HOUSE OF COMMONS

Health Committee

Oral evidence: Maternity Services, HC 276

Tuesday 17 January 2017

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Rosie Cooper; Dr James Davies; Andrew Selous; Maggie Throup; Dr Philippa Whitford.

Questions 124-255

Witnesses

I: Professor Lesley Regan, President, Royal College of Obstetricians and Gynaecologists, Professor Cathy Warwick, Chief Executive, Royal College of Midwives, Professor Marian Knight, Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit, University of Oxford, and Elizabeth Duff, Senior Policy Adviser, National Childbirth Trust.

II: Matthew Jolly, National Clinical Director for Maternity and Women's Health, NHS England, Sarah-Jane Marsh, Chair, NHS England Maternity Transformation Programme Board (and Chief Executive of Birmingham Children's Hospital and Birmingham Women's Hospital), and Professor Lisa Bayliss-Pratt, Executive Director of Nursing and Deputy Director of Education and Quality, Health Education England.

Written evidence from witnesses:

Royal College of Obstetricians and Gynaecologists

Royal College of Midwives

National Childbirth Trust

NHS England

Health Education England

Examination of witnesses

Witnesses: Professor Lesley Regan, Professor Cathy Warwick, Professor Marian Knight and Elizabeth Duff.

Q124 **Chair:** Good afternoon. Thank you very much for coming. It is good of you all to come. For those following outside this room, can you introduce yourselves? This is a one-off session following up on our progress on the maternity services review.

Professor Knight: I am Marian Knight. I am a professor of Maternal and Child Population Health in Oxford and I run the confidential inquiries into maternal deaths and severe morbidities.

Elizabeth Duff: Hello, I am Elizabeth Duff. I am a senior policy adviser at the National Childbirth Trust, the charity for parents. I was a member of the maternity review team that came out with "Better Births" and I am also on the Maternity Transformation Programme's Stakeholder Council.

Professor Regan: Lesley Regan. I am an obstetrician and gynaecologist based at Imperial College on the St Mary's campus in London and I am the new president of the Royal College of Obstetricians and Gynaecologists.

Professor Warwick: I am Cathy Warwick. I am chief executive of the Royal College of Midwives and I was also part of the group that developed the "Better Births" report. I am now a member of the group that is overseeing implementation, with Sarah-Jane Marsh as the chair.

Q125 **Chair:** Perhaps I could start with you, Professor Warwick. Can you set out for us what you feel the greatest risks and challenges are at this point in implementing the maternity services review?

Professor Warwick: The first thing I would like to say is that midwives, particularly—that is the constituency I speak for—are really positive about this policy. It says everything that any midwife would hope to see in a report.

Much of it can be delivered as we are. We can see more personalisation of care and better behaviours in our maternity units, but the big challenge is that the workforce is under real pressure at the moment. While we can implement some of the recommendations, implementing those such as continuity of carer—which we know women want; we know that has a strong evidence base—is extremely difficult if you do not have an adequate workforce in the first place.

While we are training enough midwives and enough midwives are coming out into the system, the difficulty is that not enough of them are being employed. Although we have been seeing increases in midwifery numbers over the last few years, we are now seeing flatlining. The number of midwives is actually starting to look as though it is reducing in our services. In our last review, 19% of our heads of midwifery reported budget cuts. We have done some analysis in the Royal College of Midwives

and if you look at the number of midwives now being employed by maternity services, the overall increase boils down to 0.4 midwives per maternity service in the last year.

Q126 **Chair:** We will come back and unpick more in greater depth about workforce, because I recognise that is a key area, but that would be at the top of your list.

Professor Warwick: That would be at the top of my list.

Q127 **Chair:** It was a sense of an overview at this stage of the risks and challenges, but that, for you, is the key area.

Professor Warwick: Yes.

Q128 **Chair:** Professor Regan, would you agree, or were there other areas that you felt should be the greatest risks and challenges?

Professor Regan: Certainly my biggest challenge is going to be workforce. Trying to establish accurate numbers is also quite difficult. That may seem surprising, but although we can give you quite detailed figures from our census on the number of consultants in post, the figures we have for the number of trainees, particularly in the middle grade, is much less clear. And our figures for training differ from those HEE provides.

One of the concerns is that we have a run-through training programme, from ST1 to ST7 and, at the moment, our trainees can only go in at a certain point, at ST1. So we have an attrition rate, and we have some quite detailed figures that we are processing on the attrition rate, which seems to be increasing. We also have to take account of the fact that now 82% of our trainees are female, so we need to factor in to the numbers going in for training, not an attrition, but leave, and maternity leave in particular.

Elizabeth Duff: I would agree with everything the first two speakers have said. There are clearly workforce pressures on all the health disciplines associated with maternity care, and I would add health visitors who are extremely important to women in the post-natal period. I don't think that you are hearing from any health visitor representatives, but I hope that will be taken on board because, right through their maternity journey, women are suffering. Perhaps you have seen our report out today that looks at women's experiences and shows there is struggling to cover the gaps, on the whole successfully: most women make very positive comments about their experience but are clearly very aware that staffing is thin on the ground.

Q129 **Chair:** For the record, could you set out the name of the report?

Elizabeth Duff: Of course. It is "Support Overdue: Women's experiences of maternity services 2017". If follows on from a report of the same name in 2013.

We also note that, although one policy document after another has emphasised the benefits and opportunity of providing maternity care to

probably the majority of women outside hospitals, that always seems to flounder somewhat, because as soon as a service is based outside a hospital, the next wave of funding pressures arrives. I'm afraid that it is the freestanding midwifery unit; the community service; something very helpful to women that goes on at a children's centre or a community clinic that is often in the firing line. That seriously needs to be a culture shift in some way. It is very hard but most women could benefit from getting their care in their local community. We know from "Better Births" that community hubs are being recommended. I sincerely hope that can go forward, but there will always be a fear that those outside hospital services—I mean fantastic work goes on within hospitals, but a lot of women simply do not need to be there for very much of their maternity journey.

Q130 **Chair:** Professor Knight, is there anything you would like to add?

Professor Knight: For me, it is not just about thinking about the numbers of staff within maternity services, we need to make sure that there is co-ordinated care across a range of health services and not just maternity services, because when you look at the women who die, two thirds of them die from medical or mental health complications. We see a lot of evidence that there isn't co-ordinated and joint multidisciplinary care for the medical and mental health problems, as well as for the obstetric and midwifery care. So it is about making sure that we are providing the care that those women need in the context of our maternity population becoming more complex, with more health problems as they get older.

Q131 **Chair:** Thank you for that overview. We are now going to delve into some of these issues in greater depth, starting with Heidi.

Q132 **Heidi Alexander:** Cathy, I would like to ask you about the analysis that the RCM has done with regard to maternity and the sustainability and transformation plans. You identified that in about half the STPs there was little or no mention of maternity services. Could you outline what you think the implications are of this?

Professor Warwick: I think it is difficult to know what the implications are. Of 32 STPs, 11 have detailed reports about what they are going to do about implementing "Better Births"; eight have no mention at all. I suppose that makes us feel that, in those areas, maternity services are considered to be a very low priority. While I can sympathise with that to some extent, because I am very aware of all of the pressures across the whole of the health service, I would say that, if a local area does not appreciate the value of giving high-quality care to women and their newborn babies, they are kind of missing something. The point is that, if we get the beginning of life right, in terms of healthcare, it prevents many future complications and takes pressure off of the other services.

An example of that is that we know that, if women don't get high-quality post-natal care, they increasingly pitch up at A&E with a poorly grown baby or with problems with themselves, or they turn up at their GP with perinatal mental health problems. The concern is that people are seeing maternity as a "not needing to worry about" service. It may be that they

are doing work on maternity and it has just not got into the STPs—we are not sure about that yet.

Q133 **Heidi Alexander:** What do you think needs to change now to rectify this situation? Moving forward, do you see opportunities to put maternity at the heart of all of the STPs? What would you like to see happen?

Professor Warwick: I would definitely like to see maternity services being right in there. In some other STPs it is all about reconfiguration; that's why maternity services are in the plans—it is a question of, "Will we close this unit?" I would like to see personalisation of care, continuity of carer, community hubs and better post-natal care right up there at the heart of the STPs.

Now that we're moving forward on the early adopters, the choice and personalisation plans and the local maternity systems, we should be asking that they are integrated with the STPs so it is obvious that maternity is being looked at.

Q134 **Heidi Alexander:** Cathy has just referred to the early adopters. In terms of implementing the recommendations from the national maternity review, do you see considerable variation across the country, in terms of progress being made, and what are your thoughts on that?

Elizabeth Duff: I've been very interested and largely impressed by what the maternity transformation programme has been doing. Some of the early adopter sites overlap with the pioneers for personalised care and choice. There is quite a complicated thing going on with the pioneers and early adopters and various pilots, but I am trying to keep track of it.

In a way, the worry is that the units and areas and clusters that have succeeded in the bids to be those sites—I gather there has been a lot of enthusiasm and a lot of people applying—are the areas where healthcare is already reasonably well functioning; they are ahead of the game and looking at what the opportunities are, and they will presumably get some support and funding to do that. There are going to be areas of the country where trusts and CCGs are struggling. They are perhaps not even in a state where they feel can apply for that sort of opportunity, and it is a worry that a further wedge will be driven between those who are really doing well and those who are struggling very hard. Of course, all of that will impact again on care for mothers and babies.

