HOUSE OF COMMONS

Health Committee

Oral evidence: Maternity services, HC 276
Tuesday 28 June 2016

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Written evidence from witnesses:

- National Childbirth Trust
- Sands
- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists

Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Julie Cooper; Dr James Davies; Andrea Jenkyns; Maggie Throup; Dr Philippa Whitford.

Questions 1-123

Witnesses: **Elizabeth Duff**, Senior Policy Adviser, National Childbirth Trust, **Janet Scott**, Research and Prevention Lead, Sands: Stillbirth and neonatal death charity, **Louise Silverton**, Director for Midwifery, Royal College of Midwives, and **Dr David Richmond**, Royal College of Obstetricians and Gynaecologists, gave evidence.

Q1 Chair: Good afternoon. Thank you very much for coming to our inquiry into maternity services. Could I explain before we start that, unfortunately, there is going to be a Division in the House very shortly? It would be useful if we could start with everyone introducing themselves. Then, I am afraid, we will have to disappear for a few short minutes and then come back in and start the questioning then. My apologies in advance.

The intention of the inquiry is to hear your views and early feedback on the national maternity review, and then for our second panel to respond to the points you make. Then, it is our intention as a Committee, over the coming years, to follow through the process of implementation. Today, we are particularly interested to hear your views on what kinds of issues we should be following up as a Committee over the coming years.

Before we get called away briefly, perhaps I could ask you to start by introducing yourselves to those who are following from outside, starting with you, please, Janet Scott.

Janet Scott: My name is Janet Scott. I am from Sands, which is the Stillbirth and neonatal death charity. We are a national charity that supports bereaved parents and campaigns for improvements to care.

Dr Richmond: I am David Richmond. I am president of the Royal College of Obstetricians and Gynaecologists. I was a member of the review panel. I am a doctor at Liverpool women's hospital.

Louise Silverton: I am Louise Silverton. I am director for midwifery at the Royal College of Midwives, which means that I have responsibility for the whole of the professional agenda, including models of care, research, guidelines and standards. I have been a midwife for 37 years.

Elizabeth Duff: I am Elizabeth Duff. I am a senior policy adviser at NCT, the National Childbirth Trust, a charity for parents. My remit includes maternity services, and I was a member of the maternity review team.

Q2 Chair: Thank you very much. I will open the questioning today with a question for you, Louise Silverton. As you will know, the NMR's conclusion was that "a significant increase in the midwifery workforce is not required" to deliver the continuity of care model. That is somewhat at odds with some of the evidence that we have heard about concerns about workforce and staffing from the Royal College of Midwives. I wonder if you would like to start by explaining your views about it.

Louise Silverton: We believe that the NHS in England is currently around 2,600 whole-time-equivalent midwives short of where it should be for the number of births and the complexity of the current level of births.

Chair: 2,600?

Louise Silverton: 2,600. We also recognise that some of the excellent elements in the report, such as the promotion of continuity of carer, would not in themselves require more midwives were there sufficient already employed, but there may be a necessity, in moving from one care model to another, to have additional midwives, just to make sure that you can run—essentially transition—between two different services.

Q3 Chair: In terms of the plans for training new midwives, as you know, there is considerable controversy around the changes to the bursary scheme. Are you able to tell us your views on that?

Louise Silverton: We have just completed our evidence that is going in around the bursary. We are extremely concerned about the belief among potential entrants to the profession that graduating with a loan in excess of £60,000 will put off a lot of entrants to the profession. We were told that there are far more entrants to midwifery than there are places, which is true, but that does not mean that all of them are suitable to go on to midwifery programmes, nor does it mean that there is any capacity to expand significantly the number of clinical placements that are currently available. Unlike nursing, almost all midwifery is within the NHS. There is not a huge care sector or other areas where people can get experience.

We are also concerned that the average age of our student midwives is the early 30s. Many of them come after having experienced parenthood. Many of them are second-career people, who already have degrees. We understand that there could be provisions for this, but, for someone who has already had a loan and who has considerable debts, to take on

another loan might be asking too much. These people do bring enormous skills and maturity into midwifery. Many of the people we identify as the potential high flyers and leaders—the sort of people you need to implement the maternity reviews and recommendations at a local level—are these people who come with other skills. It takes a long time if you are just 18 or 19 coming into midwifery: it takes much longer to develop that confidence and experience.

Q4 Chair: Can I just clarify this? We have already heard evidence that, in nursing, there is already a significantly increased age at entry compared with other graduates. Is that even higher? Is there an even higher proportion for midwifery of mature students or of those taking it as a second degree than there is for wider nursing?

Louise Silverton: I do not know, because I do not know what it is for other professions. The last time we did it, the average age of a student midwife was 32.

Q5 Chair: At what point? At the point they qualify, or at the point when they enter?

Louise Silverton: We did a survey of student midwives and asked them how old they were. Some of them will be first years and some will be third years. Even if you start when you are 40, you still potentially have 25 to 28 years of service for the NHS.

We are worried. We are also worried about people from non-traditional backgrounds. One of the things that midwifery tries to do is recruit people to train as midwives who reflect the local population. We are still 99.9% female, but, among that, we pride ourselves on having significant ethnic diversity. When you think that you are working with families who are going through what is essentially a social change—okay, it is a physiological change as well—and supporting people through a social and cultural change and becoming parents, it is really good to have midwives who understand the nuances of it for all sections of society. Traditionally, many of the midwives on the three-year programme, the majority entry programme, have come through access courses—which we like to promote.

Q6 Chair: For general nursing, there is going to be an alternative route into nursing, like an apprenticeship route, the AP route, healthcare assistant and onward from there. Do you see any possibility of having the same opportunities to come into midwifery, or do you think that will not be a route that will be open?

Louise Silverton: I would have probably said no last Wednesday. I am sorry to get very political about this, but midwifery, like adult nursing, is one of the seven professions across Europe that are part of the sectoral directive, where there is automatic recognition of qualifications. The requirements for entry for that are 12 years of education, and then you have to enter into a midwifery programme, which is a minimum of three years. You cannot have any reduced entry. You cannot allow for any previous education or experience, and the only reduction is for those who are already also registered as adult nurses. Apprenticeships and flexible careers don't work for midwifery, because they are not recognised by the sectoral directives, which of course apply across the European Economic Area.

Q7 Chair: Thank you for that. Do any other members of the panel want to comment on that before I move on to asking about the experience in—

Elizabeth Duff: If I may, I very much support what Louise has said about the great importance of continuity of midwife-led care for women. This is not always well understood. You often see quotes from women saying that it would be lovely to see a familiar face. That is true, and it can help women through a difficult labour to have someone they know, but it is far more than that, and the importance is absolutely enshrined in repeated, systematic reviews of this topic, showing that it reduces pre-term birth and reduces the deaths of unborn and newborn babies.

We would absolutely emphasise that the midwifery workforce—Louise knows the numbers, and I am not going to say that I know better than that—needs to be such that models of continuity can be put in place. Obviously, that is one of the major recommendations from the review.

Q8 Chair: Thank you. It is very helpful to have that clarified. Janet, do you want to add anything?

Janet Scott: I would echo what Elizabeth said about the importance of continuity, which is one of the things that parents always report back to us. They fear that something has been missed because they have been passed from one maternity professional to another. It is not just midwives; it is continuity of obstetric care as well. Parents feel very strongly that they want to see the same doctor as well as the same team of midwives.

Q9 Chair: I turn to you now, David, to discuss the situation about workforce and shortfall in obstetrics and gynaecology.

Dr Richmond: First, we are very much a UK college, so I am responsible for all the devolved nations, but focusing on England, I suppose the single biggest issue I have on a weekly basis is the pressure in units and on the delivery suites where the clinical directors or the heads of the schools say, "We have gaps in our rota." That is probably around 25% of what we call the middle tier. We have very junior doctors, and then we have more senior doctors. The more senior doctors, in the old-fashioned parlance, would be the registrars or senior registrars, who could be taking decisions on their own. At that level, which is essential in all the delivery units around the country, we have a rota gap of about 25% at any one time. Just to give you the numbers—is that helpful?

Chair: Yes.

Dr Richmond: We have just under 2,000 consultants in England, and we have just under 1,500 trainees. What I would like to bring to your attention is the staggering number of other doctors who are also within the system, whether they are research doctors, trust doctors, post-trained doctors—what we call CCT doctors—and so on, who are necessary. Across the UK—I cannot give you it specifically for England—that is 2,500. That is the total obstetric workforce that we have. Within England, it is just under 2,000 consultants and just under 1,500 trainees.

Of the trainee workforce that we have at the moment, about 82% are female. About 82% are also working full time. About 20% are working less than full time, with varying degrees of that. Some will work half time, some will work three-quarters time and so on.

The other thing I want to bring to your attention is the fact that the specialty is obstetrics and gynaecology. Of the roughly 2,000 consultants, about one fifth will be doing just maternity, one fifth will be doing just gynaecology on call, and the remaining three fifths will be doing a mixture of both. In the larger units, for example in London or the big cities, consultants will declare their interest, because that is where their expertise is. The tertiary units or quaternary referral units are where that level of expertise is. Although I am saying to you that it is just under 2,000 consultants in England, not all of them will be doing obstetric care, and some will be providing more obstetric care than others.

If we look at the rota gaps, which we have spent a little time looking at, it is a breakdown of all sorts of things. It is a breakdown in maternity leave. I suspect there is an element of paternity leave within that, too, but I can't give you a figure for that. There is a proportion that will be doing what we call an out-of-programme experience. They will be taking a sort of parallel lay-by perspective, perhaps carrying out a PhD or MD or something en route, but they are out of the clinical system. Then, we have flexible training, because some of our trainees do not want to work full time. Then we have sickness within the workforce. Sickness is slightly—

Q10 Andrea Jenkyns: What is the level of sickness?

Dr Richmond: Gosh—it will vary by trust, but—

Andrea Jenkyns: Overall.

Dr Richmond: I would not want to be quoted, but it is increasing.

Q11 Chair: How much is variation a problem—in other words, that some areas are more seriously affected than others in terms of workforce shortfall?

Dr Richmond: That is very much the case. In areas in the west midlands, we are particularly struggling. London can be hard hit. In some of the other areas, for example down in the south-west, there is not so much an oversupply, but it is less of an issue.

Q12 Chair: I will give the panel an opportunity to say what they feel overall about the review. I know some of you have been involved with the review itself, but are there any critical points around workforce that you want to make a point about?

Louise Silverton: I mentioned the importance of continuity of carer. We know some of the things that make these models successful, and particularly some of the things that make them unsuccessful. Particularly where you are starting to introduce a few teams, the thing that can actually undermine that is if the team members are pulled away to help when the labour ward or somewhere else gets very busy. This was why I was explaining that you might need additional cover, just while you are transitioning from a few teams to them being in the majority. The work of delivery unit suites in particular is very unpredictable. We also know that, where women give birth in midwifery units, the workload throughout the day is reasonably predictable but is very much skewed to the evening, overnight and early morning, which means that midwives do a lot of overnight on-call in order to be there when women give birth.

Our concerns are that providing continuity of carer means that the HR systems have to be very flexible. You cannot have women—midwives necessarily—firmly rostered. There has to be flexibility within the teams as to how they meet the needs of women and follow the women. You need to ensure that you have enough midwives, but also that the system and such things as e-rostering do not stymie them by saying, "You don't seem very busy at the moment." They are not busy at the moment, because they were busy last week, or they are going to be busy next week.

Chair: Thank you very much. I am afraid that we are going to have to disappear for a while.

Committee suspended for a Division in the House.

On resuming.

Chair: Apologies for that disturbance. We will now come on to the next section, on multiprofessional working and training. James is going to kick off with that.

Q13 Dr Davies: How far away are the royal colleges from being able to offer the type of multiprofessional training that is envisaged within the review?

Dr Richmond: A long way, in a nutshell. That is not to say that there is not enthusiasm. From my point of view, it would depend on what we really mean by multiprofessional training, whether you are talking about undergraduate, postgraduate or in-hospital safety training, skills and drills training or emergency training. If we take the first two, undergraduate and postgraduate, I think that is in the very hard box, and I am not quite sure how we are going to get there, but it is something that needs to be discussed and debated with Health Education England.

