if we could. It is work in progress.

Professor Dunkley-Bent, would you like to—

Q305 **Sarah Owen:** Obviously, that is a fantastic aim. You said that, if you could do it for every woman in the country, you would. How many staff are we short of to be able to achieve that ultimate aim of seeing every woman have continuity of carer?

Nadine Dorries: I don't think it is about the number of staff to do that.

Q306 **Sarah Owen:** Do we have enough staff to do it currently?

Nadine Dorries: It is about the trust and how the trusts deploy continuity of carer. Professor Dunkley-Bent has the figures. A high number of trusts are deploying that model, but what you are asking a midwife to do is basically to be on call 24 hours a day. That is not a working pattern that, in this day and age, all midwives will commit to or want to commit to, or indeed that we should ask them to commit to.

Having continuity of carer in the time from referral up to delivery is something that we are definitely moving towards achieving. Having the midwife there at the point of delivery at 4 in the morning, if that midwife has been working all day in the maternity unit, is almost an unrealistic ambition. We know that the work-life balance and patterns of a midwife are not going to be able to help us achieve that.

It is not so much whether we have the numbers to do it; it is whether we have the ability in terms of the expectations on midwives to do it. I do not believe that we do. This is Professor Dunkley-Bent's area. It is her expertise. She is going to give you a much better answer than me on that. I think we should go over to you, Jacqui.

Professor Dunkley-Bent: Thank you. I totally endorse and agree with everything that the Minister said. The pandemic has been a challenge for staffing and for provision of care. None the less, I can confirm that we have 2,322 midwives providing continuity of carer to one sixth of women

who birth in England each year. We have 94,458 women who are benefiting from full continuity of carer. By way of comparison, if we look at March two years ago, we had 10,500 women who were benefiting from continuity of carer. In taking it up to 94,458 in a pandemic year, I have to say that the midwives, their leaders, managers and organisations have done an exceptional job. It is tough providing care in a pandemic. As a continuity of carer midwife myself, I resonate with many of the things that the Minister has shared. None the less, those are the numbers for continuity of carer.

If I may mention black, Asian and minority ethnic women, and socioeconomically disadvantaged women, that is a target set within our NHS long-term plan. We have 165 midwifery continuity teams placed in areas where many black, Asian or mixed-race ethnicity women are currently living, and 214 teams placed in areas of deprivation. That has grown exponentially in the pandemic year.

Q307 **Sarah Owen:** Thank you, Professor Dunkley-Bent. I have a quick follow-up question. Have you seen an improvement in patient safety and women's choice in the areas where you say the continuity carer models have been targeted? How long do you think it will be before we start to see the disparity close between black women, who are five times more likely to die during childbirth, and their white counterparts?

Professor Dunkley-Bent: That is a really tricky question to answer. The wider determinants of health are not just related to 40 weeks of pregnancy. We have the social deprivation, financial deprivation, inequality, discrimination and racism that many people who get pregnant and use our maternity services have to contend with.

In the maternity space, I cannot say categorically when we will close the gap on equity—the five times more likely—and the neonatal challenge for black and Asian babies. What I can say is that the continuity of carer teams that have completed thus far show demonstrably that, No. 1, women are supported in their choices. That is why we are here. We have to support women in their choices.

Women have improved their experiences of maternity care. That is not reported through CQC data yet, because those data are collected from the pandemic year, which was last year and continuing. None the less, women are saying that their experiences have improved. There are so many more data in relation to pre-term birth. We know from the Cochrane evidence that if you have continuity of carer you are 24% less likely to experience a pre-term birth, 19% less likely to lose your baby before 24 weeks, and 16% less likely to lose your baby at any gestation during the pregnancy.

All the data and evaluation for what happened last year are still trickling in, but I can confidently say that maternity experience has improved, and adverse outcomes have reduced for those women. I would have to get

the minutiae of the data—it is still being collated—to give a more informed response.

Sarah Owen: Thank you.