I think there is excellent work being done. Again, I am often looking at where post-natal care is in all that. We hear so much about how that is the part of the service that is lacking and is causing women problems. It is not as overt as some of the other pieces of work; there is no work stream on post-natal care, despite the fact that it was a headline recommendation in "Better Births". I know it is being looked at, and we are trying to push for that and get more emphasis on that care getting into it. Again, looking at those who are perhaps a bit behind the others is going to be the key thing, rather than getting the already good ones further ahead.

Q135 **Heidi Alexander:** My last question is: from the Royal College

perspective, what is the most worrying aspect of variation that you see, and what needs to change to address that variation?

Professor Regan: I would echo what both Cathy and Elizabeth have said. I particularly empathise with Elizabeth's point about how those trusts that have really got on board with this and are surging ahead are going to be way ahead of the game. That is great, but they will leave trusts in areas where there is not even really an understanding about what the STPs are, let alone about maternity being a part of the four main streams of work for the STPs. Since joining the maternity transformation board in the autumn, I have set up a project team at the RCOG with the aim of identifying fellows and members of the college—we have about 7,000 in the UK—to champion what is going on in the STP footprints and to write to clinical directors and heads of midwifery in all the trusts to say, "Okay, so we've got to help with implementing this. What's your progress? Who are your obstetric champions locally?" In some trusts and in some STPs, we get lots of volunteers saying, "Oh yes, we're doing this, that and the other," and in others, people say, "What? What are you talking about?" So there really is an enormous variation.

Q136 **Dr Whitford:** One thing has been clearly identified as the key problem: workforce. If I could start with you, Professor Warwick, what do you think is the key issue around midwifery numbers?

Professor Warwick: The key issue is: are we employing enough of the midwives who are emerging from training?

Q137 **Dr Whitford:** So we're training enough; we're just not employing enough.

Professor Warwick: We're training enough. They're coming out. We need to maintain the training, but at the moment we have enough student midwife places and enough are qualifying; they are just not being employed in sufficient numbers. There are various issues. One is that we are seeing a rapidly increasing number of midwives retiring from the service. The number of midwives now aged over 50 is very significant. There is a need to replace as midwives leave, and the number going out is now pretty much equating to the number coming in, so you are getting flatlining of the workforce.

We need every maternity service to assess their workforce needs and then make a plan for building up their numbers if that assessment shows that they do not have enough. We have NICE-approved workforce planning tools that can be used, but the last time the Royal College of Midwives looked at this, only 40% of trusts had actually gone through a process of assessing how many midwives they needed to cope with the clinical needs of their population, and of that 40%, about half had not approved the increases in staffing levels that the workforce assessment demonstrated they needed.

Q138 **Dr Whitford:** The gap has been cited as about 2,600. Is that a figure that you would support, or recognise?

Professor Warwick: Our current figure is that we are 3,500 full-time midwives short.

Q139 **Dr Whitford:** So you feel it is actually worse.

Professor Warwick: Yes. The increase in women's needs is partly because there are just more women in the system—the birth rate is continuing to rise—but the biggest problem is actually the increasing complexity. The increasing number of women who have co-morbidities—obesity, diabetes and so on—puts enormous pressure on the staff.

Q140 **Dr Whitford:** That's a challenge right across the NHS, isn't it?

Professor Warwick: Yes, it is exactly the same.

Q141 **Dr Whitford:** Professor Regan, you have identified almost exactly the same problem. In the brief that we have, there is a comment recognising that we almost have too many consultants—not necessarily employed, but trained—and a suggestion that there will be a glut of consultants but a lack of middle-grade staff going forward. Is that a pattern that you recognise in the real world?

Professor Regan: No. What I was referring to at the beginning, as diplomatically as possible, was that the HEE statistics do not meet up with what my fellows and members see at the frontline. About 30% of units have declared middle-grade rota gaps. If we did not have consultants in those units who were able to fill those gaps, particularly out of hours, we would certainly be seeing very many more problems. It is a big concern. As Cathy says, we all talk about the increased complexity, but we are talking about a third of pregnant women being obese. That requires an enormous amount more expertise and personnel—midwifery and obstetric—to look after them. Obesity increases almost every complication of pregnancy, many fold. That is a lot to do with the pressure of work in units where you have middle-grade rota gaps and the staff are dealing with complex, high-risk situations. It is very stressful. That is adding to the attrition rate, which we have not really seen before in our specialty and is now climbing.

Q142 **Dr Whitford:** Do you feel that you do not particularly have the gaps at consultant level, or that you do have gaps at consultant level, unfilled jobs as well as at middle grade, or is it mostly a middle-grade problem?

Professor Regan: There are some unfilled jobs, but I think that is always the case. The big crunch is at middle grade.

Q143 **Dr Whitford:** It is quoted that there are—some say 25%, some say 30%—gaps and that these are almost constant. Obviously, we have a higher proportion of women, so a higher number of those on maternity leave, with more people working less than full time. That isn't just women now, men are working less than full time a lot more. Could we not prepare for that, if that is an almost constant, instead of bringing in expensive locums? Is that not something that we could plan our numbers around?

Professor Regan: I agree with you and I think we should be a lot more sophisticated in the way we do the workforce planning, particularly

recognising the increased complexity of the case mix of the women we are caring for.

That is going to need to some collaborative work with HEE, because at the moment I can't get trainees to go in at any point, except for ST1, yet there are lots of them who could go in at a later stage if we uncouple the training. They could go in having got skills and qualifications from elsewhere.

Q144 **Dr Whitford:** Again, that is something that comes up in other specialties. We used to have the ability to change track and we have lost it.

Professor Regan: Flexibility has got to be the key to making this work now. We have recently published a document, which I gave to Dr Wollaston last week, providing quality care for women, speaking specifically about how we are going to manage the workforce going forward. What is very evident is that you cannot have one size fits all. We have to use hybrid rotas depending on the needs of that particular unit.

For example, a unit in Chelmsford may not need nearly so many consultants present there, whereas a unit in south London with a high poverty index is going to need a lot more sophisticated training.

Q145 **Dr Whitford:** Were you surprised at the research that has been published suggesting that having 24-hour consultants makes no difference to safety or outcomes? Do you think that is something that needs more research, more drilling into it, rather than simply accepting headline figures?

Professor Regan: I just need to correct you there a moment. It does not say that it doesn't make any difference. It says that so far we do not have the evidence that it improves outcomes. There are quite a few confounders in that. First, the belief or intuition that having more senior staff resident in hospitals 24/7 would improve outcomes came from a publication from the RCOG in 2007, entitled "Safer Childbirth". If you look at the references there, the evidence that was accepted then is not nearly as robust as we would demand now.

If you recall, there are two units where 24/7 consultant presence and resident are working this model: Birmingham Heartlands and Manchester. What they have shown so far is that there do not appear to be significant improvements in the outcome measures they are looking at.

But I would argue that you would probably take quite a long time to be able to demonstrate that, because, thanks to maternal mortality being so low in this country, we are talking about a very large denominator of maternities that you need to analyse before you are going to be able to see significant improvements or failures.

One of the things I very much hope we are going to be able to do this year is that the HQIP have funded the RCOG to run a national maternity and perinatal audit, which will mean that at the end of this year we will have a very large number of maternities, the outcomes of both the mothers and the babies to look at, which will be stratified by individual units. Marian

can talk to you about this in greater detail, but we will then have a much more robust tool with which to be addressing those sorts of questions.

Q146 **Dr Whitford:** I assume that would also be looking in more detail rather than just survival?

Professor Regan: Oh yes. I am just giving you that as a ballpark figure. If you have a maternal mortality rate of 8.5 per 100,000, you need millions in the denominator to be saying something meaningful. But no, of course that is not the—

Q147 **Dr Whitford:** That is all I was trying to get at. I imagine—we think—that there is more work to be done rather than that the point has been proven that consultants make no difference.

Professor Regan: I think so, yes.

Q148 **Dr Whitford:** Your other point earlier was about the need for accurate training numbers so that we can plan.

Professor Regan: Exactly. But the maternity audit that was being carried out and will go on for three years—hopefully, it will be funded going forwards—will be looking at numerous outcome measures.

Q149 **Dr Whitford:** Do you have any short-term management idea for how to manage the middle-grade gaps currently in maternity? This is what we have heard in every speciality, really.

Professor Regan: Well, I think that we need to bring back the old LAT system whereby we had people coming in for a year or two, which I think has been rejected by HEE. But I think it is going to be the only way to get through in the short term. So although RCOG will work hard to produce a long-term solution, plugging the gaps, as you are rightly saying now, is a big consideration. We have to find some quick fixes to keep the service going. It seems to be much easier in teaching hospitals.

Q150 **Chair:** Could I just step in? You talked about the LAT system. If you are using acronyms, for those following from outside or writing the record, could you spell out what LAT is?

Professor Regan: It is about the limited training for service contract. So they do not have a training number, but they are doing a fixed time in contract service.