If you are looking at multiprofessional training in the environment of a hospital, I think that we are a lot closer to that. That is being undertaken in many units in England as we speak. In the report, we talk about one in particular, the one that has been generated from Southmead in Bristol. One of our colleagues and both obstetrics and midwifery have been promoting this. It has shown fantastic results. Doing that across the country has proved a lot harder than we would like. Whether that touches on workforce pressures or on the costs of running the programme, not so much for the models and simulators that might be required but for backfilling the staff to allow them to undertake the training—that is the issue. Whether it is a midwife or a doctor, allowing them the flexibility to go and spend a day, two days or three days is proving taxing around the country. Much of that I touched on when you asked me the first question on workforce.

There is a lot of enthusiasm to follow this line, and I think we will succeed at the top end in hospitals. I think the postgraduate and undergraduate levels might prove a little more taxing.

Louise Silverton: What you have with midwifery and medical training is that, in many places, they occur in entirely different institutions. The medical training, as you know, is overseen by the GMC and is provided in medical schools. The midwifery undergraduate training is in a number of higher education institutions, many of which do not have medical schools, and, even where they do, they tend to be departments of health studies with nursing and allied health professions. You would need to unpick that.

What is probably more achievable, although still difficult, is to take undergraduate midwifery education and to try to have some common training alongside the postgraduate training for doctors on the O and G route, in particular on the obstetrics side.

Speaking about multidisciplinary training in hospitals as part of CPD, to reiterate what David said about staff being released for that, we are picking up that there are many different models of this, so it can be anything from a day and a half a year to—across the river at St Thomas's—five days a year. If they are investing five days of training for every obstetrician and every midwife, many of whom—certainly midwives—work part time, the costs of that when employing people who only work half time or less is considerable.

I am not arguing for less training, because it is really important. We have examples of a lot of very good multidisciplinary training. The PROMPT programme in Bristol is one of them, but that flourishes within a very supportive environment, where all the staff are hugely committed to very respectful relationships between midwives and midwives, doctors and doctors, doctors and midwives and everybody else in the team. Unfortunately, that is not mirrored everywhere.

Dr Richmond: Could I just come back for a second, if I may? As Louise says, the course that we touched on in the review is the PROMPT one from the south-west, which is fantastic. There are others. As Louise has alluded to, there are some Canadian models, and I think there may be a Swedish model, but I am not entirely sure. It would be superb if we could use these recognised models in the vanguard situation—if we could take what is already there and promote it through these pilots; that might be the way forward. It might need to be funded, not for the hardware but for the backfill of the staff. That is the key to this. That is why we keep getting told that it fails.

Louise Silverton: It is the same problem in multidisciplinary review cases. When we were fairly junior together—we did work together, David—there used to be perinatal review meetings, and almost everybody went to them. The nature of the workload in maternity services now is such that you find that the midwives are there at one meeting, and the next time the obstetricians are there, but the difficulty is getting enough people there to do the ongoing learning from cases to discuss whether things could have been done better, which is as important in learning as the formal programme.

There are issues. I know the review talks about making sure that some common processes are being undertaken on doing reviews. David will talk about the experience at the RCOG with the "Each Baby Counts" programme. It is really important that we learn from what has happened and that people share the learning outside their unit so that they do not make the same mistakes as the neighbouring unit, and that they then complete the cycle and continue to audit to ensure a continuous process of improvement.

Q14 Dr Whitford: Coming from a breast cancer background, I can say that we went through exactly the same, where management considered that we were going to be sitting around for two hours drinking coffee, and that wasn't bums on seats. Yet it is that multidisciplinary coming together.

Is there an attempt at a review of every single baby that is lost in the perinatal area?

Janet Scott: No. There a real lack of information about that. The quality of reviews is extremely variable across the country.

Q15 Dr Whitford: We will come on to that in more detail. It is just your comment about people not coming to the meetings. Sometimes, there would not be a meeting.

Dr Richmond: Yes.

Janet Scott: That is part of it, yes.

Dr Richmond: Those are the things that go, whether it is in breast cancer or GI or whatever it is. Where there is significant pathology and lessons to be learned and you need a multidisciplinary audience to discuss it in an open and transparent way, time is of the essence, and we do not have the time.

Q16 Chair: Elizabeth wishes to come in on an earlier point.

Elizabeth Duff: Thank you. I want to raise something that is very much drawn from the kind of feedback that we get from women, which is on a different kind of multiprofessional training. In the post-natal area, that is so often where women say that they receive conflicting advice, and it can be bewildering at best and absolutely deeply stressful at worst. That may be, for example, with support for breast-feeding, which the majority of women wish to do, but the majority of them give up before they actually want to, often because they are not getting the right support or because they have been told one thing by a midwife, another by a health visitor and a third thing by a GP. That really doesn't help in the early days.

I don't know if it is possible to have some way in which the community staff looking after women in those brief times—the early weeks—could have some form of training where they are making sure that they are all based on the same evidence, which is absolutely there.

Perinatal mental health is another area where that is exceedingly important. That is a topic that has rightly risen up the agenda recently, and everyone caring for women, through pregnancy and post-natally, needs to be sure that they know what the signs and symptoms are and what to do.

Q17 Dr Davies: I think bereavement care has also been picked up on in evidence. Are there any elements of current training that you think are lacking?

Janet Scott: I would add neonatal care to that as well. That is part of the multidisciplinary training, too.

Dr Richmond: I think there is a missed opportunity in training, whereby our juniors in the medical world are working 24 hours a day, seven days a week. They do not sleep at night.

That is part of their shift. Yet, we miss that 12-hour or 14-hour opportunity for training, where the senior professional or senior trainer is accessible, not on the end of a phone—but that is impossible to achieve at the moment; it is just simple staffing numbers. There is a huge missed opportunity there.

Louise Silverton: Not wanting to go back to the 40-hour week, but one of the things in midwifery that was a huge advantage was the two-hour overlap in the afternoon. That was the time when more experienced midwives taught junior ones or taught the students. There is actually no slack, not only for that sort of informal teaching in clinical areas but for reviewing and going through cases.

I used to talk to a student when we had done a birth. I would ask her, "How did that go? What did you think that meant? How might we do it differently?" That is the only way that you learn, by having the theory brought into practice and then exploring it. You do not really want to learn by trial and error. That is not a good way of doing it.

Q18 Dr Davies: If we move on to the suggestions in the report related to technology, what are your thoughts on that? The royal colleges initially, please.

Louise Silverton: The generation who are currently having children are very tech savvy. Almost all of them have smartphones or access to tablets and things like that. We have been very slow in capitalising on that, but we have some examples of some very good materials for women. There is the Baby Buddy app, among others, and hospitals such as Portsmouth have developed their own, which are very interesting. As part of our DH-funded stepping up to public health project, which is a new public health project in midwifery, we are developing an online resource for women that will guide them to good areas where they can find everything—from "Where should my baby sleep?" and "What colour is my baby's poo? Is it normal?" to "I've got heartburn. What do I take?" or "My foetal movements have changed." With our online repository, we are developing a web app that will simply take women to the website, so that they find this 24 hours a day. The work that we did with them showed that they wanted access to trusted information, rather than Googling. There is a lot out there, and you can spend a huge amount of money. We have deliberately chosen not to have an app with lots of functionality in it. People do not necessarily update their apps. Therefore, if the guidance on babies' sleeping arrangements changes, we do not want them to have an old version of the information on their phone. By taking it straight from the web, we make sure that it is always up to date. Women need this information at 3 o'clock on a bank holiday Monday morning, so you have to make sure that things are available 24 hours a day. The advantage of the web is that they translate it as well—for those whose first language is not English.

Dr Richmond: For me, it is knowledge transfer and knowledge access or availability. We tend to be overburdened with the availability of knowledge. We have evidence-based guidelines coming out of our ears, which we can try and share with patients. That is good if the patient is IT and technology savvy. It is getting to those who do not have access to technology, the hard to reach and the disadvantaged—the socially disadvantaged, the professionally disadvantaged, the intellectually disadvantaged. That is a huge challenge.

Professional transfer of knowledge is key. From the primary care setting on a bank holiday, a Sunday or at night, it is about access to what that patient has used for the nine months of their pregnancy—the electronic patient record comes into this. Being able to

take what has been put on by the primary care or community team and then accessing it in the emergency situation is key to this. I don't know what son of FaceTime will be, or daughter of Twitter—I haven't a clue what is around the corner, because I am not particularly technologically savvy—but there must be phenomenal opportunities that we should be able to harness in this situation.

Q19 Chair: For the purposes of this inquiry, what kinds of areas in terms of holding to account for delivering on the technology changes do you feel are important?

Dr Richmond: Gosh. I would be interested in Julia and Cyril's comments later. Whether or not this is just NHS England, we should be working in parallel with this. We have the expertise in generating or synthesising the evidence. We are quite good at that, professionally, on the guidelines, for example, be it NICE or in-house college guidance. It is on disseminating that and making it available to the patients that I do not think we are quite so good. Making sure that the patient actually understands what is there is hard, I find.

Louise Silverton: The other disappointment is with the introduction of electronic patient records. It is a great idea, but there is the tradition of women having their own maternity notes, being able to write queries in them and being able to take them with them so that, if they have a problem at 34 weeks when they are away in Llandudno on holiday or something like that, they have their notes. Once you go electronic, the risk is that they do not have that, and it seems as if it is not their notes. There must be ways round this. You can put your tax return online. They send you a secure code. Why, when every woman enters maternity services, do we not send her a URL, so that she can enter her own data? Why does the midwife at the booking spend half an hour with two fingers and her back to the woman, laboriously entering data on a computer? Most women will be able to do that. For those who can't, yes, we can do it, but it then it becomes a conversation.

IT across the NHS is one of these very difficult things that sits in the too difficult box, where it shouldn't be. Not wanting to rehearse what has happened over the years, but some of the information systems within maternity services are really dreadful. They are held together with string and Elastoplast—metaphorically.

Elizabeth Duff: I would add simply the making of appointments. Too often, that is still done in a not very IT-contemporary way, resulting in women turning up and having to wait for a long time. That might be because the service is overstretched, but having to go for an appointment that does not suit them, because they are working during their pregnancy and so on—there are lots of ways in which that could be done: either one-to-one between the named midwife and the pregnant women or using an online way to fit in an appointment. There are numerous telephone calls and letters going to and fro and so on, which is not a very 21st century way of making appointments.

Q20 Dr Davies: There are lots of opportunities with technology, but how would you respond to the Down's Syndrome Association, which says that the digital maternity tool can be inappropriate for sensitive information to be imparted, and that well-trained staff are more important?

Janet Scott: There is an issue that we have concerns about, around women having information about the risks of pregnancy. That is difficult information to deliver. We

would like to be sure that that information is delivered in a non-biased and evidence-based way. It is something that has not been done without technology, so bringing technology into it brings in other issues. You do not want a women sitting at home, looking things up on her phone or booking where she is going to deliver her baby on a phone all by herself. It is really important that the technology is delivered in the context of really good care and good personal advice—and good personal risk assessment as well.

Q21 Dr Davies: Finally in terms of technology, the review recommended that nationally agreed indicators for data collection be endorsed by the royal colleges. How quickly do you think that might happen?

Dr Richmond: I would think weeks or months. I do not think that it is hard; it is just about trying to agree what is a reasonable number. I would guess 10 to 15. We are in discussion with CQC and our neonatal colleagues, so it is not just maternity. It is a dashboard, which meets the approval of the professions dealing with the mother and the baby. That is focusing the plethora of indicators that are already out there on a relatively small dashboard that is meaningful. It has to be timely. That is key. It is no use having reports that are a year or 18 months old. They need to be almost on a daily basis, but probably more likely on a weekly or monthly basis. That is possible, as long as we can get electronic access, so that it is not too burdensome.

Q22 Dr Davies: The last question from me refers to multiprofessional peer review. How often is that already happening, either formally or informally?

Dr Richmond: In maternity, I don't think it is happening as much as it should. It would be reinventing the wheel, to be honest. We used to do it 10 or 15 years ago, when the professions had much greater input into going round the hospitals around the country. In obstetrics and gynaecology—from my perspective—it was called the hospital recognition committee. That was dumbed down considerably when PMETB raised its head, and we lost the educational access—we lost our ability to do so.