Q308 **Laura Trott:** Minister, I want to ask about the ideology around normal birth. You will know from the Ockenden review that that was something that she felt contributed to the very dangerous situation in that maternity unit. Indeed, she said: "We have spoken to hundreds of women who said to us they felt pressured to have a normal birth." We know that the ideology contributed to the devastating situation that happened with James Titcombe's son, Joshua. Do you agree that the ideology has been dangerous and that it needs to be addressed in our maternity services?

Nadine Dorries: Yes, I do. There is only one birth, and that is a safe birth. It is not a normal birth or a caesarean birth, or any other kind of birth. There is just one birth, and that is a safe birth.

Reaching the point where every birth is a safe birth is when every doctor, every nurse, every mother and every woman about to give birth is involved in the decision-making process. I know that we have had this historic judgment—I do not know how it came about; whether it is media driven, I am not sure—where there was almost a RAG rating of hospitals, and that those that had done more caesareans were less safe than those that had not. It is complete nonsense because it may just be the case that those that had the most caesareans were identifying difficult births early, were putting in place the right maternity practices and having more informed conversations with women who were about to give birth.

I know this is an issue that Sarah-Jane is very interested in and works on. It is one birth, the safe birth, and we have to completely dispel this notion that there is any judgment call to be made on any type of birth any woman has, or the reasons why she has it. Every woman should have the birth she wants, which is safe for her, in consultation with her midwives, her obstetrician and gynaecologist.

Q309 **Laura Trott:** Thank you for that. Will you commit to no longer using the term "normal birth" within the NHS?

Nadine Dorries: I do not use it, and I do not know anybody I work with in my maternity team who does. Certainly, you do not hear Sarah-Jane, Professor Jaqueline Dunkley-Bent and Matthew Jolly using the terminology "normal birth". Maybe that is something we should take away and consider, Laura. Is that terminology still used in maternity units? Do midwives on maternity units still refer to normal birth? Maybe we should take that away, Sarah-Jane, Professor Jacqui and Matthew, and look at it. If they are, they certainly should not be. We should only be talking about safe births.

Q310 **Laura Trott:** It is certainly something we have heard evidence about throughout this inquiry as a Committee.

Minister, you rightly raised the issue of caesarean section rates being monitored. That is something else that we have discussed during our evidence sessions. Do you think it is time that we stopped monitoring trusts on the very crude measure of caesarean section rates?

Nadine Dorries: I am a big fan of data collection, because you can use that data to both underpin and endorse decisions that need to be taken quickly and rapidly, in order to make not just maternity units but the wider NHS safer places. I do not think I can agree on that. We want to know how many caesareans are taking place in which units, what the reasons are for those caesareans and what the involvement was of the woman, or the parents, in those decisions. I think that we still need to collect the data. I totally understand the premise on which you asked that. It is work in progress and is moving at a rapid rate. Don't judge units or hospitals on the basis of how many caesareans they undertake.

I mentioned at the beginning group B strep and breech deliveries. If we can put in place the right scanning and testing, it may be that the caesarean rate would increase and, if so, that is because we are making maternity units a safer environment, and finding out what needs to be done in advance of somebody arriving and then suddenly being in an emergency situation. Getting to the point before we reach the emergency is what is important.

My own personal opinion is that diagnostic testing in terms of group B strep and scanning for breech deliveries is all part of that process and may result in more caesareans. Would you like Sarah-Jane or anybody to come in on that question?

Q311 **Laura Trott:** Thank you, Minister. That would be very helpful. One of the things we heard from one of the consultant obstetricians was about using something called the Robson criteria as a more intelligent way of assessing the caesarean section rate. I think Dr Jolly wants to come in on that.

Dr Jolly: Yes, thank you. The thing about data in maternity is that it is important for monitoring safety, but there is a danger if you start to use it as a simple performance metric. There is not a simple linear relationship. It is not "low is good, high is bad" or vice versa. For example, with post-partum haemorrhage, I am worried about low post-partum haemorrhage rates as much as high post-partum haemorrhage rates because it probably means people are not measuring it properly, say for third or fourth degree tear rates.