Q151 **Chair:** Thank you. Before we move on to safety, what is the key barrier to a change in the system? Because it is something that we hear from a number of specialities: greater flexibility of people being able to come in other than ST1. Who is responsible for preventing that from happening? What part of the system needs to be held to account for bringing in greater flexibility, given that it is an ask from so many specialties?

Professor Regan: It is Health Education England that we have to convince of the need for flexibility.

Q152 **Chair:** So they are the ones who would be able to give this the go-ahead?

Professor Regan: Exactly.

Chair: Thank you for clarifying that.

Q153 **Andrew Selous:** Could I ask Elizabeth Duff to elaborate a bit more on the findings in your recent survey that half of the women you surveyed experienced clinically unsafe care?

Elizabeth Duff: What we looked at was the events which are defined by NICE, in NICE guidance, as red flag events. They are identified as those that do in most cases mean there is a staffing shortage, and in this case mostly in midwifery.

It was mainly processes of care that were delayed. It included medication being given, which might have been pain relief, antibiotics or other drugs needed by women, which obviously should have been given in a timely fashion because the woman was in great pain and requested pain relief. Or, with antibiotics: obviously those need to be taken as a course and it is very important that they are taken on time.

One woman reported that she was not helped to wash and that the bed she had given birth in did not have the sheets changed for 12 hours, which I imagine is really unpleasant and distressing for her and almost certainly a risk of greater infection. There were a lot of indicators like that.

Most women said, "The midwives were great, but they were rushed off their feet," or words to that effect. So they were not loudly complaining. They were all saying this was difficult, they did not know what to do and they were not in a position to do much about it at the time—obviously, they were either in labour or just after giving birth—but they were really disappointed, dissatisfied and distressed about the way they could see the service was not working quite right for them.

Q154 **Andrew Selous:** That is very helpful, thank you. Could I ask Professor Knight about the main findings from the latest study of maternal deaths, please?

Professor Knight: The report that we published in December 2016 focused particularly on cardiac disease. Again, picking up on what I highlighted, two thirds of women die from medical complications, and heart disease is actually the leading cause of maternal death during pregnancy or in the six weeks after pregnancy.

Many of the issues that have perhaps been highlighted were picked up, so we see clear evidence of working in silos. Medical specialties: with juniors specialising from very early on, they have very little training in obstetric medicine, so when a pregnant woman comes along they do not necessarily recognise that this symptom is not normal for pregnancy. We saw a number of women who had presented repeatedly for care, and no one had recognised that their symptoms were serious until, unfortunately, it was too late.

There was clear evidence of the issue of maternal mortality there. I should highlight that that is not just in terms of maternal deaths, because we also examined the care of women who had artificial heart valves in pregnancy. Of the women whose care we examined, half had severe complications, such as stroke, severe bleeding and clotting of heart valves. Maternal deaths are the tip of the iceberg—there are women with very severe problems who are not necessarily recognised as high risk. They have their care entirely separate—their cardiac care and their maternal care—which is why for me it is very important that we develop those co-ordinated services.

We know, for example, that we have very few obstetric physicians—physicians who were trained in maternity medicine—and most of them are in London. Outside of that, it is almost luck whether you know the right expert to phone when you have a pregnant woman with a medical complication.

Q155 **Andrew Selous:** Okay, that is quite a long list. What would you say are the priority areas for improvement?

Professor Knight: There are two priority areas: improving maternal medicine, so that at least in each region we have got an expert physician who has a special interest in pregnancy; and, what we did not cover this year, but covered last year, maternal mental health. It will not be news to you that we do not have good perinatal mental health services. We have still got a long way to go, and the gaps are exactly the same when we examine the care of the women with mental health problems.

Chair: I am going to ask you about that very specifically in a moment.

Q156 **Andrew Selous:** Starting with Professor Knight—but I would then like all the panellists to comment, please—how achievable are the national ambitions to reduce the rate of stillbirths, neonatal births, maternal deaths and brain injuries that occur during or soon after birth? If anyone wants to comment specifically, in addition, on the issues of obesity, alcohol and drugs during pregnancy, I would also be interested in that. Professor Knight: achievability?

Professor Knight: Obviously, I work on maternal deaths. When we assess the care of the women who die, we assess that with a change in care the outcome would have been prevented in about half of them. On that basis, if we optimise care we should be able to achieve the ambition. But it will require specialists outside maternity services to be involved.

Q157 **Andrew Selous:** Okay, thank you. I don't know whether others on the panel want to reply.

Elizabeth Duff: I want to make a couple of points. One of the findings in "Better Births" was promoting continuity of carer models. There is repeated evidence from systematic reviews to say that continuity of midwife-led care reduces pre-term birth, foetal loss and neonatal death, as well as being what women greatly prefer, which is to have a relationship

with a midwife. I would certainly like to have that well up the list for helping safe outcomes for women.

The other thing that I have always noticed from the excellent MBRRACE reports from Marian and colleagues is the way in which certain groups of women—sometimes black and Asian women, and women living in poverty—are at greater risk of losing their babies through stillbirth and of, to some extent, maternal death. I think that is perhaps something we have not been able to target enough in the recommendations.

Again, where services generally improve, it must be shown that these women who are at risk of poorer outcomes are being addressed as well—and post-natal care, which I will say like a broken record every time. Most maternal deaths happen in the post-natal period—a dangerous time.

Professor Regan: You probably know that the RCOG launched a programme entitled "Each Baby Counts" nearly two years ago, with the aim of reducing the number of term stillbirths in babies damaged by birth asphyxia. One of the differences in this programme has been to evaluate all of these incident reports concerning these stillbirths and badly damaged babies. Impressively, we managed to get 100% of the trusts in England and Wales to sign up to this.

What is striking is how many of these stillbirths are not accompanied by robust inquiries post event, and one of the things that we will be doing in June this year is launching a report for the second year of data looking—and hopefully demonstrating—that this is beginning to improve.

Professor Warwick: I would just add something. I hope that we can meet these targets. They are incredibly important. But there are two things I would say: you mentioned obesity, alcohol and drugs. What those issues highlight is that maternity care is about far more than care in labour. We really do need to invest in antenatal care, post-natal care and the period between pregnancies for women. It is critical that we recognise, for example, how much work a midwife can do in health education preventative work; I believe that we tend not to have paid enough attention to that.

The other thing I would say is that a lot of the initiatives that are now going on are incredibly positive, but they are adding to the pressure on the services. Women are now, quite rightly, turning up far more frequently at maternity units reporting, quite rightly, that their babies are moving differently. Hopefully, that will mean we detect the problems early. But that is another huge number of attendances that the workforce has to deal with. We need to keep an eye on these unintended consequences.

Q158 **Andrew Selous:** That is very helpful, thank you. How much progress has been made so far on achieving these national ambitions?

Professor Knight: In terms of where we are on maternal mortality: if you take 2010 as the start, we have gone from 9 per 100,000 to 8.5 per 100,000. We are still going the right way, but it is obviously not a huge change. But maternal mortality is uncommon. Stillbirths and neonatal

deaths are also reducing, but I don't think that, as yet, this is at the rate where they need to be.

Q159 **Andrew Selous:** What would be your top action points to reduce that number still further—to make further progress against that national ambition?

Professor Knight: In terms of maternal deaths?

Andrew Selous: Yes.

Professor Knight: In terms of maternal deaths, my top action point is: when you look at absolute numbers of women that die, it is the number of women that die by suicide that is the big number. If we can address that, then it will go a long way towards achieving that ambition.

Chair: We will come on to that in a minute.

Q160 **Rosie Cooper:** Accepting the benefits, and I do, continuity of carer isn't a new idea. Baroness Cumberlege required us to do it in the late '90s; I was chair of the Liverpool Women's Hospital and Professor Regan's predecessor, David Richmond, was the medical director.

We tried to implement this, but within a short time we abandoned it because of the huge cost. I am very interested to see how these recommendations about providing women with continuity of carer are now being implemented: how you see the challenges and whether this current model is costed. Is that the reason for the variation in implementation?

Professor Warwick: At the moment, we are trying to establish exactly what implementing continuity of carer will cost. NHS England is doing quite a lot of work and we are doing a lot of work at the Royal College of Midwives.

NHS England is doing quite a lot of work and we are doing a lot of work at the Royal College of Midwives. I personally think that, even if you need to employ more midwives to deliver continuity of carer and therefore there is an initial increase in cost, the fact is that the evidence base for continuity of carer is now very strong. If we can achieve the outcomes that this process is meant to deliver, such as reducing the number of premature births and increasing the amount of breastfeeding, in the long run we will save the health service a great deal of money. If it reduces the need for interventions in labour, that is another cost saving. The cost-benefit equation is quite complicated, and we are going to need a bit more time to understand it fully.

The big reason for the variation in implementation of continuity of carer was probably less to do with cost and more to do with the level of commitment to the evidence. Essentially, what happened is that people introduced continuity of carer schemes and then there was pressure on the rest of the maternity services.

The midwives who were meant to be working in that way got pulled in to cover our labour wards—and midwives cannot work in two different types of system and be successful. So we need a very strong commitment to this. I hope that what we will see in the early adopter programmes and the choice and personalisation programmes—the ones that are looking at continuity of carer—is that when there is a commitment to this it can actually work and deliver benefits. I know that midwives do want to work in this way—not all of them, but there are enough of them who do.