If you go round many of the colleges at the moment, you will find that there is a greater enthusiasm to go back to those days, when we went in perhaps in a network or a region to review the performance of hospitals. I think that is a great way forward. It comes back to workforce and time, and a facility and ability to do it. It is considered acceptable, not only to the profession but also to management, and it would be a tremendous way forward. It would actually help CQC.

Louise Silverton: But it was not multiprofessional—and nor is the review that local supervising authority midwifery officers do of midwifery services. They do quite extensive audits into the service, and they are very useful. The CQC uses them. They are a bit like the canary in the mine, and start picking up things that are going wrong.

With the loss of statutory supervision in the proposals that have just come out before we finish the consultation—and shortly going to other statutory instruments—those LSA reviews will no longer take place. Unless strategic clinical networks are empowered to do these overviews and audits—and I certainly think that they should be multidisciplinary and not just focusing on midwifery—a significant resource will be lost.

Chair: Thank you. We now move on to investigations.

Q23 Julie Cooper: Moving on to the "Each Baby Counts" report, what lessons have been learned from the report? That is a big question, I realise.

Dr Richmond: It is a little bit early, because it was only launched on the 10th, as you know. From a college point of view, we were surprised at the number. The professions—when I say "the professions" I mean the clinicians in both midwifery and obstetrics—were staggered by the findings in the report, not only the number but the appalling review of these babies who were dying or born in such a poor condition that they are likely to be disabled. There was also the lack of involvement of parents, not only in the reviews, but regarding the transparency of that report. There are lots of lessons there.

In the fullness of time, when we have got all the reports in and we go into the nitty-gritty of why these things have happened, there will be further lessons to be learned, I am quite sure, but we are quite a long way off that, partly because the number that were being reviewed is not enough, the quality of the reviews is poor and the standardisation of the tools that were used was also poor. We shall address each of these.

On a positive note, I personally think that we can do a lot about this. I can tell you that 100% of the units in the United Kingdom signed up to this initiative within three months because, from a midwifery and obstetric perspective, they thought this was something that they wanted to embrace and support. I feel that my cup is half full, and I think that we are on the right track but, admittedly—and I am sure Janet will speak more broadly about stillbirths and neonatal deaths—if we look at the particular focus of this report, which admittedly was on a cohort, just a small proportion of these, we did this deliberately, because we wanted something identifiable and something that we could do something about.

Q24 Julie Cooper: Did you want to add to that?

Janet Scott: Yes. It is really great, the "Each Baby Counts" work, and it is important, but we must also remember that the deaths before labour begins are also really important. In those deaths, you see a similar—in fact, worse—picture for the investigations of those antepartum stillbirths. That was demonstrated in the MBRRACE confidential inquiry into antepartum term stillbirths, so we have evidence for that. We also have anecdotal evidence—endless anecdotal evidence—from parents. We must remember that many of those deaths are potentially avoidable, too, and that, when those deaths are looked at, a very high proportion may be attributable to poor care. It is essential that these deaths are looked at, not just for those parents whose babies have died, but because of the lessons that are learned for all of maternity care. A huge amount can be gleaned from this.

Q25 Julie Cooper: Dr Richmond, you have touched on the fact that there are some very disturbing statistics in the report. Given that, there is obviously a degree of urgency. You said that organisations had already signed up within three months to take action here. Can we afford to wait for the new Healthcare Safety Investigation Branch to come up with a set of standards on this, or is action needed immediately?

Dr Richmond: First, there is going to be a standardised perinatal toolkit, and I think that it is being awarded literally as we speak, either this week or—excuse my ignorance, but I have been sworn to secrecy.

Louise Silverton: Very soon.

Dr Richmond: That is going to be available, and it will standardise the way that people can go about reviewing these tragic events.

I keep going back to the first set of questions, which is making this something that, within the health service and in society, we want to see on an annual basis, which is mandatory, so that you must do it. There must be a multiprofessional and possibly peer-reviewed perinatal report from each hospital, so that we can look at the antepartum, intrapartum and neonatal deaths and at the morbidity arising from these babies who don't die but are born in such a poor condition that they are likely to suffer for the rest of their lives. We owe it to society. I think that is possible, but somewhere we need to mandate it, somewhere we need to give people the time to do it, and make it acceptable within the working week to do this.

Janet Scott: What we do not want is the web tool that will be developed being turned into a sort of tick-box that somebody sits at a desk and fills in. It is essential that it is part of a really dynamic meeting, where people are allowed to say what they have seen go wrong without fear of being personally blamed—unless there is good reason to do so—and where parental views are fed into that, because parents have a lot to contribute. As David says, however, there is already real concern about how that is going to happen.

Louise Silverton: As part of what David is saying, if you are doing this on an annual basis, the next year, you should report about what has happened about the learning from the previous year and how that has been implemented. Otherwise, it just becomes a series of reports—

Q26 Julie Cooper: So, it is continual improvement, learning from experience.

You touched on parental involvement in this. How do you think the parents should be involved in investigations—in particular investigations and in wider reviews of maternity care?

Janet Scott: Well, how? You just ask them, really. Parents really want to tell their story. There is a worry—

Q27 Julie Cooper: Are they involved enough already?

Dr Richmond: No.

Janet Scott: No.

Q28 Julie Cooper: Is there considerable scope for improvement?

Janet Scott: The vast majority, 90% of parents, do not even know that a review has taken place, let alone that they have been invited to participate in it. What happens then is that they might find afterwards that they disagree and there is a lot less satisfaction with the process—they have not really been able to get into it.

The parents are there all the way through, so they are the only ones who have that overview, and they can contribute a lot to understanding what has gone well and what

hasn't. We have recently surveyed parents and we asked them how they would like to be involved. Some would like to write and some would like to attend a meeting. It is variable. It needs to be flexible around what individual parents want to do. There is a minority of parents who do not want to contribute. It is about asking parents, "How do you want this to happen?" but to shut them out is the wrong thing.

Q29 Julie Cooper: So, there is a recognition that that approach has got to be made.
Janet Scott: Yes.

Elizabeth Duff: I will just add a word more generally about feedback from parents, not necessarily because there has been a very serious incident, but there should be maternity service liaison committees, which are multidisciplinary forums with lay representation associated with each clinical commissioning group, and they are in place in most. They are usually able to design ways of bringing in user feedback, although they are not user groups themselves, but they can do excellent work in bringing in feedback about services all across the board, including support for those parents who have had really tragic outcomes, but also for people who have very constructive views and may have had a positive experience but would like to spread good practice. They can be right across. They do some excellent work, and they merit support.

Janet Scott: Very often, what parents want to feed back is about good care that they have had. It is not always negative. There is a lot to learn from that.

Q30 Dr Whitford: The report suggests personal maternity care budgets, which some people reading it found slightly surprising. I will start with you, David, but I would like everyone's opinion. In what way could that encourage safer care?
Dr Richmond: I think it is good for choice, but that is not answering your question. I think that this will work only if we have a bigger footprint for maternity care. At the moment, it is very much focused on the foundation trusts in England. That is the denominator, and that is where all the business goes through. If, as we have alluded to in the report, we were to focus on a larger footprint, not only of patients but of hospitals, be they delivery units in a hospital, alongside midwifery units, freestanding units or home births, and we begin to ask, "What's best for the mother?" the mother will have a greater choice, as long as the professionals can begin to signpost where they might be best served and give the mum the opportunity to interact and have part of the say in where she might like to be cared for, rather than, at the present moment, it being dictated, "You're going to have your baby in that obstetric unit," because there is little choice.

Q31 Dr Whitford: So you feel it would help choice, because the mother—
Dr Richmond: Yes, I think it would help choice, and if we get choice and safety together—they have got to be so closely interlinked.

Q32 Dr Whitford: And you do not think that there could be a conflict, in that you actually want a continuum, because we don't always absolutely know what is going to be required towards the end?

Dr Richmond: Yes.

Q33 Dr Whitford: Do you not think, when you look back at Stafford, Mid Staffs and Morecambe Bay, which people are fighting to make foundation trusts, that there would be that disincentive of, "Well, we need to keep the money here. We mustn't let her go there"?

Dr Richmond: There absolutely is at the moment, which is why this has got to be broken down.

Q34 Dr Whitford: Do you not think that a personal budget, in that way, could make it worse, if someone loses her as a customer to another organisation?

Dr Richmond: Absolutely, and if we don't change to a larger template that has the authority to provide the best care for a cohort of women in a bigger region, whether it is an STP or a strategic clinical network—ideally it should be the latter, but an STP would do to start.

Q35 Dr Whitford: Does that not then make the personal budget irrelevant, in that what most women want to know is that their STP in the place they live is good all the way from community to home to hospital, depending on what they require?

Dr Richmond: I personally would doubt that each of the 44 STPs could deliver the whole package, so I think it will probably be a number of STPs in a strategic network that are likely to provide the total package, which then allows the woman to choose—if that is what she wants—the bits of the service that might be best for her.

I think this is going to be a really small number. I would not like to give you a percentage, but I think it will be a very small percentage of the total—

Q36 Dr Whitford: —who would choose to use a personal budget?

Dr Richmond: Yes, I think so.

Q37 Dr Whitford: What would that be based on?

Dr Richmond: I suspect they are looking predominantly at antenatal care. I suspect they may want to choose a variety of providers for antenatal provision. Where I live, that might be possible; in the north-east of England, that might not be possible. There will be bits of geography where it is more likely that independent providers of antenatal care—women might want to choose that. I personally think that intrapartum care is much more challenging, but that is coming from an obstetric point of view.

Q38 Dr Whitford: Do you see it as a positive thing, or do you think there is a danger of fragmentation from it?

Dr Richmond: I am going to sit on the fence. I am happy for this to be piloted, which is what I said in the review, and that is exactly what is going to happen. Let us wait and see how it pans out and then review the situation in 12 to 18 months.

Q39 Dr Whitford: I will come to you, Louise, before bringing in the others. This is quite a big thing.

Louise Silverton: We think it is an interesting idea, but it needs to be tested. We need to see how it works in the pilots. I think it has come about because some women say that they can't exercise the choice that they want. It is not necessarily simply antenatal care. It might be that they want continuity throughout the whole pregnancy, birth and post-natal care. It might be that they want something very different or very personal to them that is not being offered locally. The fact that it isn't offered locally might be down to issues of resourcing and midwifery staffing. From our experience, when times are tough, what tends to go is the home birth service and the freestanding midwifery unit. Why would a woman arrange to have a baby there if she knew that it might not be there at the point when she actually needs it?

If we show, when we do the pilots, that it simply shakes up the providers, is that what we want, because the women get the choice they want, or is it actually a move to get a plurality of providers within maternity? If that is the case, there has to be caution about ensuring that those boundaries between elements of care and different givers do not become barriers. We know from our colleagues in the United States, where nurse midwives, although they work with obstetricians, do not have admitting rights to obstetric hospitals, that it leads to blaming when there are delays in transferring. One of the joys for women in the UK being part of the NHS is that we are not fighting over turf. We are not fighting over being paid for elements of care.

Q40 Dr Whitford: Do you see that as a danger of this, if your income, as a hospital, depends on it?

Louise Silverton: It is a danger if it is not designed properly. The providers that the women take their vouchers to have to be part of the whole set-up. They have to have the same standards and the same CPD. There need to be clear protocols for transfer and accepting women back when whatever has happened has been resolved.

Q41 Dr Whitford: As part of the review, was there an exploration of how that would work, in essence, if women are given the average? Obviously, lots of women are cheaper because they are fine, but there are a few women who are lots more expensive.

Louise Silverton: I was not part of the review, but that was a question asked by a number of media outlets when the review was launched. Women do not necessarily come with a bundle of money. They can change from being a woman without risk of complications during pregnancy to becoming a woman with complications. For those who do not have complications at the start of labour but develop them, you assume that the tariff, on average, is enough to cover that in that way. What happens if a woman starts care in labour under someone to whom they would give a voucher, and needs to be transferred? There are risks there about arguing over money and who picks it up. One would hope, again, that this is teased out when they actually try it.

Q42 Dr Whitford: Can I ask you for the view of the Royal College of Midwives? Do you have any sense of that at this stage?

Louise Silverton: Our view is that it is an interesting idea, and we are waiting to see. We need to ensure that it produces not only choice for women but that women feel safe. The issues of safety are not just medical safety but that women must feel safe in a particular environment, with a particular model of care, as well as it being medically safe, and that it does not have any unintended consequences

Q43 Dr Whitford: Would you see it causing planning difficulties in that, once you come back to being a place where people may shop, it becomes difficult to plan a local integrated service?