It is important that we monitor caesarean section rates, but we should definitely not performance-manage trusts on them. We use the Robson criteria. We now have a national maternity dashboard that went live in January. There are some very specific metrics on it—14 clinical quality approved metrics—three of which are based around the Robson criteria.

We divide trusts into quartiles. If you are at one extreme, you need to have a conversation and think about why you are there, and triangulate it against your other outcomes to see whether it is because you have a particularly high-risk population, or possibly you are not getting your counselling correct. You may be absolutely getting your counselling correct and there is a very good reason why you have a high caesarean section rate; it is reflected in lower brain injury rates, for instance.

There are dangers from doing too many caesarean sections and unnecessary interventions as well. It is all about using the data to create a better understanding of our maternity services, so that we can reflect and improve. We have not actually used caesarean section rates as a performance metric for many years, so I was interested in some of the evidence you had in previous hearings that people perceived that that was happening. We need to work hard to stop that.

Laura Trott: Thank you. Sarah-Jane, is there anything you want to add?

Sarah-Jane Marsh: I am at one with Matthew. It is an important measure, but it is absolutely not a target. I think there were some examples a few years ago when people were colour-coding against particular percentages. We were clear that we were not RAG rating people's percentages, but it is an important dataset to look at.

On normal birth, we are clear in maternity transformation that we do not use the phrase. We find it profoundly unhelpful. I hope that helps to strengthen the Minister's response. We have not used it at all in the five years.

Q312 **Chair:** Laura, could I follow up on that briefly with Sarah-Jane? One of the things that some women talk about is that they feel under pressure after a first C-section to have VBAC the second time round. Could you confirm that it is absolutely not the policy of the NHS to put women under any kind of pressure in that situation?

Sarah-Jane Marsh: I can; 100% no. It is for the clinical team to work with a woman to make the decision that is right for them. Sometimes women who have had a caesarean section feel quite passionate that it is something they would like to pursue, should everything move along as planned, but it is for us as maternity teams to work with women to make sure that they get the birth that is right for them: personal and safe.

Q313 **Laura Trott:** I have a question about the information that is given to women around the safety of the various options in front of them on birth. One of the things that midwives have been saying to us is that, actually, women who come in with very clear views on how they want to give birth are very worried about the safety of particular types, but not necessarily about others. Is there work going on to help women understand the various options available to them, and, very importantly, the safety and the implications of each of those options?

Nadine Dorries: I think that is for Matthew Jolly or Sarah-Jane.

Laura Trott: Dr Jolly?

Dr Jolly: Absolutely, there is work going on. I think the Montgomery *v*. Lanarkshire ruling was really helpful in bringing that to the forefront. Nadine Montgomery has engaged with us and helped us with driving it forward.

We are working on it with the colleges, the human rights charity Birthrights and NHS England and NHSX teams, particularly on developing a consent tool, which we call the "I decide" tool, to try to guide people through the consent process. Within that, there is a whole structure that leads you through how you give information and how you confirm that the person being given the information fully understands what they are being told and you can clarify that they have been given the key points.

There is more to do. I would like to carry on with our work with NHS UK on getting high-quality objective information available to all women. That work is under way. Clear information giving, and contextualisation of that information, so that women can make true, informed decisions, is an absolutely key part of what we are doing.

Q314 **Dr Davies:** Dr Jolly, I am keen to explore with you the idea of a third routine ultrasound scan, largely at term, to determine breech presentation. That was pushed by Professor Gordon Smith when he spoke to us in December. Do you agree that it can save lives and also reduce asphyxia during birth and birth trauma? Is it something you would support?

Dr Jolly: Absolutely. I have been working closely with Professor Gordon Smith on it. There are a relatively small number of tragic deaths and brain injuries related to breech, but each individual matters and, if there is something we can do about it, we should be doing something about it.