Rosie Cooper: Thank you.

Elizabeth Duff: I obviously take your point that certainly introducing a new system is going to need a lot of effort and some extra resources and costs. However, from the woman's point of view, at least—although I do not run a unit, so I have not had that experience—if you have got women A, B and C and midwives X, Y and Z, most of the time what the woman wants is to have midwife X. If she has midwife Y, why is that costing more or less?

I know it is not quite as simple as that, but I do not fully understand why it is seen as so much more expensive in the long term. As Cathy said, making changes and introducing new systems obviously needs some input, but the evidence of benefit, short and long-term, is very strong. It is women's preference nearly all the time—there are some really heartbreaking little quotes in our report of women who felt so vulnerable and potentially unsafe because they were being cared for by strangers at a time they felt vulnerable anyway.

The very basis of continuity should be informational continuity, which is that, even if you see a different person, they are giving you the same advice. Women are still saying that they saw four midwives, perhaps post-natally, and they all had different ideas about how to feed a baby. That absolutely has to stop. You may not absolutely be able to have the same midwife that you have got to know all the time, but they should have the same advice for the woman in her particular circumstances.

Q161 **Rosie Cooper:** Absolutely. These teams that you are recommending are four to six. We were operating on nine, still costing, at that point, nearly £1 million more per team—so that was huge. I am interested to see how the modelling you do provides better answers. Professor Regan, on the tariff and CNST premiums—where are we up to with that? Is it still—

Professor Regan: This is a bit of a crunch point, too. Having spent time recently talking to the senior obstetricians in the Manchester experiment, to call it that, they are managing to make this work financially because they have got a very high-risk unit and the vast majority of women—they deliver 9,200 per annum—are attracting the medium or the higher tariff. It will be very difficult in a low-risk unit to have that sort of increased workforce expenditure.

Q162 **Rosie Cooper:** I absolutely agree. I can remember, as Chair, speaking to a Minister and saying that two thirds of the tariff is going on the CNST premium, and in three years' time I will therefore not be able to—

Professor Regan: Exactly, and I think Liverpool has a similar number of deliveries to Greater Manchester.

Q163 **Rosie Cooper:** It is very difficult. I think, if you will forgive me, that for the premise you have been working on—you have workforce planning tools; only 40% of organisations are employing the right number—if you add this to the mix, I question how you are going to get commissioning groups to pay for this.

Professor Warwick: I think one of the other issues about continuity of carer is that it potentially has huge benefits around the workforce. A lot of midwives want to work in that way, and one of the problems for maternity services' expenditure at the moment is that we are spending a vast amount of money on agency midwives, bank midwives and overtime for midwives, because we haven't got enough midwives working in the service. If we could introduce continuity of carer models, it would potentially allow us to use our workforce much more flexibly, in a way that satisfies them. There might be savings in that respect as well.

Q164 **Rosie Cooper:** We need to turn the "might" into a real thing to make it work.

Professor Warwick: Yes. The initiatives will hopefully demonstrate that.

Q165 **Heidi Alexander:** Can I follow up on some of the remarks you started to make earlier about the need to improve perinatal mental health services? I would be interested in your thoughts on why progress in that area has been so slow.

Professor Knight: When I go out around the country presenting the results to get change into practice, one of the commonest responses I get, from obstetricians in particular, is, "I recognise that the woman I'm caring for has mental health symptoms and problems, and I want to refer her to a perinatal psychiatrist, but I don't have one. What do I do?" That is the question that I cannot answer.

When we examined the care of more than 100 women who died by suicide, it was clear that the vast majority were symptomatic for a long time. They were regularly presenting to different health professionals with symptoms, and nobody took a holistic view, recognised their distress and was able to point them in the right direction.

It was quite clear that many of the staff working in crisis services were not aware of the unique features of perinatal mental illness—particularly how women can get worse very quickly—or the importance of red flag symptoms, such as expressing violent thoughts about suicide. Those women were quite often sent away with an appointment for a week's time, or not thought to be at risk because nobody saw that overall pattern.

One of the things that is very clear to me in the discussion around continuity of carer is that need for a person. GPs are not involved as much in maternity care and ongoing care as they used to be, and for me there is a clear role for the GPs in taking that holistic view. Unless there is a

service that has the right trained staff in it to escalate to, that is not going to be helpful.

Q166 **Heidi Alexander:** Do you think that the Government's plans in this regard are sufficient at the moment? You have referred to the availability of specialist psychiatry services for these women. What is your assessment of the Government's plans—whether they will be sufficient to meet the need and how much progress is actually being made?

Professor Knight: I can't answer that question; I would go back to the Maternal Health Alliance, which has certainly produced some figures and have answered that. I know Lesley has done some work on obstetricians and what they feel they have access to, but I haven't looked specifically at the Government's plans and whether they will make a difference.

Professor Regan: There is an enormous amount of frustration among obstetricians and midwives who are in antenatal clinics week in, week out, who recognise problems and tell-tale symptoms but there is not a perinatal network to refer them into.

For the past year, I have been working with colleagues at the Royal College of Psychiatrists and Royal College of Midwives to set up training programmes to help with the identification of the problems. What is evident is that we also need connectivity between the various specialties, so that they can be referred in.

Initially, when I was asked, again by Health Education England and NHS England, to think about training programmes for obstetricians I said, "Yes, but we need to map out the workforce." Who are the obstetricians with specialist interests or skills? I was presented with a map that was actually the psychiatric service.

As you will imagine, being a consultant psychiatrist with a special interest in obstetric psychosis, you need different skillsets from an obstetrician who is identifying someone who has just walked into their antenatal clinic with a set of twins and gestational diabetes.

I'd say it is on the way but, in answer to your question, I think we need to put the foot on the accelerator because every year we are seeing the same report on 9 or 10 December, and this number of suicides is not going down. That, of course, is the tip of the iceberg, as Marian has been saying. The perinatal mental morbidity—not just the deaths, which are quite easy to count—but the morbidity, is very significant.

Q167 **Heidi Alexander:** Okay. Do you have any views on the availability of in-patient perinatal beds across the country? I know that they went down in the period between 2010 and 2015. I wonder whether any of you have any views on the sufficiency of inpatient beds in this area. Elizabeth.

Elizabeth Duff: I believe the Government have pledged four new mother and baby units, which are pretty much the ideal place—if you can use that term—for women who are very seriously ill. They can be in there with their

baby, so that they are not separated but they are supervised enough to ensure that neither comes to harm.

I cannot say whether that will be sufficient or whether they will be established quickly enough, but it is clearly a good effort. We know at the moment that women who need that sort of care are being sent miles away from their homes to be able to have their babies with them. But that means that their partner, mother or whoever else they might need cannot visit easily. It is a desperately overstretched service at the moment. We do welcome the promise of new units and hope that will be enough, although I suspect it still may not be.

Q168 **Maggie Throup:** I want to bring us back to post-natal care and I address this question to Elizabeth and Cathy. Could you comment, Elizabeth, on how important a part of maternity services as a whole is post-natal care, both in the hospital and the community setting?

Elizabeth Duff: I think it is a hugely important part, which, unfortunately, does not often get the attention it deserves because, of course, women especially expecting their first baby go through pregnancy focusing on what will happen at the birth, with a lot of preparation usually and some apprehension about what is going to happen and the unpredictability.

It is quite hard for women the first time round to imagine what it is going to be like when they are at home with a tiny baby. They don't know what they themselves are going to feel like and they don't know how the baby is going to behave. Both those things can cause enormous anxiety that translates into physical symptoms and emotional wellbeing and possibly poor mental health.

The thing that strikes a lot of women, as they go through pregnancy, is that the contacts they have with midwives and doctors get more and more frequent; if they go past their due date, it is often very frequent indeed. Then the baby arrives and whatever happens around the birth happens, but then very quickly the level of care they are getting falls away.

It seems to many women all wrong because they are now feeling awful. They've got stitches, they are not getting any sleep, they are trying to feed, they have got sore nipples, there are sore parts of the body all round and they have got a baby who is probably not sleeping or feeding. Life is in many ways pretty grim, in spite of the fact that they basically have a healthy baby.

Often at that stage, midwives are few and far between, very overstretched, both in hospital and when they get home. Health visitors' duties were recently reduced to four basic development checks on the baby. I am being told by some health visitors that that is now being seen as a maximum rather than a minimum and they are going to have to cut down on that.

That is four basic development checks between birth and two and a half years old, so that is quite a long time with visits spaced out over that period for parents who are anxious, either about their own health or the

baby's. So there are a lot of different issues and that is part of the problem. Things are different for each family, but many of them are finding the care inadequate.

Q169 **Maggie Throup:** Do you want to add to that, Professor Knight?

Professor Knight: No; that is it from me, from an evidence point of view. It is this concept that in post-natal care one size fits all. Each woman needs tailored post-natal care.

Of women who die post-natally, the majority have multiple health and social problems and they clearly need a very different type of perinatal care—much more intense and tailored—than your healthy mum having her second baby who is quite confident, knows what she is doing and has not got any worries. To me, we have always had this, "You will have a visit then and a visit then," and that is what you will have. That is what I struggle to understand when you look at what women actually need.