Louise Silverton: It could do. That is one of the issues of choice that we have in the NHS anyway. Where a service is already overburdened, it is the equivalent of your being at the very back of the plane: there was a choice of meat or fish and, by the time they get to you, all they have is fish because they have run out. We need to look at capacity because, to have realistic choice, you need spare capacity, and we do not have any at the moment and we do not have any spare money either.

Q44 Dr Whitford: Can I bring you in, Elizabeth, before Janet, to see if you have any comments on the personal budgets?

Elizabeth Duff: Yes, thank you. I have been musing and thinking about the idea and trying to analyse it for some time. I must say, when I first heard, I did not find it very appealing overall, partly because I thought, initially at least, that the women who would benefit are those who are already at the top of the tree in a way—those who are well informed, who speak English, who are well educated and well connected. We have a number of those in the NCT—I would be the first to say it, and there is nothing wrong with that—but we are also very concerned about women on low incomes, who perhaps speak poor English or are poorly educated. They are perhaps even more marginalised because of all sorts of things. They might be drug and alcohol users; they may even be women in prison. All these women have babies. It would be very pleasing to think that what comes out of this maternity review benefits not only all women having babies a little bit, but those who are most at risk a lot, and that it reduces the risk of poor outcomes for such women and their babies.

I wanted to know how this mechanism could benefit those women. I have received and understood some arguments about that, which I can see, but I am not quite as convinced about it as I would like to be.

There was an example that I knew about—which could have been resolved by a personal budget—concerning a young woman with learning disabilities, who had no family support. She needed somebody in the sense of a doula or birth companion, to be with her and make sure that she understood what was happening. Someone from my organisation fulfilled that role and was paid for by the social services. I imagine that that would be the sort of thing, which was a very beneficial thing to happen, that, with a personal budget, could have been arranged for her. Even so, it would have needed a lot of input to make sure that that woman could make that choice and realise what the consequences were.

As with David and Louise, we really look forward to seeing the results of how it works, how many people wish to use it, which sort of women they are and how much help is needed for women to get the best out of such a system. There are certainly opportunities for good to be done that way, although there are also threats of fragmentation, as has been mentioned. It would be lovely to think that more continuity of care—which I am always talking about—could be obtained, but it is also worrying that it might go the other way. Like the others, I am a little bit on the fence, but I am very much looking forward to the results of what happens.

Q45 Dr Whitford: So far, all of you have the view that it will be something that a small number would choose to do, rather than becoming the norm for everyone. That was my concern. How on earth do we plan anything if everyone is just trying to shop? What women want is that everywhere is good.

Dr Richmond: Yes. At the moment, you can have a normal delivery or an abnormal delivery, in essence, and you are still going to need the fixed costs of a hospital should things go wrong. Even if there was to be a breakdown for an individual who wanted to go down the personalised budget route, it would not just be at the normal birth total, I would imagine. There would have to be some top-slicing in order to maintain a hospital environment, should they need it. There would be fixed costs, which I think one would need to factor in.

Q46 Dr Whitford: If I come now to Janet, particularly, what do you think, looking at the risks of it, would be the real benefits of it, in the sense of asking the woman to manage that journey herself?

Janet Scott: It is a difficult one. We know that most stillbirths happen in pregnancies that were considered low risk. Most women do not expect things to go wrong, because there is very low awareness of the risks of pregnancy. That is fine, because most pregnancies do end well.

If women are being asked to make choices, they need good information to base those choices on, and there is not good information about safety levels in hospitals, whether it is comparing one unit or whatever with another, or whether it is within those hospitals. We know that there are specific areas of risk, which are not well identified in some pregnancies, and which may lead to an avoidable stillbirth. There is no information about whether this hospital is really good at protocols for decreased foetal movement and whether this one is good at detecting poor growth. There is no information about that. How do women do that when they are sitting at home thinking, "Where shall I go? Where is the good information?" Information is absolutely key.

Q47 Dr Whitford: But even if we had the information that hospital A is really good at this and hospital B might be good at something different, so that women can weigh one against the other, are we not then into the situation that, instead of fixing both of them, which means that all the women get a better service, everyone takes their budget to one and the other one keels over and turns into a ghetto?

Janet Scott: Someone will still be going to that one. That is the worry: who is going to be left with the less good services?

Q48 Dr Whitford: This is what I mean. I am just trying to understand what could be the big benefit that would come out of this when, in actual fact, what people most want to know is that the one that is five minutes up the road has passed the standards, is really reliable, and has staff who are lovely, rather than thinking, "I could travel 20 miles to somewhere different."

Janet Scott: From our perspective, we would agree with what you have just said. Everyone wants their local unit to be good. From my perspective, from Sands's perspective, introducing choice puts a burden on families to make these decisions. If something goes wrong, you think, "Gosh, I didn't know that there was that risk or that I was exposed to poor care. Maybe I did something wrong." I am not sure how this is going to drive safer care. I am prepared to see how it will work and what the pilots do, but I think we need to watch this.

Q49 Dr Whitford: You cover a broad range in this field, and this is not something that has come forward, such that your members, whether medical, midwifery or patients, have said that this is something they want.

Louise Silverton: A few of our members would like to be providers. That is acknowledged, but it is not a call in the same way that we have seen with people with long-term conditions, who feel, "I have diabetes. Perhaps I want to join a gym. Perhaps I need to learn to cook." It is not that sort of thing. Pregnancy is a very short period of time to negotiate, for some people, without having the burden of having to choose.

Q50 Dr Whitford: So, it is not a response to a demand within the field. That is what I was trying to pick up on.

Louise Silverton: Not that we have picked up, no.

Q51 Chair: Are there any final points that any of you on the panel would like to make in response to the national maternity review?

Dr Richmond: We have not talked about GPs, which I think is very important. What came to mind was post-natal care, but you could probably equally go to the other end of maternity care: pre-conceptual care, early antenatal care, and that integrated element of looking at what is best for the women.

By and large, the primary care system in this country has worked extremely well, but the level of GP input into maternity care has dropped dramatically over my professional lifetime, from where you would see GPs coming into the delivery unit and actually doing births to hardly having any responsibility for antenatal, intrapartum or post-natal care.

Secondly, the post-natal element has become the Cinderella element of maternity care, partly because of the thrust to get mums and babies out of hospitals as fast as possible. If you have a normal delivery, it is hours, not days, and a Caesarean section is in single

figures. Often, the mum will go home 24 or 48 hours after a Caesarean section. The opportunity for the mother and baby to bond, and to share information, is lost.

Finally, I do not think we are as good as we used to be at the handover—that sounds a terrible word—of the baby to the health visitor and of the mum to the GP. Having that continuum of care, with secondary care involving a midwife and a doctor, and linking closely with the GP, has diminished considerably, to the detriment of the service.

Q52 Chair: You are certainly right. When I started in general practice I was attending home deliveries, but, by the time I finished, that had completely finished.

You mentioned handover. Where specifically do you think GPs should be more involved in maternity?

Dr Richmond: Me personally?

Chair: Yes.

Dr Richmond: Intrapartum is more or less gone, although there might be a few enthusiasts. It is at both ends. Personally, I think it is at the preconceptual end, and particularly when the mum has some health issues herself when she is handed over from primary care into the maternity system, as picked up by the midwife or by the obstetrician, be it diabetes, genital abnormality or hereditary conditions—things that we need to know about. That could be better. I have also touched on post-natal care.

Q53 Chair: At both ends of the handover.

Dr Richmond: Yes.

Louise Silverton: I would follow on from that by saying that women who have experienced, for example, gestational diabetes, gestational hypertension or pre-eclampsia, particularly those who have had pre-eclampsia or hypertension, are at a considerably raised risk of developing cardiovascular disease sooner than they would do if they have not experienced that. Unfortunately, there is some lack of continuity with GPs. GPs do not necessarily know what has happened. I think this is really important, because these women need to be watched. Women with gestational diabetes need to be watched, because they will develop type 2 diabetes sooner than if they had not done. That certainly needs to be looked at.

On the report, I have been a midwife for a long time, and we have had reports going back a long time—"Changing Childbirth" and various other reports—but this is the first one that has had an implementation plan. We need to say, "Well done, NHS England." We have an implementation plan. Perhaps this time something will happen, although I do think we keep reinventing the wheel.

Q54 Chair: On that point, are you happy with the implementation plan or are there points you would like to make on it?

Louise Silverton: I have seen only drafts, because I am not part of that programme. The section on prevention does not sufficiently acknowledge the midwife's role in public health, and that is a great lack. I think it should say a lot more. We are the people who are

really getting the foundations for the public health input, not only for pregnancy but for those parents raising the baby and the child of the future. I do not think that they acknowledge that. They have quite a lot about health visiting, but there is very little about midwives in there.

The final point is to recognise the profile on post-natal care. I think women are being severely let down on post-natal care in the community. It comes down to how the tariff has been arrived at. Before it was set, the tariff was so whittled down, because it was a poor contract. Essentially, trusts costed what they provided, and what they provided was woefully insufficient; £240-something for uncomplicated post-natal care at the hospital does not get you very much.

Elizabeth Duff: I agree with Louise. Overall, I and my colleagues in the NCT were really pleased with the recommendations and results of the maternity review. Although we have made some potentially critical comments today, I want to make it quite clear that the vast majority of it was very welcome, and I think it was aligned with the feedback that has come from parents over years and years—and currently and in the future.

There is one point that we have not touched on at all today: the success of midwife-led units looking after women who have no need to be in hospital and the way that they have succeeded in providing that care, making smooth transfers where it is needed, so that there isn't a panic for the woman concerned. They often provide local care so that women do not have to travel so far unless they need the more specialist care.

The idea of community hubs, which may be co-located with midwifery units, which came out through the maternity review, is excellent, and I very much hope that those successful midwife-led units go on being supported in enabling women to have low-risk births, often with a much better degree of continuity and working with familiar midwives, which is of greater satisfaction to both the midwife and the woman. It could happen in hospital as well, where I think the midwife units provide an excellent model.

Chair: Thank you very much for that, and thank you very much for coming this afternoon.

Examination of Witnesses

Witnesses: **Baroness Julia Cumberlege CBE DL**, Independent Chair, National Maternity Review, **Professor Sir Cyril Chantler FRCP FRCPCH FMedSci, Vice Chair**, National Maternity Review, and **Sarah-Jane Marsh**, Chair, NHS England Maternity Transformation Programme Board, and Chief Executive of Birmingham Children's Hospital and Birmingham Women's Hospital, gave evidence.

Q55 Chair: Welcome and thank you very much for coming. I am sorry that the second panel has been delayed by the Division earlier. Could we start this session by you introducing yourselves to those who are following from outside the room?

Sarah-Jane Marsh: My name is Sarah-Jane Marsh. I am the chair of the NHS England Maternity Transformation Board. I am also the chief executive of Birmingham children's hospital and the chief executive of Birmingham women's hospital.

Baroness Cumberlege: I am Julia Cumberlege. I am the Independent Chair of the Maternity Review.

Professor Chantler: I am Cyril Chantler. I am the Independent Vice Chair.

Q56 Chair: Thank you all for coming this afternoon. I want to start off by trying to explore further the workforce issues and how far that will create barriers to what you are trying to achieve within the National Maternity Review. Perhaps I could start with you, Baroness Cumberlege.

Baroness Cumberlege: We did do some modelling. One of the things that has come out of the first session, and it is something we feel very strongly about, is this continuity of carer: the person looking after the woman throughout the antenatal, the birth and post-natal care. We did some modelling on that. It did not come out that in fact we would need a lot more midwives.

However, I think it is fair to say that there is a shortage and there is pressure on midwifery services. One of the things that really interests me is that on the NMC register there are 2,500 midwives who are not working in the service at the moment on the frontline. Clearly, some of those are not working for very good reasons; they are taking a break because of family or whatever,[1] and they may be doing other things that are essential in terms of running the services. Nevertheless, we know that there are quite a lot of midwives who feel that they are disadvantaged in the way that they are being treated and managed. Too often I hear the phrase, "I love the work but I hate the job." Something has to be done about reorganising and looking at new ways of care[2] to ensure that women have a safer service, have choice but also that the workforce is happy in the way that it is working.