I have huge respect for our National Screening Committee, and there are reasons we have processes in place for making sure that we do not do unintended harm through screening. I obviously respect their opinions, but from my less expert view on screening, it seems absolutely the right thing to do. The scan is very specifically just looking for breech. It is not a growth scan. It does not have some of the unintended consequences of other scans, so I am hopeful that it will receive the correct support, and that we will be able to roll it out, but I have to wait for the screening committee's final decision.

Q315 **Dr Davies:** We were told that it could be a point-of-care scan delivered by trained midwives or other clinicians, as opposed to clogging up the existing scanning systems. Would you agree with that? How do you see it being implemented? Is it a simple process?

Dr Jolly: In my own unit, we have actually started introducing midwifery scanning on the labour ward as part of our induction process. I am training midwives at the moment in presentation scans, and they are

enthusiastic and perfectly capable. Midwives are really skilled, and that is well within their capabilities. Yes, I think it is perfectly achievable.

Q316 **Dr Davies:** Perhaps I could turn to the Minister, Nadine Dorries, to secure her views on this agenda and whether she would help to push it through, should the screening committee agree.

Nadine Dorries: Absolutely. I echo the words that Matthew has just said about the small numbers. People often say to me that the numbers of babies who lose their life as a result of group B strep are small. On average, it is one a week and, on average, 70 babies a year live with lifelong disabilities after contracting either meningitis or sepsis as a result of group B strep being present in the birth canal at the time of delivery. I see both of those things coming together.

Matthew and I have discussed it. One of the hurdles has been jumped over in terms of training midwives to undertake the scan at 35 weeks. It does not give the detail on sizing and other things that you would get from somebody if you were having a full scan, but it allows the midwife to know if the baby is breech. It provides an extra element of safety during the birth and, therefore, is something that I absolutely support. I know that Professor Jacqui Dunkley-Bent, Sarah-Jane and others who work in the field, as well as myself, will put their shoulder behind it to make sure we have it rolled out as fast as possible.

I do not want group B strep to be the forgotten relative in this. It is the same time—35 to 37 weeks, although Matthew would say there is some variation in the time—so I do not see any reason why, if we are going to scan mothers at 35 or 36 weeks, we do not also swab them at the same time for group B strep. I will absolutely put my weight behind it.

Q317 **Dr Davies:** And there are no barriers to funding?

Chair: Never, never.

Nadine Dorries: It is £11 a test for group B strep. There are roughly 360,000 births a year, so I can give you the costings for that. I would do my absolute best to ensure that there was no gap in funding for that.

Matthew would have to tell us what the costing would be for the scans. Matthew might contradict me on this—please go ahead—but I think there is scanning equipment that could be used. I know that A&E units receive out-of-date scanning equipment that comes from scanning rooms. I know that some of them have a surplus. It does not have to be the most up-to-date expensive scanning equipment to be able to tell if a baby is breech or not. Am I right Matthew, or would you like to contradict me on that?

Dr Jolly: You are right to an extent, in that you do not need the most sophisticated scanning equipment to tell whether a baby is breech or not. I think Professor Smith's vision is that there would be easily handheld scan machines that midwives could carry with them and use in the community. You do not want to be carting around an old scan machine in

the back of your car. I think there is some new technology that is going to make it even more deliverable.

I do not have the costing data available. I suspect that there are all sorts of clever things on procurement, where we do not want to commit to a cost now. We have guys who want to negotiate the best value for the public's pocket that they can, so I am not going to speculate on the cost.

Dr Davies: Thank you. It all sounds promising.

Q318 **Taiwo Owatemi:** Minister, I would first like to ask a question around maternity voices partnerships before moving on to questions about leadership.

With regard to maternity voices partnerships, we learnt from our previous evidence session the importance of having diversity and ensuring that patients' views are well represented. Two of the main barriers that were highlighted in preventing that was the fact that many women from low socioeconomic backgrounds and BAME backgrounds found it difficult to attend meetings due to not having sufficient childcare provision, and also not having the financial remuneration needed in order for them to be able to attend the meetings. What is being done to address that?