Professor Warwick: I endorse what Marian is saying. We tend to spend all our time assessing women and asking what they need at the beginning of the pregnancy. I think there are some maternity services now that are starting to assess, after women have delivered their babies, what the woman needs post-natally.

Some woman need a midwife—they need a midwife regularly, they need quite intensive care. Other women can depend on the maternity support worker—they make an enormous contribution—and some women really do not need an awful lot of support from professionals at all, because it is a second baby and everything is straightforward.

There are things we can do to dramatically improve post-natal care, but it has to be valued and it has to be commissioned properly. What we have seen happening in recent years is that, as everybody focuses on care in labour, if you do not have enough midwives they all get pulled from the community services and from post-natal wards into what is the more immediate risk area and then, even if you have done a lot of good work, you just cannot deliver the service.

So it has to be valued, it has to be well commissioned and it has to be individualised and personalised. I totally agree that this is an area that we must focus more on.

Professor Regan: It is a very important area and I would put it in the "missed opportunities" bag. I will not repeat what has already been said about the woman's well-being, but if you just think about pregnancy as a trial test run, often the physiological challenges of pregnancy mean that you develop, as a woman, various complications, which often right themselves after the baby and the placenta have been delivered, but they are predictive of what that woman is going to need, in medical terms, later on in life.

To give a quick example, if you have gestational diabetes during pregnancy, it is almost entirely predictive that you are going to develop

type 2 diabetes by the age of 55 or 60. Often, if you have high blood pressure or pre-eclampsia, you are going to develop cardiovascular problems at a much earlier age.

I think this is an area where we should be persuading people to invest to save. If you have a really robust post-natal assessment of how that woman's pregnancy had affected her and what the complications were, you could do a lot in terms of triaging women who are going to be low risk in the future and those who are going to be high risk and need more medical input.

Maggie Throup: It seems almost like preventative medicine.

Professor Regan: Yes—it is such a wasted opportunity. Of course, in an ideal world I would target everything on adolescents and make sure that they were fit before they ever became pregnant, but it is not an ideal world, is it?

Q170 **Maggie Throup:** That leads on to my next question. Do you think sufficient focus has been given to post-natal services by the work of the maternity services transformation board? If not, what improvement do you think they could make?

Professor Warwick: We picked this up in the "Better Births" report, that we needed to improve post-natal care. It was the area that was evaluated least well by women at the moment. I can't absolutely remember, but I think we were talking about this at the last Maternity Transformation Programme Board meeting—or maybe it was the Stakeholder Council—and it is definitely an area where we need to pick it up as a board and check we are giving it enough attention.

Q171 **Maggie Throup:** The board is aware more needs to be done.

Professor Warwick: It may be in the Stakeholder Council where that discussion took place, but we know it is an area we need to focus on.

Elizabeth Duff: I must say I was disappointed that it was not settled with great clarity as to which of the work streams was going to address this. I was initially told it would be in the workforce work stream and subsequently, that it would be in the local transformation work, but both are work streams with an enormous amount to do. They all have a lot to do, but those are probably two of the massive workloads. So I just keep going on about it in the hope that it is really in there and does not get lost with all the other challenges.

Q172 **Chair:** Before we move on to James's question, can I clarify with Professor Warwick, given Professor Knight has been very clear about the need for flexibility, what is to stop that just being put into place? I am not clear about why that cannot now happen so that there is greater flexibility around the way you deliver post-natal visits, rather than it being such a rigid programme.

Professor Warwick: There is no reason why it couldn't just happen, really. It is about disseminating good practice, I think. Certainly in the

Royal College of Midwives, we continually try to get information out to different maternity services about the good work going on in different units. It is a real challenge getting good practice in one place picked up in another.

Q173 **Chair:** Is that something you would like to see the transformation board take more seriously?

Professor Warwick: I don't think you can necessarily dictate things like this from a board level.

Q174 **Chair:** But if it is one of the most serious causes of maternal death.

Professor Warwick: I would have to give it some thought as to how best to disseminate good practice.

Q175 **Chair:** Sometimes we hear these recommendations and nobody puts them into practice. Everyone agrees that it is a good idea, but nothing changes. I just wondered what your thoughts were.

Professor Knight: We can just have that assessment, after birth and before the woman goes home. In some cases, it has to be the consultant obstetrician doing it, again, depending on the woman's needs. If somebody has just made that assessment and asked what this woman needs, it will not necessarily be midwife visits. It may be she needs referral to the epilepsy nurse specialist. It will depend on her needs, but if somebody can have responsibility for making that assessment at that point—

Chair: Somebody needs to take responsibility for it. Maybe when you return next year we will see what progress has been made on that.

Q176 **Dr Davies:** The National Maternity Review suggests the idea of personalised maternity budgets to underpin the delivery of personalised care plans, where women would be able to choose the provider of antenatal, intrapartum and post-natal care. Do you think this idea can lead to a true improvement in the quality of care or is it a distraction? This is a question to all of you. Don't all rush at once.

Elizabeth Duff: People are starting at the various sites around the country with the pioneers, this is being looked at now, and I don't think any of us can say anything until we know what is happening there.

It is a very interesting idea. I can't say that we have felt a huge amount of enthusiasm because of some concerns about the details of how it will work. Many people have said, "What if the woman runs out of money and then has a major haemorrhage or something that needs a lot of care?" I have been assured she will not be refused care, but that is already creating a situation where the budget—obviously, there need to be boundaries to what it is used for.

Also, you will not be surprised to hear that I am worried women might spend all they can spend in the antenatal period, because they have needs then for some extra care, and when it comes to post-natal, they might

wish they had kept a few hundred to have some extra visits or something they need for themselves or the baby.

We look forward with great keenness to hear how it comes out.

The other thing, of course, is that women who perhaps do not have very good English are not very familiar with NHS processes or their local systems. The amount of time it could take a midwife or somebody else to explain to them how it works—to get them to trust the fact that they have to tick a box and then it goes off and whatever happens, happens—could be worrying for quite a lot of women. Of course, it is voluntary, we realise, but in some ways it could create something of a two-tier system. That is another thing—I am keeping an eye on that.

Professor Regan: I think it is going to marginalise women who are disadvantaged and that is a big concern. I work in Paddington in an antenatal environment where the overprivileged live next door to the grossly underprivileged. Who got what would be stark if it was just dependent on budgets.

Professor Warwick: An awful lot of work is going on at the moment to find out exactly what this entails to be clear that women do not put themselves at risk by accessing the wrong services, and making sure they have the right money to access what they do need. We need to wait and see how this develops. The Royal College of Midwives has had some anxiety about personal budgets and we would prefer it if women could make personal choices about their maternity care without having to be handed this kind of power.

Where potentially it might help is that a significant number of women want to access a home birth and find that their local maternity service simply is not providing it and then access independent midwives. It may enable women to be able to get that paid for, but of course there is currently a problem with independent midwives and insurance.

Chair: We will come on to that.

Professor Warwick: The whole thing is a bit uncertain and I think we are going to have to see how it plays out.

Professor Knight: For me the important risk is that we exacerbate inequalities in women who already have complex health and social problems. We know, for example, that in the US exactly that group of women are the ones who can't access healthcare, because of money issues. That is the one developed or high-resourced country where maternal mortality is increasing. We have to be very careful about unintended consequences.

Q177 **Dr Davies:** So there is a fair bit of scepticism about the potential impact on disadvantaged communities in particular. Is there anything you feel that could be done to assist those women or do you think the whole concept is the problem?

Professor Warwick: Until I know more about how it is going to work, it is difficult to know how to help women get the biggest advantage from it. It feels to me like a bit too much of an unknown at the moment to be sure how to answer that question.

Q178 **Chair:** That is something we will follow up on in later sessions. Professor Warwick, you referred just then to the situation with independent midwives, many of whom have written to me over the past week because it would appear that the plug is being completely pulled on their ability to practise by the NMC. Are you able to elaborate on what you feel about the situation and what impact it will have on being able to provide choice—and also the concerns for those women who may choose to have no supervision whatsoever?

Professor Warwick: If the consequence of independent midwives not being able to access appropriate insurance is that we see women, many of whom are at quite high risk, doing what they call free birthing, I think that is a terrible outcome.

Q179 **Chair:** To clarify for those following, that means they have no assistance whatever.

Professor Warwick: Yes. I think we have to do everything we can to try to avoid that situation. Having said that, the Royal College of Midwives has worked with policy makers and the Government over many years to try to ensure all midwives can access affordable insurance. The vast majority of midwives are now getting insurance. They have formed small co-operatives and they have managed because they have very good overarching governance arrangements to get insurance. So the number of midwives who are left practising completely independently and who are now in difficulty is relatively small, and they are looking after a relatively small number of women. I suppose I feel that there is one solution left, which is to try to help these midwives get honorary contracts with their own local maternity services. In London that is quite common: a head of midwifery will give an independent midwife an honorary contract, enabling her to work under the governance processes of that trust and be indemnified. If we could encourage other heads of midwifery to do that, and encourage the independent midwives to comply with whatever governance is required, that is a reasonable way forward. It probably hasn't actually gone yet, because it was only drafted this morning, but I have just written to Simon Stevens to say I feel that might be a solution.