Q57 Chair: As you envisage it, there would be groups of midwives working together and women being able to use their personal budgets to access a continuity of care. Surely one of the issues is that, if we are going to provide choice and that level of continuity to everybody, it is surprising, reading the report, that you did not feel that would need an increase in the current workforce.

Baroness Cumberlege: That was the modelling that we received. Throughout this review we have been very careful not to be top-down. We have tried very hard to be bottom-up because we think that people in the service know the service extremely well and will know how best to work. We were anxious not to say, "This is the way you have to do it." We have looked across the country. If you go over the river to St Thomas's, they have six maternity teams working, where they are providing continuity of care. St George's medical school[3] is the same. In fact, we went to Birmingham and we saw a very

[1] Baroness Cumberlege correction: replace "whatever" with "or for other personal reasons".
[2] Baroness Cumberlege correction: replace "new ways of care" with "new ways of working".
[3] Baroness Cumberlege correction: replace "St George's medical school" with "St George's University Hospitals NHS Foundation Trust".

interesting project there where they managed to get continuity in antenatal and post-natal care but not throughout the birth.

We visited a huge number of places round the country and met thousands of women, midwives and others, who could just drop into our centres and tell us what they thought. Many of them were saying that they wanted continuity; that was very important to them. They also wanted choice.

We see safe care and choice as two sides of the same coin. We believe that both are very important. Sometimes people talk about safe[4] versus choice. No; the two are very closely linked. It is quite disappointing that the NPU based in Oxford, which did the research for us, found that 33% of women had no choice at all and they were told where they had to go in order to give birth. I just do not think that is acceptable. Most of us decide how we are going to live our lives and what we are going to eat. Our children get some choice of school, in terms of having parents who can exercise a preference, and we know that most parents get that. If you can afford it, you buy the car and the holiday you want.

Q58 Chair: I do understand that, but I am trying to get to whether that lack of choice is because of the shortage of the workforce or just poor planning. What is causing that to happen?

Baroness Cumberlege: We start with the woman. Throughout this report, the woman, her family and the baby are the most important thing to us.

Q59 Chair: I get that, but where you are seeing that there is poor choice—in some areas you are saying there is good choice but there is huge variation on this—where there is lack of choice, is it fundamentally because there is not the workforce, or is it just because people are not planning properly and thinking about it?

Baroness Cumberlege: Very often it is because they are not given the choice. They are not told that there is a choice. In Hampshire, they have an app from which women can see locally what the choices are. It seems to me that that technology should be spread throughout so that people can actually see what the choices are. We think that that is really important.

Q60 Chair: To press you further on this, if people could see where the choices were, you think that that would happen. Is that what you are saying? It is just that women are not aware of it, rather than it is just not available to them.

Baroness Cumberlege: I think that at the moment they do not know what the choices are. In the future, they are more likely to have some different choices from what they have now, but I know that some women are going to say, "I have listened to all the evidence. Midwife, obstetrician, what do you think?" and that is a choice, if they go with exactly the information they are given. My postbag, emails and all the information I am getting is from women who do not get a choice, who want a choice, who have made a decision.

[4] Baroness Cumberlege correction: replace "safe" with "safety".

Q61 Chair: Just to be clear, what you are saying today is that it is because they are not being given a choice or supported to make those choices. It is not that they are not there.

Baroness Cumberlege: Yes, absolutely. I think that they need unbiased information and it is up to them to make a decision. Then it is up to the NHS to wrap the services around them.

Q62 Chair: Earlier you used the phrase that you are hearing that people love the work but hate the job. How much of that is because they are not able to deliver care in the way they want, for example, through providing continuity and job satisfaction in that regard, and how much of it is just because of overload of all the other things that the NHS staff get burdened with, such as bureaucracy and other issues that sometimes get in the way?

Baroness Cumberlege: If I may say so, that is a very good point. One of the things that midwives have told us is that 50% of their time is spent form filling. When we went to see an electronic system at St Thomas's on Friday, we were told that we could cut that time spent by 50%. We have seen a very good example in Holland, Buurtzorg, which is community nursing. We hope you will visit that, if you have not seen it already. You can see small teams of district nursing, in our terms, how they work together and how the satisfaction rate has gone up hugely from the people they are looking after. There is a very high retention rate of the staff involved.

There are different ways of doing things. I also think that the hospitals have such pressure put on them. You will have seen and heard, as I have, of hospitals that close their labour wards, and some of them quite frequently—as much as four times a year. Women have told me that in labour they have had to go 50 miles to another place to give birth. That is unacceptable. We have to take the pressure off the hospitals so that they can operate not at 100%, but, as we saw in Holland and Sweden, at 80%. It is totally different.

Q63 Chair: You will have heard from our first panel that there is a shortfall of 2,600 midwives. You are saying yourself that there are a lot of midwives out there who are qualified but not working. Am I right in thinking that your view is that, if we could make people love the work and love the job, they would be attracted back in, and you see this as being a way forward?

Baroness Cumberlege: Absolutely. We know that there are many midwifery practices. These are groups of independent midwives who would like to come in. We have set out very clearly what that means in terms of their contribution and the way that they have to be accredited so that we can make sure it is a very safe service. We would like to see other people coming into the service.

Q64 Chair: In the series of reviews that we would like to do, we are going to focus on implementation. Perhaps I could ask Sarah-Jane Marsh to come in here. How should we be holding you to account? What is a realistic timescale for moving forward along these lines? Do you agree with what Baroness Cumberlege has said?

Sarah-Jane Marsh: Absolutely. We have only had one implementation board so far, but from the outset we have recognised that the workforce is both the biggest risk to implementation and the biggest opportunity, because that is where all the energy and enthusiasm is. It is going to happen on the ground because this is the change that people

have said they want to see. Workforce is one of the main work streams of the implementation board and it is the one where we are going to spend the most time initially. We know that if we do not get that right, we will not get anything right.

We fully accept the gap that has been described at the moment. It is obviously a gap around our ability to deliver current models of care. As part of the implementation, we now want to look at whether there is an opportunity in the new model to not only make more attractive roles, ensuring that people can work in teams together and feel more supported so that people may want to stay in role and we can retain more people, but whether there are other new emerging roles that we have seen as best practice as part of the review that we could look to implement across the country. In some places we have seen the midwifery support worker. They are able to take on real roles. We have some examples of where they have been the second attendant at a home birth and the evaluation of that has gone well. There is still more work to do, but there is every sign that that could be a role we could develop more into the future.

There is also the midwifery assistant role. We have heard about the role of doulas and how they are valued by women.

Chair: Sorry, you said—

Sarah-Jane Marsh: The doula. It is a support worker who can come along the journey with the woman and support them during labour. It is really important that we do not sidestep the fact that there is a gap and there are issues, and we do need to do more to be able to retain the midwives that we have. We need to do workforce planning to ensure that we have the right number for the future. These new models of care do not just rely on obstetricians and midwives. There are other really key important parts of the maternity team as well. That is one of the things that we are going to be exploring very early on as part of the implementation. We need to take the best practice. We have seen so often that, if we can take a little bit of the good in the NHS that is everywhere, and put that all together, you could see the emergence of quite a different sort of maternity workforce.

Q65 Chair: You will have heard the concern expressed from the first panel about the impact of NHS bursaries. Is that something you are actively looking at and what impact that could have on your future workforce?

Sarah-Jane Marsh: The workforce work stream in the implementation is being led by Health Education England. They are ensuring that that ties to all the broader work that is being done around the impact that bursaries might have. We recognise that, unless we have the right number of people coming through the profession and training into the roles, not only will we have a problem now but we will have a problem into the future. Whatever lessons are taken from across nursing would apply equally in midwifery.

Q66 Chair: We heard earlier too about trying to expand clinical placements for nursing students. Do you have any comment that you want to make on that at all?

Sarah-Jane Marsh: The more people that we can get trained to fill the workforce gaps we have, the better. We know that, when we do not, we rely on bank and agency, and that is when the costs go up.

Q67 Chair: But do you agree with the previous panel that there could be complications in expanding the number of clinical placements?

Sarah-Jane Marsh: I am not sure. In relation to—

Q68 Chair: Trainees; that even if there were increased numbers there would be pressure on placements.

Sarah-Jane Marsh: Of course. I think it would be very difficult to do immediately, but, in my experience, if you work very carefully with universities and other providers, it is something that you are able to do over time. People can be very responsive around that, so I cannot see why it would be a problem in the medium to long term. I am sure it would be a problem to do immediately.

Q69 Chair: Professor Chantler or Sarah-Jane Marsh, are there are any other specific areas in terms of implementation of the workforce work stream that you would like to draw to our attention as a Committee?

Professor Chantler: Only a general comment about the whole report. Implementation is going to be crucial to it. There have been other reports, not least the King's Fund report of 2008, which is excellent. It is the implementation. There is more to the doing than bidding it be done, as has been said. We have 28 recommendations grouped into seven areas, and they all matter. The notion that you could cherry-pick and have a good outcome is to be resisted. They are all justified in relation to each other. I can expand on that later, if you like.

Q70 Chair: I am particularly interested to hear which ones you feel are at the greatest risk of being dropped or you feel concerned might be downgraded.

Professor Chantler: Some are potentially more difficult than others because they have to do with how the NHS itself is developing. I will give you one. It is not about units but about local commission maternity footprints—so 1.5 million people. It only works if you take into account the main hospital provider or providers, the alongside unit, the midwife unit and the home births all working together. If you work together, you train together. That is particularly about service training, which is PROMPT or MORE^{OB}, the Canadian model. It has to be within that network.

You talked about maternity practices. Think of them like general practices. They are part of the national health service, and they have to comply with the governance of the national health service. If they provide a service within the network, they train together and work together. Then you have to have proper ways of reimbursing them. One of our areas of concern is about the so-called tariff. Tariff is a bad word. Basically, you want payment that promotes good practice and does not obstruct it. At the moment it obstructs it.

The Royal Liverpool maternity hospital, where David Richmond comes from, is not part of a big hospital; its fixed costs really matter to it. Therefore, we propose that the fixed costs and the variable costs have to be dealt with separately. I could go on forever, which you do not want me to do.

Q71 Chair: It would be helpful if you could perhaps write to the Committee setting out your concerns so that we know what areas we should be looking at.

Professor Chantler: I do not think they are concerns. It is all in here; we just want it implemented.

Chair: It is just implementing what is in the report; thank you. Unfortunately, there is a Division in the House; so apologies. We will be back as soon as we can; thank you.

Sitting suspended for a Division in the House.

On resuming—

Chair: We are actually quorate. A couple of other Members will join us in a minute but I am conscious that we have kept you rather a long time, so we will crack on and go to Maggie next.

Q72 Maggie Throup: This question is particularly for Sarah-Jane. I am aware that you have had only one meeting of the implementation board, but how do you see the separate Neonatal Review being integrated into the implementation of the Maternity Review?

Sarah-Jane Marsh: One of the agenda items at our first meeting was to make sure that it is, because we know it is absolutely critical that we do not look at those two things in isolation, particularly when we think about the new maternity systems that will sit at the STP level that David described earlier. Neonatal absolutely has to sit alongside and inform that because the two things are critical. We are very sighted on the need to bring those two things together.

Q73 Maggie Throup: Have you any more thoughts as to how you will do that?

Sarah-Jane Marsh: At the board level we have the representation, the intelligence, the learning and the outcomes of both of those. The place on the ground where they meet is in the strategic clinical networks, where we have maternity and neonatal sitting side by side. The people who have led on those reviews are very clear about the links between the two. They will have some oversight of the implementation. As we said earlier, we are very keen that it is bottom-up, but we need to make sure that we are setting the standards and we are very clear about that. There will be oversight there. Maternity and neonatal will sit very closely side by side within those strategic clinical networks anyway, because you cannot disaggregate the two.

Q74 Julie Cooper: We were talking about choice in provision in pregnancy, but what about the variation in service? I am concerned about that. What recommendations in the report best tackle variation in quality of provision available?

Baroness Cumberlege: I am going to ask Sir Cyril if he would answer that because it does fit very much into the way that we are thinking about not only preventing problems from

arising in terms of continuity of care, which you have heard a lot about this afternoon, but about investigations when things go wrong. It is certainly about ensuring that we have a proper information system held by the woman to which everybody has access. We are very anxious that she should be in the centre of care. This should be electronic. We want an electronic maternity record, but also the woman's birth plan should be on that so that people can share that information.