Nadine Dorries: I cannot answer the specifics of your question, but I will say this. It is a point I referred to a little bit earlier in the questioning. Earlier this year, I established a maternity inequalities forum. We met twice; there were MBRRACE members and maternity voices members, and Jacqui Dunkley-Bent and I chaired it together. We brought in a number of organisations and stakeholders in the sector to talk about the inequalities that women experience from BAME backgrounds, low socioeconomic backgrounds and deprivation within the context of maternity safety and the problems that it presented to them.

As I said, we have only met twice because Covid got in the way, but some really important issues were raised at those forums. One that stuck in my mind is that some of the women you are talking about expressed the fact that they do not feel there are women like them working in maternity units—someone who talks like them, looks like them and has their experience of life, and has walked in their shoes. That is something we have certainly taken away and are looking at.

Professor Jacqui Dunkley-Bent, as our chief midwife, does a lot of work in this area. She can probably give you more detail on that question than I can, but I want to reassure you that it is not something that is not across my desk: it is. I set up the forum particularly to look at inequalities in maternity outcomes. Jacqui has been doing work on that.

Q319 **Taiwo Owatemi:** Thank you, Minister. Before I go to Professor Dunkley-Bent, I would like to know whether you would commit to looking into those barriers, such as childcare provision and having financial remuneration for their time, to ensure that the voices of women from all backgrounds are heard as part of partaking in MVPs.

Nadine Dorries: At this point in time, no, I cannot. I am trying to rack my brain and think whether that was one of the recommendations in the MBRRACE report. I cannot commit to that at the moment. We have priorities; and brain injury training, multidisciplinary training in midwifery and the leadership fund were priorities at this point in this spending review. We have another spending review this year, and we have more spending reviews going forward.

I am not saying that it will not be a priority at another bid for funding, but this time around it was not. Something like that would have to be evaluated in terms of need and outcomes and what it would deliver in maternity safety outcomes and avoidable harms, as well as whether it was affordable or not. A great deal of work would have to go into that. I am not saying we would not look at it—we would—but maybe Jacqui has already done some work on it and is aware of the issue.

Professor Dunkley-Bent: Thank you for the question, and thank you, Minister Dorries, for the inequality roundtables. They have been absolutely phenomenal in helping us to shape our thinking about how we create equity and inclusivity.

With regard to remuneration, we already have the integral CNST—clinical negligence scheme for trusts—safety action 7. It is a safety action that I own personally. We all have our jobs to do, and that is mine. It relates to maternity voices partnerships. Within that, we have incentivised trusts to ensure that the chair of the maternity voices partnership is appropriately remunerated.

We need to move further on childcare provision. When I was working at Guy's and St Thomas', for example, we created crèche facilities out of our budget and resource because we desperately wanted women to engage with our services. While we are incentivising through the CNST scheme so that all trusts have to remunerate MVP chairs if they want to achieve their CNST, there is more to do on the wider issues on childcare and suchlike. They will get their travel, but childcare may not be in the mix. It might be variable in how it is resourced, but I am very happy to look at that in the next CNST round.

In addition to the diversity of maternity voices partnership networks, I can confidently say that, between our last roundtable and this meeting today, we have been promoting service user participation with black, Asian and minority ethnic women. In particular, National Maternity Voices, funded by NHS England, has supported the development of a black, Asian and minority MVP network. They are ensuring that MVPs are inclusive of black, Asian and minority ethnic parents. They are prioritising mentorship schemes for black, Asian and minority ethnic parents. There are webinars and many more things. We are really pushing the boundaries on this, and stepping into that space in the context of where people live who would not ordinarily engage with our services.

Q320 **Taiwo Owatemi:** Moving on, Minister, I want to ask questions about

maternity champions. In our written evidence, many trusts report on the varied effectiveness and lack of consistency in that role in particular. What is being done to increase the visibility of maternity care at board level?