Q180 **Chair:** Could you, and perhaps also Elizabeth Duff, comment on what I was told that these women are being told by the NMC that they cannot even accompany the women they are supporting through pregnancy into a hospital setting for a delivery? Does that strike you as being—

Professor Warwick: Accompany them almost as a doula?

Q181 **Chair:** Yes, to be a supporter. Simply by being a midwife in the room, they are being told that their fitness to practice would be called into question. Does that seem to you to be very heavy-handed?

Professor Warwick: It seems a bit surprising, yes. It is always difficult for a midwife to be with a woman and not be midwife. It does create some potentially difficult scenarios. I have certainly worked in circumstances where independent midwives have accompanied their women while an NHS midwife then provides the care. It does seem slightly bonkers when you have two midwives and we are short of midwives, if you see what I mean. I hadn't realised the NMC was saying that.

Q182 **Chair:** This is what I was told. Elizabeth, do you want come in?

Elizabeth Duff: I agree with Cathy. It is so frustrating that there doesn't seem to be a solution. I haven't got a magic bullet but, as you say, the situation you describe sounds unnecessary.

I am quite surprised in a way that it is up to the NMC to say that. They don't own the premises or anything. I am afraid I can't really add more to that. I know a lot of women who would be very disappointed if independent midwives were completely disenabled from practising. There is some excellent work among independent midwives, whether they are contracted into the NHS or out.

Q183 **Chair:** Would it be possible, Professor Warwick, to send us a copy of your letter because we could potentially follow that up?

Professor Warwick: Yes, of course.

Q184 **Chair:** Any final points that people feel they haven't had an opportunity to make this afternoon? No.

Thank you very much for coming this afternoon.

Examination of witnesses

Witnesses: Matthew Jolly, Sarah-Jane Marsh and Professor Linda Bayliss-Pratt.

Q185 **Chair:** Good afternoon.

Before we start, please would you introduce yourselves for those who are following from outside the room?

Sarah-Jane Marsh: My name is Sarah-Jane Marsh and I am the Chair of NHS England Maternity Transformation Programme Board and I am also the Chief Executive of Birmingham children's hospital and Birmingham women's hospital.

Matthew Jolly: I am Matthew Jolly. I am an obstetrician and gynaecologist working at the Western Sussex hospital trust on the south coast, and also National Clinical Director for Women's Health and Maternity Review.

Professor Bayliss-Pratt: My name is Lisa Bayliss-Pratt and I am the Director of Nursing for Health Education England.

Q186 **Dr Whitford:** If I could start with yourself Matthew. As someone who is a

bit closer to the frontline, how much progress do you think has actually been made in maternity transformation in the last six months?

Matthew Jolly: I think it is still relatively early days. It is a massive programme, but what has been really heartening is the engagement that we have had particularly through the clinical networks and through clinicians through the RCOG, through specialist societies like the British Maternal and Fetal Medicine Society. There seems to be a groundswell of real support and engagement. There will be areas where people are less engaged, but those systems lead us through the networks. We have also had a series of roadshows with all the clinical networks where we have had service users, midwives and commissioners as well as frontline obstetricians all meeting and sharing ideas about the vision, talking about how they are going to tailor the implementation to fit their geography. So it really feels like things are starting to happen, but it is a massive programme and it is not all going to be done in the first six months.

Q187 **Dr Whitford:** What would you say is the biggest risk to implementation?

Matthew Jolly: Again, I think lack of engagement: where there are pockets and where there is lack of engagement. In any change programme, there is a curve of early adopters, the main body and the laggards. There is no reason to believe that we are going to be dealing with a different population and different behaviours. What we have to do is make sure that we create that momentum to pull the laggards along as and when we identify them. What we certainly do have is a large number of very enthusiastic early adopters, which is heartening.

Q188 **Dr Whitford:** As you say, there is always a normal distribution from one end of the scale. You want it to be as tall and thin as possible. Is it just about hoping that that will happen, or is there any particular technique? That would involve the others, if anyone wants to add something to that on how we make the gap between the early adopter and what we call in Scotland "the coo's tail" as short as possible.

Matthew Jolly: I do not know if there is a specific technique for that but I think that, as the local maternity systems start to publish their plans, we will get a feel for just how short and peaky that curve is. My soft intelligence is that it is quite a significant peak and there is good engagement, but it will be tricky at this stage to be scientific about how you measure that. I think that the proof will be in the pudding in seeing how things develop over the next few months.

Q189 **Dr Whitford:** Do you think there are any particular areas that need support to make that happen, to keep that wave moving?

Matthew Jolly: I am not aware of them at the moment.

Q190 **Dr Whitford:** If I could come to you, Sarah-Jane. Obviously you are leading this. How do you tackle that variation in services across the country, and between the early adopters and the laggards, if you want to call them that?

Sarah-Jane Marsh: Our first insight into this was the look at the sustainability and transformation plans that were referred to in session one. That was the first time that we could really see whether people were starting to come together as local maternity systems to think about the implementation of "Better Births". There was a timing issue, in that a lot of the STPs were already under way before we made it absolutely explicit what it was that we were expecting. In a future cut of STPs, we will see some progress.

Q191 **Dr Whitford:** Do you think that is why it was missing from basically half the STPs; it was not even mentioned?

Sarah-Jane Marsh: It wasn't explicit to individual STPs that they had to include something around maternity and "Better Births" at the time that the STPs were set out.

Q192 **Dr Whitford:** You wouldn't have thought that they would have got to that by themselves, without you having to tell them?

Sarah-Jane Marsh: Yes, it would be very much a hope and expectation that people would have prioritised maternity services as part of their STPs. When we saw what came back in the October submission, we could see that there were some quite significant gaps. We started to get more specific about what we required each STP, and therefore each local maternity system, to do.

What we have now said is that by March this year, people need to be really clear about who each of the local maternity systems are, what organisations are part of each of the footprints and who is leading them, because in some areas it is not clear who is leading the implementation of "Better Births". We have given people time from March until to October to develop their plans fully.

Our intention from a transformation board is to give those areas that don't seem to be progressing very quickly—the so-called laggards—more support. So, to use some of the resources that we have and some of the expertise to support them. Some of that might be marrying them up with the early adopters, so that they can start to take that learning and implement it from there. It is fair to say that there are some that are very advanced and some that are very behind. In fairness to those that are behind, we have only started to get much more explicit about our expectations over the past few months.

Q193 **Dr Whitford:** We heard a lot from the first panel about the need to integrate with other services, particularly cardiac disease and mental health, obviously—we can go into that in more detail later. Is that something you are looking for in the STPs? We don't want maternity services that are in isolation; they need support from the wider area. Is that question on your agenda?

Sarah-Jane Marsh: A hundred per cent. They are very much maternity and newborn services to start with and we are very much now leading maternity and newborn transformation. That is a very obvious area of

interface where we have made quite a lot of progress since the last Health Committee, when we were rightly challenged on it.

Yes, it is a local maternity system that we are asking people to develop, not just focused on maternity but everything else that connects to those services. In some instances—maternal medicine is an example that we just talked through—people may need to look more broadly than their local maternity system. It may not be that we are going to have specialists in all of the 44 STPs. It may need to be bigger than that. We are asking some of the LMSs to come together and look at how they work across boundaries for the more specialised maternal and neonatal services.

Q194 **Dr Whitford:** That leads on to an issue that we have in Scotland in particular, though it applies to areas in England as well, which is that of rurality. You can't actually provide everything in every single corner of everywhere. On the issue of having midwife-led units for local people who are healthier and then pulling higher-risk births into a hub-and-spoke or whatever, is that something that is in it and that you are looking for?

Sarah-Jane Marsh: A hundred per cent. This is all about working in networks essentially, ensuring that services work together, share information, outcomes and governance. We are able to move women between services where that is appropriate—either escalate them up because they need a more intensive service or de-escalate them if they don't. That is the idea—that we almost get away from individual providers being the maternity unit to these wider maternity systems.

Q195 **Dr Whitford:** Integrated with them.

Sarah-Jane Marsh: Absolutely.

Q196 **Dr Whitford:** And can records be shared? That has grown quite a lot in Scotland, but I keep hearing it is an issue here electronically.

Sarah-Jane Marsh: That is one of the work streams on the transformation board, to ensure that we are able to share information, for the very reason that you say. That is for safety and for women themselves so they don't need to keep repeating information and everything else.

Q197 **Heidi Alexander:** I have a quick follow-up on this in relation to the STPs and the standards that we were talking about earlier in relation to 24/7 consultant presence. In the past, I know that has driven reconfigurations and proposed reconfigurations. Given that we heard some of the earlier witnesses say that the jury is out regarding the outcomes and improvement in outcomes that that 24/7 consultant presence has, to what extent is that driving reconfigurations in the STPs?

Sarah-Jane Marsh: There is a difference between 24/7 consultant cover and consultant presence. To have an obstetric unit you need to have consultant cover 24/7, so that a consultant is available to come into the hospital in half an hour to be able to help support if necessary.