Professor Chantler: Safety goes all through the report. That is where we started from. Part of what stimulated this report were the events in Morecambe Bay. We were very conscious of the fact, putting it clearly, that, if you had a baby in Sweden, five years ago there were 20 damaged babies for every 100,000 live births. There are now five. In our country there are 35. So it can be done because there are units in our country—David Richmond mentioned North Bristol—that are as good as anywhere in the world. There are other units like that, but it is not generalised; that is the variability.

There is no simple solution. There is a whole series of things. I mentioned learning and working together. It is crucial that, after every poor outcome, there is a proper investigation that involves the families and that it is done on the basis of full disclosure. What they did in Sweden was to develop an insurance-based system, based on the concept of avoidable harm but not immediate blame, which inhibits full co-operation.

I know about the importance of justice when things go wrong, but we are talking about justice for the baby. We need to improve the outcomes. Part of this is saying, "Let's have a proper investigation," and this links into the new Healthcare Safety Investigation Branch, which you will know about. It is organised on a regional basis with outside assessment; the colleges and so forth are involved. When you know what went wrong, you can feed back to the clinical unit immediately because that seems to be what has worked in Sweden.

You also support the family through that process. You do not wait 10 years through the litigation process to get the learning back, by which time it is too late. If you do all those things together—you work together, learn together, investigate and get the learning back with proper support through information systems and continuity of care—putting all that together, there is no reason to suppose that we cannot get the stepwise improvement in this country that they have seen in Sweden, and, I understand, in Canada, although I am not familiar with that.

We are proposing a rapid redress system as an insurance-based system to aid that just as they have in Sweden. If we are successful, that will not only improve the outcome for babies but will save this country an enormous sum of money. Last year, NHS litigation for 137 or 139 babies was a pay-out of £574 million. It is estimated to be going up to £1 billion a year by 2020. If we could get the same amount of success as they have had in Sweden, that sum of money will be much less. Then we should have the capacity not only to support the families where clinical negligence has been proved but the other 70 families, who have just as many problems in looking after their disabled children but do not actually get that support.

You put together the whole thing: the rapid investigation; the learning together; the working together; the insurance system to get the support to the families; and the learning back. You will then have a system that will promote safety. Within that are such things as co-ordination of care and the digital record. That is why I say it all has to be done together.

Q75 Julie Cooper: That is very encouraging to hear. It is obviously what we are aiming for and we all want to see these numbers as low as they possibly can be. Even in pregnancies where something does not obviously go wrong or there is not an obvious problem, how will the implementation of the report ensure that more vulnerable women or women who have barriers to the choice that you talked about overcome the inequalities in maternal care—for example, women who have language barriers, or, as the other panel mentioned, women in prison or those suffering with substance abuse issues?

Baroness Cumberlege: We looked very carefully at that when we were doing the review. We particularly looked at disadvantaged women. I think of the day I spent in Brighton with the Gypsy community, which was very interesting. We also talked to women from black and ethnic minority groups, and many others. One of the things that really struck me about that was that they were the women who would probably most benefit from continuity of carer—somebody looking after them.[5]

When I went to Bristol and said to them, "You are looking after women who have really severe mental health problems; that must be such a challenge," they said, "No. Actually, it is the first time somebody has really cared about these women and listened to them. They are very grateful for some help and some guidance." I think this is all very possible, and I also think, as do others, that they do want some choice but not always.

Q76 Julie Cooper: Following up on that, I think Janet Scott in the first panel said that she hoped this would lead to an improvement for all women during pregnancy, but a significant improvement for these more vulnerable women. Would that be your view as well?

Baroness Cumberlege: Absolutely.

Q77 Julie Cooper: We are looking to achieve a differential improvement.

Baroness Cumberlege: Yes, and in our report we have quite a lot on that, especially on women who have mental health problems. I was staggered that 20% of women during pregnancy and the first year after the birth of their baby suffer severe mental health problems. These women need a lot of help, especially after the baby has been born. Bringing up a child is very challenging. Where we have families today who are not as integrated as they used to be, you have to rely on professionals and others to fill that gap.

Sarah-Jane Marsh: I would add that we have several pioneering sites that we are working with at the moment; they are early implementers of the choice and personalisation budgets. Again, we are in the very early stages, but part of the work we will be doing with them is to see the outcomes of the introduction for all women, but especially that they are able to demonstrate that it is universally applied and that it is going to make a significant impact for some women in the harder-to-reach areas. We do not have outcome measures yet, but that is something we discussed at the board. The outcome cannot be that the woman was given choice; it has to be that as a result of that choice we have a safer outcome and a better experience, otherwise we have not achieved anything. We are in the very early stages but that is built in. We recognise that we are taking a step here into something that we have not done before. Before we do it on a mass scale across the whole

[5] Baroness Cumberlege correction: add "throughout antenatal, the birth and postnatal care."

NHS, we need to understand the best ways to do it, as well as some of the potential pitfalls. We are working closely with those pioneers and getting reports back at every board to see what the progress is.

Q78 Julie Cooper: In terms of the personal care budget, that might well be something that the more articulate, educated or advantaged women are able to access. They will see an improvement but I would worry that it is at the expense of other less able women.

Sarah-Jane Marsh: Again, I totally accept the challenge. We are asking the pioneers to demonstrate to us how they are going to support all women who want to exercise a choice to be able to do that. I do not think anybody has a plan to say, "Does anybody want choice and here's a leaflet. Fill it in," or whatever. We are asking people to build in that there will be workers there who can support people through that choice—and help and guide. It is how we get that information to be independent. Very clearly, we need to make sure that that does not happen, otherwise we are not setting out to meet the vision in Better Births.

Baroness Cumberlege: I would like to add to that. Originally, we thought that we would perhaps have three or six different CCGs who would want to do this. We put it out to invitation, and a third of the CCGs in the country applied to do this. We said that one of the criteria was that you had to come together in order to form a bigger footprint than just one CCG. In some of the pioneers we have seven CCGs, for instance. In one, which is a very rural area, we only have two CCGs coming together. All together, we have seven pioneers whom we have chosen and they do cross the spectrum. We have some very challenging areas in terms of disadvantaged women. As Sarah-Jane has been saying, we have been looking very carefully at that as well as the other areas.

Q79 Julie Cooper: Presumably you will be monitoring this carefully to measure the impact across the spectrum.

Baroness Cumberlege: Absolutely.

Sarah-Jane Marsh: Yes.

Q80 Dr Whitford: What will be the process of actually working out the nuts and bolts of the new payment system? There is no detail in it. Will it be a consultation or how will you decide it?

Baroness Cumberlege: We have the seven pioneers now to do the personal budgets. We have put some resources into each one of those, so we are expecting them to do things differently in different areas. After all, this is a pilot and we need to learn from each of them how they are doing and how different they are from another one and so on.[6] Again, I did not really want to choose people and say to them, "This is the way you have to do it." We have said to them, "It is up to you. You decide how you are going to do it." We will have seven areas that will probably do things differently in each area. That is fine by me.

Q81 Dr Whitford: How will you evaluate them at the end?

Baroness Cumberlege: Yes, very much so.

[6] Baroness Cumberlege correction: replace "another one and so on" with "each other."

Q82 Dr Philippa Whitford: But how—so that you can then say, "It is model six that seemed to have the biggest impact, and that is what we would suggest the rest of the country follows"?

Baroness Cumberlege: We are bringing in evaluation. We have to work through that, as Sarah-Jane has said. It is not just the choice; it is what that has done in terms of outcomes, satisfaction and safety—all the important issues.

Q83 Dr Whitford: At what level has the personal budget been set?

Baroness Cumberlege: It has not. Again, it is up to the individual pioneers. At the moment they have to work with the tariff that they have, which is in three different sections. We do not like the words low risk, medium risk and high risk, because women have told us that they hate it. They feel that once they are high risk they are going to be in deep trouble. We are talking about standard care, intermediate care and complex care. The difference between those tariffs is quite considerable. If you look at standard care, it is just over £3,000 for each one.[7] If you look at complex care, it is over £6,000. The intermediate comes, as one would expect, intermediately. Then it is up to the women and the pioneers to choose how they want to implement this. Some may say, "We want to go just for the standard care." Others may say, "We want women to choose everything." Again, we are going to see how that pans out.

Q84 Dr Whitford: So it will be down to the woman to choose whether she was complex.

Baroness Cumberlege: On the advice that she is given. She must have unbiased information. If she is assessed to have standard care, that will be the tariff. If they say to her, "Look, you have had real troubles in the past," and there is talk about whether she needs an obstetric service or not, it is up to her to choose. The choice is hers but she must have the unbiased information.

Q85 Dr Whitford: She is choosing which budget she is as opposed to choosing how to spend the budget she gets given.

Baroness Cumberlege: Yes; she is choosing which type of care she wants. She is choosing where she wants to have the baby. Some will obviously choose to have an obstetrics birth; others will have a freestanding maternity unit or a home birth.

Q86 Dr Whitford: I understand that. I am just trying to understand how the woman has the choice of which budget she gets. Surely, everyone would choose to be the £6,000, no matter what they choose to spend it on.

Baroness Cumberlege: No, they don't. We know they do not want obstetric care throughout.

Q87 Dr Whitford: It comes down to what they choose to do. If a woman chooses obstetric, then that automatically carries a £6,000 tariff.

[7] Baroness Cumberlege correction: replace "one" with "woman".

Baroness Cumberlege: Yes. Of course the money does not go into her bank account and she can't buy another buggy or whatever with the money. We have a very good example in terms of long-term conditions and the way that personal budgets work with those, but this is a different system.

Q88 Dr Whitford: Yes, I am aware of that. Obviously it is a different system because, as we talked about in the first panel, it is not trying to deal with a lifelong chronic illness. It is something that is going on for maybe one and a half years from pre-conception right through to support. I am just trying to understand how that choice will actually get you the outcome in the end. How will that improve the care that the woman gets, including safety?

Sarah-Jane Marsh: We are only a few weeks in but people are approaching it differently. Where everybody is starting from is getting together a list or guide of services that are available locally for women to choose. At the moment, as Julia has said, one of the issues is that not everybody is aware of all the choices available to them. Therefore, they just go to the local hospital or whatever because that is the thing that everybody in their family has done. The first thing is to get a guide of what some of those services are, and then to think through how the woman can sit down with somebody who has the expertise to guide them to say, "These are the different choices that you have at this stage."

One of the powers of our models, potentially, is that the right decision for you when you book your 10-week appointment might not be the right thing at 32 or 34 weeks. At the moment, you might not know how you are going to feel sometime down the line about what is right for you. You may initially choose a home birth or a midwifery-led unit or whatever and you may escalate later to needing obstetric care. Equally, we are not very good at de-escalation at the moment. People may originally have said, "I would like obstetric-led care," but now feel quite confident because they have had a very good pregnancy and the baby is in a good position and so on, who now think, "I have changed my mind; so I will go for midwifery-led and home birth." We need the flexibility built in so they can change along the way. It is not a one size fits all. We are not saying that it is this way or that way, but everybody is moving in the same direction to be clear about the menu and the fact that women are not locked into a choice once they have made it. They can move in and out of different packages.

Q89 Dr Whitford: Is there not an issue, though, about both managing and providing the capacity? Having one organisation that encompasses everything from home birth to very intensive obstetric is one thing, but I am concerned about fragmentation when you have them competing with each other to get hold of the budget from the patient. There is still that issue that, if you have A, B and C, what if everyone chooses A so that A cannot cope? Our problem at the moment is that everything is at capacity. How do you manage that when you have no idea what women will choose?

Sarah-Jane Marsh: One of the mechanisms for delivery is around the STP that we have talked about: the sustainability and transformation programme. This is true not just in maternity but in the rest of the NHS. We are moving towards delivering care in systems rather than in organisations. We almost want to make it impossible for organisations to say, "I can act in a silo here and just do what I need to do to compete and get the income I need to make the service sustainable." We cannot afford to run a health service that way.

The maternity plans that we are looking for people to provide via the STP will be a system-wide maternity plan that needs to address some of those issues. We are not looking for the Birmingham women's hospital plan or the South Central CCG plan; we are looking for a joint plan for that area, which means that everybody is signed up to the consequences.