Nadine Dorries: One of the issues in terms of the maternity leadership fund is that, at board level, we have a maternity safety champion on the board, and we disseminate maternity incidents up and the learning back down. That is the role of a maternity safety champion. It is in the title: to increase maternity safety within maternity units. I am not sure if we are at the point of every trust having somebody. Perhaps someone could help me on that.

Q321 **Taiwo Owatemi:** From my understanding, we are not at that point.

Nadine Dorries: I think we are certainly well on the way to having a maternity safety champion on every board, identifying and understanding issues of avoidable harm and maternity safety. That two-way flow of information is certainly one of our objectives at every trust level.

Sarah-Jane, do you have the numbers of how many trusts have maternity safety champions on their boards?

Sarah-Jane Marsh: All trusts have maternity safety champions. I think the issue being raised is how engaged they are. Some people have a job title, but they are not necessarily doing all of its responsibilities.

I feel quite passionately about this, as does our chief nurse Ruth May, who is the senior responsible officer for maternity transformation. It is about the whole board needing to engage. Yes, it is important that we have a designated champion, but you cannot designate safety to a board member and just hope it is all going to be okay.

For example, when Donna Ockenden's initial findings were first published, we immediately called a meeting of all the chief execs of maternity units. Amanda Pritchard, the deputy chief executive of the NHS, was there along with me, Ruth and others. We talked about the personal responsibility of the chief executive not only to read the report but to ensure that all of the key actions happened. Of course, it is important to work alongside the maternity safety champion, but we cannot get into a place where that person is standing alone. It is around the whole board's awareness, as the Minister said, as well as important training in the role. There is also ongoing work in NHS England to make sure that maternity is part of a single oversight framework, so that it becomes a key part of all conversations that NHS England and Improvement have at the national, regional and local level.

In maternity, there is occasionally a group of people who are exceptionally passionate about it, but we can sometimes be slightly off-centre, if that is the right word. I feel that over the last year or so, we have been drawn much more into the mainstream. That is where we need to stay, and we need to make sure that every board member feels

responsible and knows their role in delivering, alongside the safety champion.

Nadine Dorries: What I am doing at a national level is establishing a patient safety board within DHSC, which I will co-chair with our director, to strengthen oversight and governance of measures to improve patient safety. That will include the safety of maternity services. The board will have oversight and know exactly what patient safety champions are doing. They will know about the progress, and will identify gaps and ensure collective action across the Government to reduce barriers to delivering patient safety.

I want to reassure you that there are multiple levels of surveillance in maternity safety and identifying those gaps. It is all eyes on those gaps, improving incidents and getting learning disseminated.

William Vineall: That board needs to look at the range of incentives we have, whether they stack up correctly with the problems we have and whether that means you have to do more of things, less of things or things differently.

On the question of leadership, I agree with Sarah-Jane. Obviously, one of the things in the maternity leadership training fund that we have just announced, post Ockenden, is getting improved trust board awareness. As Sarah-Jane says, the champion can come to the board, but the board has to hear that and then push it out to the wider organisation.

I noticed that when Jimmy Walker gave evidence he said that one of the things that had taken the HSIB maternity reports from the level of, as Sarah-Jane said, just the maternity unit out to the wider organisation was having quarterly meetings where you could exchange information and find out best practice. That is all part of putting the responsibility back into the organisation, but putting it across the hospital and not just in the maternity unit. For our own maternity programme, I think we had a very tight focus on the maternity services and all the people involved. Some of the learning of the last five years is to get to some of the places where things still have not improved, such as Shrewsbury and Telford and places like that.

We have to look at the organisational basis. That is part of the reason why we set up the patient safety board. It is part of the reason why we are focusing very much on the trusts with intractable problems. We do not let good statistics, good progress or good initiatives get away from the fact that we need a decent level of leadership in particular organisations in some places more than we do in others. As Sarah-Jane said, there is a bit of a corrective emerging to the programme we have had over the last few years, building on successes, but taking us to a bit more granularity of leadership.