That remains a very important standard. It is not possible to run an obstetric unit without that. Having the consultant actually present on site

as part of a 24/7 rota is the issue that was being discussed, where we are not sure that the evidence is clear that that is the case. My understanding and reading of the STPs is that there is not a significant amount of reconfiguration that is based on issues with consultant cover rather than presence. We know it is an issue in a small number of areas. I do not think that has been brought about by any means by the maternity transformation; it is something that has been known about for a long time.

We believe that the power of the maternity transformation and the local maternity system is that everyone in the system looks together at the solutions, rather than hospitals perhaps only a short distance apart in urban areas coming up with a solution that works for them, but maybe not for the system as a whole. We are saying that within the local maternity system a woman needs to have a choice between obstetric-led care, an alongside midwifery unit or a free-standing midwifery unit or home birth. That may cause a different sort of conversation but, in itself, it should not lead to any closures that were not being discussed anyway.

Q198 **Chair:** May I clarify for the parliamentary record that by SMS you meant specialised maternity services? You used an acronym—you talked about SMSs, I think.

Sarah-Jane Marsh: I didn't pick that up—I do not know that acronym myself.

Matthew Jolly: LMS?

Sarah-Jane Marsh: Local maternity system. Apologies. That is an acronym we use a lot.

Chair: Sorry, I misheard you. It was just for the benefit of those who are following the debate, to make sure that we clarify it for the record. Thank you for that.

Q199 **Dr Davies:** On workforce, I have a question for Professor Lisa Bayliss-Pratt. Do you agree with the Royal College of Obstetricians and Gynaecologists when they say that workforce is the biggest threat to maternity services?

Professor Bayliss-Pratt: I don't think it is the biggest threat to maternity services, but we recognise that there are concerns about the current maternity workforce. As a result, you would expect it to be part of work stream 5, which is about the workforce. We need to understand the workforce requirements of this new model of care, and we will be working with the local maternity systems and STPs to ensure that we get the right workforce. But it is not just about obstetricians; it is about paediatricians, midwives, maternity support workers, the neonatal workforce and sonographers. At Health Education England, we are trying through our local workforce action boards to focus on the importance of recognising competencies, and on the competencies that we need across the workforce so that we can have flexible, effective, sustainable teams.

Q200 **Dr Davies:** We have heard that middle-grade obstetricians in particular

are in need. Although this is in Wales, my local doctor-led maternity service nearly shut down, or was downgraded to a midwifery-led unit, simply because of the absence of middle-grade doctors. Are particular efforts being put into that area, that gap?

Professor Bayliss-Pratt: Absolutely. There are particular things and, Sarah-Jane, you might want to talk about the fellowship initiatives that you are looking to explore in your overseas work to ensure that we have those middle grades in place. Do you want to mention the fellowships?

Sarah-Jane Marsh: It is a massive issue—you were saying in your own area—right across the NHS. We know that there are gaps in almost all the rotas. That is because the training places are very much about how many consultants we need for the future, not how many trainees we need on a middle-grade rota. Therefore, putting my employer's hat on for a minute, in my Birmingham women's hospital job, we are left with an issue of gaps in our rota and no trainees to fill them, so we have to look at other ways forward.

Increasingly, people are starting to look to fellowships—getting people to take time out of training, to come from overseas or to do specific projects alongside. There has been a lot of interest from international doctors in coming to get training in the NHS. But it is a challenge and it remains a challenge. In many areas of the country where there are gaps, that is where we see the use of locums. We know that is not particularly sustainable, although locums do a great job and make a huge contribution.

It is one of the areas that is exceptionally difficult, but I do not think that it is different from any other area of medicine—a lot of the solutions that we are looking at in obstetrics are very similar to those that all branches of medicine are looking at. We simply don't have the number of trainees that we need to fill the rotas and therefore we are having to develop these fellowships, international doctors and advanced practice of other practitioners. The example in neonates would be advanced nurse practitioners who are now often able to be on a registrar rota, but it is a huge challenge.

Q201 **Dr Davies:** And resident consultants as well.

Matthew Jolly: Yes, that is part of the solution.

Q202 **Dr Davies:** Is that a sustainable long-term solution?

Matthew Jolly: I think it has a lot to do with how you implement it. If your culture in the organisation really makes them valued members of the consultant team and you create the job plans in a way where they have a really interesting job, then it can work really well for work-life balance—bringing up a family and doing the job at the same time. On the other hand, if you structure it in a way where people do not have that rewarding job, it is not going to work so well. It is something about sharing best practice. The RCOG has got the workforce group together at the moment and I hope that one of the things they are going to do is describe the

difference between where those resident core consultant jobs have become a real success and people in those posts are singing their praises, and areas where they feel they are a substitute junior doctor, rather than a valued member of the consultant team. If there can be shared-out best practice, there is hope that we can make them really successful.

Q203 **Dr Davies:** If we could move on to midwives, what is your response to the assertion by the Royal College of Midwives that 2,600 more midwives are required in England alone?

Professor Bayliss-Pratt: As Professor Warwick pointed out, it is not the fact that we are not training enough midwives; it is the fact that the midwives are not staying in the system. Bearing in mind that there is more work to do to understand the needs of the workforce, with the new models of midwifery we estimate that we will have a supply of between 3,000 and 6,000 midwives, but it will depend on how they are nurtured, supported, invested in and retained in the workforce. It is not that we are not training them, but the fact that they are not staying in the workforce, for a variety of reasons. That is work we are undertaking at Health Education England, with partners, to look at how we can retain the workforce and what are the things that we need to do to help people to stay in the workforce. It is not necessarily that we have not got the supply; it is about utilising the supply and ensuring that the jobs are in place for them, with flexible working opportunities and incentives to stay in the environment. This initiative is one of the areas that will help people, because, as Professor Warwick pointed out, midwives want to be able to give personalisation choice. They want to deliver continuity.

Q204 **Dr Davies:** If those initiatives are not successful, do you feel that more training would be a reasonable step?

Professor Bayliss-Pratt: It is important, as we progress along this journey, that we at Health Education England ensure that we have high-quality data to understand where the people are, where the posts are, what are the attrition rates and what are the retention rates. We will be working with our local workforce action boards from HEE and the local maternity systems to ensure that we are ahead of the game as we progress with this programme.

Q205 **Rosie Cooper:** May I come in on that? I don't quite understand. We are training enough midwives but we are not employing them. Are you saying that for every midwife who wants a job, there is a job? What is the level of vacancies currently?

Professor Bayliss-Pratt: In terms of the workforce analysis we have undertaken, we have identified the demand around how many midwives a service needs. In the past—this is not our role in the future—we have commissioned enough student midwife places to fill the projected posts that would be in the service at the time.

Q206 **Rosie Cooper:** I get all that—it is all the high-level stuff. What is actually going on? Do we have a surfeit of midwives who can't get jobs, or are you suggesting that we are training them and they then don't want to be

employed? How many midwives today want to work but can't get a job, do you think?

Professor Bayliss-Pratt: To be absolutely honest, at present we do not have that data. We know that it is not the same across the country. In some places we know that posts are easy to fill and in other places they are more difficult to fill, because everybody is not the same across the country in terms of their supply and the amount of midwives that they have got, their age, and the hours that they want to work. The figures tell us at the moment that there are enough midwives on the Nursing & Midwifery Council's register to provide the posts that the service is asking for.

Q207 **Chair:** I think the vacancy rate was one part of the question.

Rosie Cooper: Yes. What is the vacancy rate?

Professor Bayliss-Pratt: We do have the vacancy rate. Sarah-Jane, can you give any indication of this? I have it here in my notes. The vacancy rate is not particularly high from what I understand. In fact, although there is a shortfall at the moment—

Q208 **Rosie Cooper:** Could you let us have those details, because it is really important for your evidence to show whether we are training—My background, from the length of time I have been involved in the health service, is that what we have is claims of too many nurses or not enough nurses, and of too many doctors—

Chair: If you are able to identify that during this session, tell us before you leave. That would be fine. We could come back to that at the end.

Professor Bayliss-Pratt: That would be helpful.

Q209 **Chair:** Just one other point to follow up on something from the first session. We have heard a clear request for more flexibility so that people can come in at parts other than ST1. Is that something that you are going to action? We have heard that the block was at Health Education England. Is this something you are going to allow, to have greater flexibility?

Professor Bayliss-Pratt: Yes, that is something we have been talking about in the fringes just now. The issues that we have to work through on that are about how do you ensure that, if people want to change track, they can get accreditation of their prior learning so that they do not have to go back to the beginning again. Those are conversations that we need to have with the RCOG and the GNC to understand that if that is one option, how do we ensure people are not disadvantaged or have to go back and not gain credits for the training they have undertaken.

Q210 **Chair:** Or accredited, perhaps, for overseas experience and that kind of thing? Will we hear there has been some progress on this when we ask you next year?

Professor Bayliss-Pratt: Absolutely, we are happy to take that away and look at it.

Chair: Thank you very much for clarifying that.

Q211 **Andrew Selous:** You mentioned a little bit about not being totally sure about some of the workforce issues on the hours people wanted to work, flexibility and so. When you write to us, could you add a couple of paragraphs about that and how you intend to get that data, because that sounds pretty significant? We are moving into a world of more flexible working and people have choices and may not always want to work the slots that the NHS has.