Q90 Dr Whitford: Does that not then lend itself back towards more area planning and area funding? You say, "We have X number of women so we expect this many deliveries; we know from our data, which hopefully will be good, that there will be that many home births, that many midwife and that many obstetric," rather than turning the woman into a customer where you have created this complexity whereby you do not quite know in any financial year how that will go.

Professor Chantler: Yes. The thinking behind this recommendation is important. As Julia said, choice and safety are not alternatives. They are crucially linked together. We know that our obstetric units are overburdened. We also know from the surveys done by the National Federation of Women's Institutes that 87% of births occur in an obstetric unit but only 25% of women say that is what they want. We also know that 10% say they want a birth at home but only 2% get it. In midwife-led units, there are 2% of births but 6% of women want them.

If more women want births outside the hospital, and it can be done safely, then isn't it a good idea to facilitate their choice?

Q91 Dr Whitford: But do you really need the personal budget to do that? Is that not training us to actually sit and have a decent conversation with the patient?

Professor Chantler: Indeed. That is the question that is being tested. They are not getting money into their hands, but will the budget encourage the system to listen to the mum so that she gets her choice? We will find out whether it does or it does not, but that is the thinking behind it. Also, how can we bring into the provision people who are specialised in home births and so forth? This is where these independent maternity practices, which will be part of the NHS if they are working for the NHS, come in.

I was in a hospital in the north of England and I listened to two families tell me what a terrible time they had had with their first births, with instrumentation. There were terrible mental health issues after that. On the second occasion, the three community midwives in the hospital came along and said, "We will support you to have a home birth." One had had a Caesarean section before. Both thought it was absolutely wonderful and it was all fine.

Hospitals are not always the right place. I am a paediatrician. I have spent hours in neonatal units and they are not always the right place. This is part of a strategy. You are absolutely right that it is not about a hospital or a midwife-led unit. It is about the local commissioned maternity network, which will be required to improve its services, to report its annual report, to work and train together, and to facilitate choice for families in a safe way. It is all together.

Q92 Dr Whitford: If you actually create a network that has everything from home birth to high intensity and we work on training—as I said, being a cancer surgeon and

learning to work to give women the choice, it was not a budget that changed that. I would be afraid that something like this could go the other way. With regard to Mid Staffs and Morecambe Bay, with people trying to be a foundation trust, what if they say, "We need to get her to go for that"?

Professor Chantler: That is why I mentioned that the payments system has to promote good practice and not obstruct it. We can give you an example, which I will not do now, of a unit where it is quite clear that the present payments system was obstructing this sort of co-operation. There is a saying in our profession now, and that is that the patient is the pilot and the doctor is the navigator. It is about giving people information and supporting their safe choices. It is only a little part of it. I do not think it will go the way you fear, but obviously we do not want that to happen either.

The one thing I do know is that it is no longer the case that a good cancer surgeon, important though that is, will give you a good outcome. Medicine is no longer about individuals; it is about teamwork. What went wrong in Morecambe Bay was teamwork. What is going wrong across this country in some places, but not in others, is a failure of teamwork. Everything we are doing here is about how you promote that teamwork. You talked in the earlier session about multidisciplinary teamwork. This is training on the job. This is postgraduate. It is not about how you alter the undergraduate curriculum. I used to be the dean of a medical school and I could talk for hours on that, but this is much more important. It is about how you get teams to work together.

Q93 Dr Whitford: Is that not really where we should be putting our effort? Rather than having different systems competing for this personalised budget, should we not have a multidisciplinary team, educating them to listen and understand the woman, and put the money and the energy there?

Professor Chantler: They will not be competing.

Baroness Cumberlege: I did the report on Changing Childbirth all those years ago. Even then we were talking tremendously about choice and continuity of carer. We tried to instil that into the service. As we know from the surveys the NPEU surveys have done, 33% of women do not get a choice; they are not even told about it. The idea of a personal budget was to try to use a trigger, a mechanism, some way of trying to give women a bit more clout in order to get the choices that they wanted. We have been very careful to tie it into the NHS services so that the money will not seep out of the NHS; it will be contained within the NHS.

We would love to hear from the Committee if you have other ideas that we can adapt or adopt in order to give women the choice that they are not getting now. This was just a mechanism, a trigger.

Q94 Dr Whitford: My concern is that it is the staff you have to change. I am just not sure that a funding mechanism changes the interaction of GPs, obstetricians or midwives with the women. That is who sits there, takes the time to listen and speak to the woman, explains things and accepts her choice. I just worry that this budget in the background could cause problems or at least not particularly get past this idea that the woman should be sitting there, understanding her options and making a choice.

Baroness Cumberlege: We will wait and see. We have seven pilots, so we will see what comes of them.

Q95 Chair: I want to ask about the pilots. We were hearing earlier from Sarah-Jane Marsh that you had not really decided on your outcome measures either. Therefore, how are you going to compare all these different systems if you are using different outcome measures?

Sarah-Jane Marsh: We have not decided on them because we literally only gave the pioneer status a couple of weeks ago.

Q96 Chair: So it is not that you are not going to do that.

Sarah-Jane Marsh: No.

Q97 Chair: I am just worried how you will compare whether it is a place-based system without personal budgets or—

Sarah-Jane Marsh: We have been clear that, while there is flexibility about the way you do the design, we have to be able to benchmark the outcomes to see which is having the greater impact. That is one of the pieces of choice and personalisation work that the board is doing. How do we get meaningful outcome measures that we can track over time and benchmark against each other to see which ones are working more effectively?

Q98 Chair: Will you also look at comparing that with models such as Philippa has described, where you are actually focusing on training the team to deliver choice rather than using a different method of delivering budget?

Sarah-Jane Marsh: There is no reason why not. That has outcome measures as well. That is another of the work streams of the board with outcome measures. There is no reason why we could not compare those too.

I can talk about the Birmingham example because I know it better. Birmingham is a pioneer site, and almost the reverse has happened to what you have described there. There is widespread recognition now that unless we work together and have a common shared understanding of the services we provide—what sits on what part of the risk system—we will not be able to provide a single front door for choice for women; we will just completely confuse them. For the first time, certainly in my time in Birmingham, we have had a big event where we have got all the midwives together from all the different providers and said, "How could we do this?" There is a real sense of opportunity to work in a different way to the extent—and this is not a decision—that we have started to talk about the idea of maybe an accountable care organisation. Again, similar to cancer, can we be single organisations of care no matter where they might sit? Having single leadership teams potentially and single governance structures across patches could be a way to overcome this and for us to encourage women to move between the services. I think it has provided an opportunity to have a different sort of conversation. We have deliberately picked pioneers where they have been able to demonstrate that that leadership is there. A kind of "every man for himself" competition where "we are in this to attract the most women we can" model is not something that we have awarded the pioneer status to, and nor would we, because that is not what this is about.

Q99 Dr Whitford: Obviously, the system is so different, because in Scotland we have health boards. We simply have place-based planning. We do not have hospital or primary care trusts; we now have integration joint boards. That is how our services are put together. It is the complexity that I am anxious about.

Professor Chantler: We expect there to be 40-odd locally commissioned maternity networks. We expect them to produce an annual report of their outcomes, in terms of clinical and functional outcomes, and patient satisfaction. We expect the boards of the organisations within that network providing the service to look at those outcomes and to intervene if there are problems. We expect the colleges to help them achieve that. We expect them to look across regions, compare their results and to help each other. That is all in this report. This is why I am so intent on thinking of these 28 recommendations taken as a whole. If they are cherry-picked, it will not work.

Q100 Dr Whitford: Baroness, you talked about what you had seen in Holland, which was running at 80% capacity instead of 100% plus, which is what we run at here. Surely to turn our 100% plus into 80% would mean that we would need 25% more capacity. Surely we would require at least some increase in staff or else we are still going to be at capacity.

Baroness Cumberlege: The issue there is that, if we actually see women exercising their choices, we know that some of them are going to choose midwife-led units. We know that some of them are going to choose home births. That will take some of the pressure off the hospitals.

Q101 Dr Whitford: So it is really just getting them out of hospital and into those choices.

Baroness Cumberlege: It is not for us to get them out.

Dr Whitford: No, for sure.

Baroness Cumberlege: It is up to the women to choose whether they want to. I just think at the moment, where we are having labour wards closed, it really is unacceptable for this country at this time.

Q102 Dr Whitford: So your recognition is that the capacity issue is at the obstetric end where we are bringing perfectly healthy women to have their births, when in actual fact many of them could be in midwife units.

Baroness Cumberlege: If they choose to do so, yes; absolutely.

Q103 Dr Whitford: I am sorry for focusing on the budget, but that is my bit; that is the bit I am exploring. How do you see that working for the very complex patient? You helpfully described that it was from £3,000 up to £6,000, but what would happen for the very complex patient where in actual fact that individual's budget goes way beyond £6,000?

Baroness Cumberlege: One of the things we are recommending in the report is that, first, we want to see this tariff system overhauled. As Sir Cyril was saying, we want to make sure that it does not act as a barrier to choice or other things. Certainly we want it to be

fair. At the moment we do not think it is even fair. The budget at the moment is not sensitive enough to women's needs. We also think that there should be a tariff for neonatal care because that is so intensive and so expensive. At the moment that does not seem to be recognised. We really want an overhaul, and that is going to take quite a lot of time to achieve. We are very anxious that this report should be implemented at a brisk pace. We want to see it happen quickly, as far as we possibly can, but we do recognise that some things are going to take a bit longer than others. One of them is the tariff and how we can reorder that to make it more sensitive and to make sure that the money follows the woman.

Q104 Dr Whitford: So you would not particularly want to go to place-based commissioning around birth. You would still want to keep a tariff that is reformed.

Baroness Cumberlege: Not necessarily, no; we are open to ideas. We were asked by Simon Stevens whether we would look at the future shape of maternity services, and so clearly we are open to ideas. We put down the ideas that in nine months we actually came to conclusions on. Someone had a sense of humour in saying nine months, I think, because that was the time we were given. There are so many ideas in the service. We tried to listen to as many as we could, but I am sure that as things evolve we will get better ideas.

Q105 Dr Whitford: You have touched on the idea of independent providers should the woman choose that, but then they have to accept certain standards.

Baroness Cumberlege: Absolutely.

Q106 Dr Whitford: What if, in actual fact, a patient chooses that service but it is only a handful of patients? That provider might say, "Well, I am not going to set up and order this, that and the other for two patients." How will you enforce that they, in essence, come into the NHS, as you have described?

Baroness Cumberlege: It is up to them to choose if they want to come into it. We are not forcing them to come into it.

Q107 Dr Whitford: But would the patient be able to use them?

Baroness Cumberlege: Not individuals. We are saying that a maternity practice has to be a number of midwives working together within the NHS. As Sir Cyril said, it is like GP practices. They are in the service but they have more autonomy. In order to make sure that they enjoy the work and the job, we want to make sure that they have more autonomy over their work. We can see some midwifery practices coming together and wanting to provide that choice, but I am sure it will be patchy. We cannot expect an evenness across the country because, again, it depends on them.

Q108 Dr Whitford: Does that mean, in essence, that it would not include independent providers who are outwith the NHS, as in private providers?

Baroness Cumberlege: It would not include private providers.

Q109 Dr Whitford: Even if that was the woman's choice, she cannot say, "I fancy the BUPA home; it looks nice."

Baroness Cumberlege: No. She would then have to pay for it privately out of her own income. It would not be part of the NHS.

Dr Whitford: Okay; thank you very much.

Q110 Maggie Throup: What does the review have to say about the difficulties of delivering maternity services in remote and rural locations?

Baroness Cumberlege: It is very difficult. Catherine Calderwood, who is your CMO in Scotland, was on our review team. We did keep her to the end because we saw this as a really difficult area. I rang up Tony Faulkner, who is the person who has been doing the work in Cumbria. Tony was very interesting. He was a previous president of the Royal College of Obstetricians and Gynaecologists. When he looked at the plan, he said, "It's easy. You have to put this unit with that unit, and then that unit…" and all the rest of it. The thing about Cumbria is that it is beautiful—we saw it in the sunshine and it was just sensational—but there is an awful lot of it. That is the problem. In the middle there is a mountain, so you have a real difficulty with the coastal areas and so on. They have worked so hard in Cumbria and they are beginning to get the solutions through now. We will watch what they are doing.