Q322 **Chair:** Thank you. I want to wrap up with some final questions. We have had a very extensive session this morning, and I thank all the panel for

your time.

I want to ask Dr Jolly about the "halve it" campaign, which is to halve the rate of serious incidents from their 2010 levels. It was introduced in 2017. It has four categories: maternal deaths, stillbirths, neonatal deaths and neonatal injury. Could you go through those four areas and tell us how we are doing on that target?

Dr Jolly: Certainly. We have also extended it, to try to reduce pre-term birth from 8% to 6%. We continue to be as ambitious as possible.

From the stillbirth perspective, using the reference year of 2010, we have seen a reduction of just over 25% in stillbirth up to 2019. We have additional interventions in place that I think will continue to drive down the stillbirth rate. We are continuing to explore underlying causes and other ways that we can carry on driving that forward.

The neonatal death data has been more complex. That is because practice has changed since 2010. When we initially looked at the neonatal death rate, it looked like we had not made much progress. In fact, what had happened was that a lot of babies at less than 24 weeks, where no one had made an attempt to even see if the baby was showing any signs of life at all, had been recorded as a miscarriage in 2010. We now try really hard to assess them and consider resuscitation, so a lot more babies at less than 24 weeks that were miscarriages are now recorded as live deaths. That skews the data.

If we look at deaths after 24 weeks, there has been a 23% fall in neonatal deaths. Again, we have lots of things in line to carry on driving that forward. Of those neonatal deaths, probably about 25% are associated with congenital abnormalities. I am not sure how many of those we will be able to reduce. There will be a component that will always remain fixed, but there is still lots in line to try to drive that further forwards.

We have only recently received the latest brain injury data. That shows a different story, with a rise in brain injuries being recorded between 2012, when we had the earliest data, up to 2014, after which we have seen a fall. I can only speculate about the initial rise, but I think it may well be that we got better at measuring it, not that things were getting worse. Since 2014, we have seen a fall. Some of those data have now been published. If we look at term brain damage rates, there has been a 15% fall, with an overall fall of about 9.7%. There is more that we need to do. Again, there are interventions that will not have fed into those data but are in the pipeline, so those are improving as well.

The maternal death rate has not changed a huge amount. There is a fall of about 9% since the 2010 reference year. That is probably our biggest challenge because there are relatively small numbers. What is interesting is that we have seen a big change from deaths related to direct maternal care. There are more related to indirect causes—pre-existing maternal

conditions, and so on. We have fantastic support from some of the best epidemiologists and scientists in the world looking into underlying causes. I am confident that the maternal medicine network will help drive down those deaths further. There is more to do.

On pre-term birth, the interventions we have done with the Saving Babies' Lives care bundle are only just coming online. The target was to go from 8% to 6%. We have got to 7.5%, so we are a quarter of the way there, again with more interventions in place.

I am sorry; that was a bit of a quick run-through.

Q323 **Chair:** It is extremely helpful. Jacqui, do you have anything to add to that in terms of your interpretation of those numbers?

Professor Dunkley-Bent: Nothing to add. I think Matthew gave a good comprehensive run-through of our improvements.

Q324 **Chair:** A final question to Sarah-Jane Marsh, if I may. If you look at the campaigners—the families—who have brought some of these issues to light, sadly one of the most common threads is that when they initially went to their trust, whether it was Morecambe Bay, Shrewsbury and Telford or East Kent, they felt like they had met a brick wall. You are a chief executive of an NHS trust. Do you think that the culture is changing? Do you think chief executives today really understand that if families come forward they must listen?

Sarah-Jane Marsh: I think that the culture is changing. The rule of thumb I always use is: remember what you are there for. You are not there to protect the organisation; you are there to protect the patients, or in this case the women and families who use it. That is your foremost responsibility and accountability as a chief executive. You absolutely need to listen to every word, and work with families until things reach a conclusion for them; not until you have reached your conclusion. I think some places find that difficult, but I know, certainly from talking to many of my colleagues, that that responsibility is felt greatly and that people spend time meeting families, properly reading complaints and reading their HSIB reports. It is a sobering experience for anybody.