As I understand it from Catherine, what they are trying to do in Scotland is upskill some of the workers. They are sharing obstetricians across different sites. Sometimes it means that they have to go and stay in an area for six weeks or something like that. They are looking at other, very innovative ways of working, but I have to say that it does cost more. Some of these small units are providing a really good service and we would not want them closed, but it does cost more. In Cumbria, they have found that and they have flexed the budget so that they can support some of these more isolated units. Then I went to Lincoln, and I have been to Devon and Norfolk and seen other areas as well. It really is a challenge.

Professor Chantler: We have learned that there really is not a universal solution. That is why we talk about networks. You have heard this before but the local networks are part of regional networks. It is at that level that they have to work out how they can support people in diverse communities. The solution, for example, in Bournemouth and Eastbourne is not the same as it is in Barrow-in-Furness or Whitehaven.

Sarah-Jane Marsh: The important thing is for there to be a sense of shared governance, because what we cannot have is people delivering different standards of care and that not being exposed and fully understood. Going forward, it is not about saying the system needs to look like whatever it needs to look like, but everybody needs to take part in those networks and governance systems and share the outcomes. If things are not working, then they need to put different solutions in place, but everybody has to be part of that overall system.

Q111 Maggie Throup: You said you have a pioneer covering a rural area. Is there anything else that needs to be done differently during the implementation stage, or are there specific challenges that you feel should be addressed?

Sarah-Jane Marsh: Yes. We were really clear, in selecting the pioneers, that we had to have a range and it was really important that we had a pioneer from a rural area. Likewise, we are about to move into the next phase of early adopters. The early adopters will be

looking at the whole implementation of the report. Again, it is really important to us that we have a variety of areas with different sorts of provision included in that because we know that solutions look different in different places. Predominantly, again, it is the workforce challenge that we talked about at the beginning and sorts of rotas and numbers of staff that are required. There are fixed costs almost irrespective of how many women access the units, but we know they are absolutely crucial, and the small to medium-sized district general hospitals and delivery units are the backbone of maternity. Through these systems, we have to look at how we can support them.

Q112 Maggie Throup: I want to move on now to another subject and pull everything together. Do you agree with the suggestion that has been made to us in written evidence that bereavement care should be specifically covered in the recommendations in relation to better post-natal care, as well as being part of the multiprofessional training?

Sarah-Jane Marsh: Yes, absolutely. Bereavement care is such a crucial thing that we provide in maternity and in paediatric services. Sometimes that needs to be up front; sometimes people do not realise that they want it until later down the track, and we need to be there for them whenever that is. It is crucial. We know the impact that not providing it can have. It is also related to the fact that we should be completely open and transparent about all our investigations if something has gone wrong. We know it can be very difficult to move into the bereavement phase if families do not yet have the answers to the questions they need the answers to. It is a crucial part of the review and the implementation that that bereavement care is there for everybody who needs to use it.

Baroness Cumberlege: Can I say that we have the transformation board, which Sarah-Jane is going to chair? Under that, we have a stakeholder group and Sands—

Sarah-Jane Marsh: Side by side, Julia, not underneath.

Baroness Cumberlege: We are going to challenge you, because the stakeholder is there; so we have the NCT, with Elizabeth Duff and Janet Scott from Sands. We have all these people; Sir Cyril is the vice chairman of this board and I am going to chair it. We are not going to stop working with them. We are going to continue, and I am sure that we will be challenging you if people like Sands say that you have not made enough effort on bereavement counselling or the service generally.

Sarah-Jane Marsh: We have thought really carefully about all the stakeholders that have been involved in Better Births. We are in an implementation phase. It is a different sort of skill to do implementation, but what I just said to Julia was not a joke. We have said that we really want the council and the board to sit side by side and for there to be accountability. If there is anything that any stakeholder feels is not being implemented true to the review, or if there is any issue, they can come back to the board through Julia and say, "We want a discussion; we want a paper; we want a joint meeting," or whatever it is. They are the people who have put their heart and soul into this and it is our responsibility now, as the implementation board, to make sure that we do not lose sight of any of that.

Q113 Maggie Throup: An organisation like Sands is a great stakeholder, but will there be any mechanism for parents to input directly?

Baroness Cumberlege: Yes. Even on the stakeholder board we have somebody who has suffered a really tragic personal situation. We wanted people who had suffered the traumas to be on the board as well. It is not just organisations; it is for individuals as well to have an input.

Sarah-Jane Marsh: To come back to the pioneers and the early adopters, because there are so many differences nationally, it is really important that we continue to engage with women and families in the local systems. There is good evidence that that is happening. We need to make sure via the board that it is universal and that women are involved in the implementation as well as the design.

Q114 Maggie Throup: You will be pleased to know that we are moving to the last phase of questions. We have received evidence that an implementation body should be established to drive through the changes. Is that the role that you see for the implementation board?

Sarah-Jane Marsh: Yes. The implementation board is a cross-system partnership board to ensure that Better Births is implemented. We also have under us other maternity transformation work streams. There are things around safety and midwifery supervision and so on, so that we do not act in isolation on our own evidence of maternity transformation. I am chairing that on behalf of NHS England, but we have stakeholders round the table from NHS Improvement, Health Education England, Public Health England, the Royal Colleges, the CQC and so on. We have our nine work streams. Each of the members round the table is either involved, leading or participating in one of those work streams, but our joint absolute commitment is to move now into the delivery phase. So, yes, we are that board and our accountability then sits through to NHS England.

Q115 Maggie Throup: You might have answered my next question. Do you think that the board has the necessary levers to establish sustainable change?

Sarah-Jane Marsh: Yes.

Q116 Maggie Throup: With all those different bodies involved, it sounds like it.

Sarah-Jane Marsh: I think it is fair to say that, in the NHS as it is currently organised, implementing large-scale change is perhaps more complex than it might have been previously. I am sure that is something that you have explored at another time. It can perhaps be more difficult than it was previously. Nevertheless, we have all the right people round the table to be able to do that. We have made sure that they are the people who would naturally lead that work stream, so I think we have the right people around the table. They understand the accountabilities in the organisation. We have also signed up all the chief exec leaders, so they are really clear that they are signed up to it as well.

We have the STPs, which we have talked about. They are the local delivery mechanism. For the first time, we also have maternity indicators in the CCG assurance plans. The CCGs will be held to account for improvements across a range of indicators in maternity. That will be part of CCG ratings, which is something we lobbied quite hard to have in order to make sure that CCGs have that at the forefront of their minds. I think we have all the technical levers.

The other thing I would say, to go back to where I started, is that the real lever is the workforce. In my day job and in this role, I meet so many people who say that it feels like it is the time for maternity. Almost every service has its day and everybody seems to be listening to us now. We have a whole series of opportunities and we want to do this. The majority of it does not need a lever at all; it just needs really dedicated clinical teams to go out there and make the changes that they want to make for women. I sense that energy coming. I feel that the levers are there and I feel we have everything we need to make progress, but it is a very significant challenge. Of course, we are making it in the current financial climate, which makes everything challenging because it is.

Q117 Maggie Throup: You have just painted a very positive picture, but what do you see as the barriers?

Sarah-Jane Marsh: We have a very thorough risk register; so we have identified some of those barriers ourselves. There are some issues about making sure that all the business plans of the individual organisations join up in terms of timescales so that we do not end up in a situation where one part of the system sees something as a priority and another one does not. That is why we have a work plan. We are asking everybody to sign off almost before we get going on that.

The vice chair of the implementation board is Keith Willett, who you are probably aware has led on the trauma and urgent care implementations. He said that in all the large-scale changes in which he has been involved the problems are workforce, finance and information sharing, in that order. He has no reason to believe that the maternity transformation will be any different. I think we are very sighted on those as our three big risks, but we are doing everything that we can to make sure we mitigate them through the board.

Q118 Maggie Throup: What plans do you have to involve the public in the work of the board and the implementation of the review?

Sarah-Jane Marsh: We have said that the really important part of that is the stakeholder council; we sit side by side. The stakeholder council has core members but it can also go back out to the big group of people involved in the review at any time it needs to, if it needs to source more information. We also have some key implementation events over the next month. We have an official launch to make sure that everybody is fully aware of what we are doing, and we have a series of set piece events.

We have also been doing more work on communication. Some of our implementation board documentation is quite wordy, "management-y" and potentially a bit bureaucratic. One of the challenges we have given ourselves is how we keep meaningful communication coming. A woman who has found out she is pregnant today will know that on the back of the implementation board she will get a better service in six or seven months' time. We are very clear that we need to keep that communication and that dialogue there. We see this as a blueprint for the future, but we also know that if other things come up as we go along—if there are challenges, a new idea or if we spot something—then we can be flexible and make sure that is also embraced in the programme.

Q119 Maggie Throup: Obviously you are aware that as a Committee we like to do follow-up sessions. My last question is this. How will the work of the implementation board, including costs of delivering the recommendations, be reported?

Sarah-Jane Marsh: We have our work plan and our nine work streams. Each of those has key milestones in them. Month by month we will know where we will be and what progress we expect to have made. Some of them can be implemented sooner than others for some of the reasons that we have just described. In the run-up to a future session we could provide you with the progress that had been made but also what our next challenges would be, the cost envelopes of those and any financial gaps or opportunities that might have arisen. That would seem like a sensible way to proceed, because then you can hold us to account for achieving what we said we would achieve at that date but also provide challenge around what the next phase is.

Q120 Maggie Throup: It might seem a bit of an unfair question, but you obviously have some ideas.

Sarah-Jane Marsh: Absolutely. The agenda is so huge that we recognise that we need to take a risk-based approach, particularly at board level, and to ensure that we dive on to the subjects that are potentially those of greatest risk. Hence we are going to spend a significant proportion of the September meeting talking about workforce. I am very happy to be open and transparent about what we see as the risks and the milestones as we go through, so that you can see where you would expect us to be and whether we are on track. I am sure it will not happen, but if, for whatever reason, we have gone off track we will have a very clear understanding of why that has happened and how we might turn it back round.

Baroness Cumberlege: In relation to the 28 recommendations, we have set out the owner—the person responsible for the recommendation—the timeframe and how we will know whether it has worked or not. I hope that will be helpful to the Committee.

Q121 Chair: That will be very helpful. As we go through, don't wait for it to be another year. If you feel that things are slipping and you would like to communicate with the Committee any concerns you have, then please do.

Baroness Cumberlege: That is very kind. Can I just say to you, as Members of Parliament, that I am so conscious that you are all tied into your own communities and constituencies? I think it would be very helpful if members of this Committee were also to ask locally, "Have you been doing this? Has this happened? Do you know?" That would be really helpful to us because we want to implement this at a brisk pace. We just know that, if you let things slide, you lose momentum and then nothing happens. I do not want another Changing Childbirth; I want Better Births.

Q122 Chair: Yes; there are far too many reports sitting on the shelf.

Professor Chantler: I do think that NHS England has made a really good start on this. The enthusiasm of Sarah-Jane and other people in taking it forward is encouraging. There are some things that I thought were probably going to be really difficult. Indeed, the rapid resolution and redress scheme is very new, but the Department of Health has been really

helpful in that. Where it will end up I do not know, but they have done a lot of work on it and it is a very important part of the recommendation.

Continuity of care absolutely requires a digital record; it cannot be done any other way. With regard to both the care plan, which usually the midwife discusses at booking, and the mother, the woman, owning that plan—not the NHS—right through the process but linking into the GP record, which is crucially important, and the obstetric unit, we did not know how to do that 10 years ago. I was involved in it then. We now do know how to do it and we know it can be done because we are doing it. It is not just in births but in the practice I chair now in north- east London for people with chronic illnesses. We are doing it, so that is going to happen. That is the one area where I understand that there is some money. It is just a question of getting our share of it.

Q123 Dr Whitford: In the first panel we heard concerns about the multidisciplinary team having time to review cases of stillbirth or disability. The report showed that more than a quarter had insufficient information. Is this something through MBRRACE that you see improving? I assume that that would be one of the outcome measures. At the end of the day, we want fewer bereavements.

Professor Chantler: It is crucial. It is the core of the report and there is money to get it going.

Chair: We have now finished our questioning. Thank you very much indeed for coming this afternoon.