I have met a lot of families who are angry. Sometimes, they talk about litigation, but it is a secondary emotion to fear, upset and hurt that they do not understand what has happened. You need to peel back and get the answers. I have sat in front of families and said, "I know the trust I am responsible for is responsible for your child or baby's death." Not many families will go on from that and be hugely critical. People want answers. They want to know that you have learnt and that, in memory of their baby or child, you will improve things for the future.

It is hugely important. It is important that these stories and experiences come through in training. It is not just about looking at statistics. It is about understanding that 99.9 is not good enough if the one left over is avoidable harm. We are definitely getting better, but the theme

throughout the evidence from all of us is, "So much done; so much more to do." We have come a long way, but we are not complacent. We do not think we have finished. We are probably halfway through a 10-year programme. We are all very passionate about moving on to the next five years, and making sure we build on the successes. We must also learn from the things we should have done better.

Q325 **Chair:** I would like to stay with the issue of families and patients for a final question to the Minister of State.

We have been talking this morning about a huge range of things that we are doing to try to improve maternity safety. The starting point was some terrible tragedies that were often appallingly badly handled. You clearly care about these issues a lot, but what is your message to Sarah and Tom Richford, James and Hoa Titcombe, and Richard Stanton and Rhiannon Davies, about how we are going to make sure that other families do not have to go through what they went through?

Nadine Dorries: I am just the Minister. As it is with the roles of Ministers, I will not be in my place forever. That is why I want to put the emphasis on the amazing team that we have working in this area—people like Sarah-Jane Marsh, Professor Jacqui Dunkley-Bent and Matthew Jolly—whose life's work is about improving patient safety, maternity safety and the outcomes for women and families. I hope that they are reassured, if they are watching the evidence today, to know that a huge amount of work is being undertaken.

I was involved in setting up the inquiry for East Kent. I think there were six months between the issue being raised, which I think was in June 2017, and HSIB going in and conducting their report. Chair, you were responsible yourself for the formation and implementation of HSIB within our maternity services, and the maternity inquiries, the number of investigations that have taken place and the amount of learning that has been disseminated across the service. We have amazing people. We have new processes in place. With East Kent, we can see that process from the complaint, to HSIB, to the CQC coming in, and to Professor Jacqui Dunkley-Bent and her team going in to support the trust to help with training, and to ensure that East Kent was from that moment a safe place for women to go in and give birth. SaTH is a little further behind, but much is happening.

If I had one criticism myself, it is that where I sit at the moment I almost see too much going on. I see too many layers and too many initiatives. My concern is that we have so much activity and so much going on that we may be at the point of finding it difficult to get our hands on the data and to disseminate learning. The issue is that, when a problem arises, we need to know what that problem is and how we go about making sure that it never happens again.

One of the things that I have requested in my role as Minister is that we take an overview of everything. The maternity safety transformation

programme has been going for five years. Some of the systems and layers that were put in place are reaching the point when they need to be evaluated. We need to make the entire maternity safety issue simpler to report on, analyse and implement. If I had a criticism, it is that there is almost too much going on, and it is time to have a review of that.

Anybody who is concerned about maternity safety can see, as I certainly believe and know, that maternity units are a much safer place to give birth now than they were when I had a child, or even five or 10 years ago. That drive, with fantastic people like Sarah-Jane, Jacqui and Matthew, is going to continue going forward. Long after you and I have gone, Chair, that drive will continue with people who have made it their life's work.

Chair: Thank you. That brings us to the end of this morning's session. Thank you very much, Minister of State, for your time and your very frank answers.

Thank you, Matthew, Jacqui, Sarah-Jane and William. If I may say so, I am delighted that you are still in the same positions you were in when I stopped being Health Secretary. We talked about continuity of carer, but continuity of policy and leadership is very important in this area. Thank you very much for your time and your commitment to this very important issue.