Professor Bayliss-Pratt: It reiterates my earlier point that it is not necessarily about roles, it is about competences and teams and how we can all work and learn together so that we have flexible local responses to meet the needs of local populations.

Q212 **Andrew Selous:** Thank you, that's good. Sarah-Jane, starting with you, in the earlier session you will have heard the National Childbirth Trust talking about the findings from its recent survey that half the women in the survey received clinically unsafe care because of staffing shortages. How do you respond to that?

Sarah-Jane Marsh: My understanding of that assessment is that since we have had the NICE safe staffing guidelines, we have been able to be much clearer than ever before about when we are not able to meet the safe or the optimum staffing guidelines that we have set for our units.

A red flag essentially means that the director of nursing or midwifery has got sight of the fact that there is a serious staffing issue within a unit, which I think is positive, because previously we did not have the information to know whether we were having a red flag event or not and people are now able to respond accordingly.

Often that means moving midwives around from antenatal and post-natal care to delivery suites where the level of risk is higher and many units do respond in that way. That obviously has a knock-on impact, but I think we have good evidence that that is the response that is often made and, by and large, our maternity units remain very safe places.

But that is not a position we would want to be in in the longer term and that is why challenging ourselves around workforce going forwards and having the right staff is absolutely critical. It is also the reason while the national figures are very useful and we need to understand them, we need to better understand what is driving local scenarios as well.

Some places are finding it harder to recruit than others and we need to understand whether some places have models of working that midwives prefer and learn from some of that practice as well.

I would not want for one second to say that I know there are not staffing issues across maternity units. I think they manage very well on the ground with the staff involved and those who are leading midwifery services, but it is not what we want for the future.

I think often it impacts on experience and the overall quality of the service provided, rather than safety. In times of pressure, midwives very much prioritise safety over everything else, which is obviously what we would want them to prioritise; but that is when some of that care and that time that you need to spend with a woman once she has given birth—some of that support in the early period: that is the bit that is getting impacted on.

Q213 **Andrew Selous:** Thank you very much. Dr Jolly, what is your take on the National Childbirth Trust report, as a practising front-line clinician yourself?

Matthew Jolly: I think we should always be grateful for that sort of feedback, because that is how we learn to do better. I think it raises some interesting questions. I think it shows that our ideas about alongside midwife-led units are potentially very valuable. I think if we can take some of those people who are currently on our consultant-led units who do not particularly want to be there, or need to be there, and give them the option of that more personalised, slightly lower-tech, slightly less intense care, on the alongside midwife-led units, we are actually going to free up our workforce on the labour ward to address some of those issues. I think there are some exciting opportunities in the maternity transformation programme, for using our staff resource in the best way possible to address some of those issues; but none the less there are lots of other surveys coming out showing how many women have an excellent experience through their maternity service, so I would not want our frontline midwives to get too downhearted by that report—but rather use it as a stimulus for doing even better.

Q214 **Andrew Selous:** Thank you. Can I ask you perhaps again, starting with you, Sarah-Jane, across the system as a whole, how frequently are maternity units having to close their doors to women in labour because of these staff shortage issues? What is the general level and extent to which that is happening across the system as a whole?

Sarah-Jane Marsh: As the maternity transformation programme board, we do not have an operational remit, or a remit on performance and regulation, so it is not something that we would be monitoring or looking to; I do know that that is happening on a not infrequent basis.

Q215 **Andrew Selous:** So where would the data be held, then, if we want to direct our questions somewhere else at a later date?

Sarah-Jane Marsh: I would assume that would be through NHS Improvement rather than NHS England.

Matthew Jolly: And the CCGs commissioning services would want to know how often their local services are—so that would be part of the relationship between the commissioner and the provider.

Q216 **Andrew Selous:** Okay, but nationally, just trying to get a feel for the extent to which this happening, who would have the data?

Sarah-Jane Marsh: I think we would have to get back to you with the answer to the question of who it is. I assume it is a reportable event, and

therefore it has to be reported up through the regulatory system when it occurs. I am aware that often maternity units will, within their own maternity systems, come to agreements for certain periods of time to be able to support each other; and some of it is probably done more informally, when people say "We are under a big amount of pressure at the moment; could this other unit help us out for the next few hours, because we really wouldn't be able to manage with another one or two coming through the door?" I am not aware of a lot of incidents where units close for many hours or days at a time, but I am sure the data would be available and we will be able to get that to you.

Q217 **Andrew Selous:** Okay, thank you. Moving on to stillbirth and maternal deaths, what progress has been made in the last year in moving towards that 20% reduction that we are aiming for by 2020?

Matthew Jolly: As far as stillbirths are concerned, we have developed the Saving Babies Lives care bundle for reducing stillbirths. There has been a lot of work implementing that and a lot of enthusiasm around the system for implementing that; but we have hit some barriers and some problems in some areas, in the implementation. People are working on that. We have got an academic group in Manchester at the moment doing an appraisal of that implementation, trying to understand where the barriers are, where people have implemented successfully, and how we share that best practice. So I hope that we would start to see some effects from that implementation of the Saving Babies Lives care bundle on the stillbirth side of things.

As far as maternal death is concerned, the MBRRACE reports are very influential. As soon as that report comes out, that will make people think about how they can improve their own services, and it is about what we can do to help on a national level to implement those improvements. One of the bits of work I am particularly pushing at the moment is about how we develop access to high quality maternal medicine specialists across the country. It is something that people have wanted to do, but have never really managed to land in the past.

I had a meeting with the women's health and clinical reference group, who are leading specialised services, last week, and I have got that group's support. I have got a round table with the Royal College of Obstetricians and Gynaecologists, trying to get all the major stakeholders, on how we are going to implement that. I am in talks with Health Education England about how we can develop the role of the maternal medicine specialist, and I am talking with the payment work stream about how we might create the money to throw in the system to actually pay for those services.

If we work in conjunction with our development of local maternity systems on how we commission pathways whereby it is easy to escalate and make sure that women with complex problems get the right care in the right place at the right time, I really think we will start to impact on those indirect maternal deaths, which is one of our biggest challenges.

There is also something about developing an educational role so that those frontline physicians who perhaps do not know so much about obstetric medicine improve their practice. Scotland has had its Three P's in a Pod approach, which is about how they educate the physicians in terms of recognising the dangers in obstetrics in maternal medicine. What is really heartening is that I have met enthusiasm for this across the system. It is just about understanding how you make it happen and transfer that enthusiasm into actual delivery. I think the maternity transformation programme will give me the levers to do that.

Q218 **Andrew Selous:** You have mentioned the latest MBRRACE report into maternal death already in your earlier answer: the report that came out on 7 December, just before Christmas. Are there any particular points that you are acting on, having digested that most recent report?

Matthew Jolly: I had started before the MBRRACE report, to be fair, because we had been going round talking to our lead clinicians and I talked to the MBRRACE team, anyway, so this was not a surprise to me. It is about that whole system-wide engagement. These are not the low-hanging fruit. These are complex problems with whole system-wide change to achieve, but we are engaging with the system to do that. It reinforced what I thought. The interesting thing in particular in that report is that it is very much about ischaemic and quiet heart disease and how people do not expect young pregnant women to have heart attacks. We have to make sure that you think the unthinkable now and that that enters into your sphere of thought when you are assessing people with chest pain and so on in pregnancy. It is about educating the wider system.

Q219 **Rosie Cooper:** You were in the audience before, so I will not repeat the narrative, but, on the same theme, how are the recommendations for providing women with continuity of carer being implemented? What are the challenges of doing that and what about the cost of doing that? How will you feed that into the system? Looking across, is progress variable throughout the country?

Sarah-Jane Marsh: This is one of our big challenges, but also the thing we feel really excited about. I agree with you that it is something that has been talked about for 20-plus years. We have had a few attempts at it. We have also looked to what is happening in other countries. If we could get this right, we could actually lead the way across the world. To me, that is hugely powerful.

Because there is not a blueprint for us to follow, we have almost had to start some of this work from scratch. We have seven early adopters. As part of the bidding to be an early adopter, we asked people to describe the process that they would use to develop a model around continuity of carer. All of our early adopters—some of them are having events today—are busily working through a model that could work. They are looking at the workforce requirements and the cost of those requirements.

In the majority, the priority area is to try to guarantee continuity for those women who will have totally midwifery-led care throughout their

pregnancy, so those who are going to go for a birth in a midwifery-led unit as well. It is harder to achieve for women who are then going on to have their birth in an obstetric unit. So that is the priority area that many are looking to.

We are asking those people to come up with their model so that we can start to evaluate and pilot it, so that by the time we go to a larger roll-out, we can understand more about those workforce and financial implications. If I am really honest, apart from a couple of places in the country that are already having a go, we are only really looking over the next six to 12 months at trying this in seven places: our seven early adopters.

Then we have funding as part of the transformation programme to have some fast followers, essentially. Here is a model: we have tried it in an urban area; we have tried it in a rural area; we have tried it in a mixture. This is something we hope other people will be able to take up.

So we are in the first throes, but there is a lot of enthusiasm, particularly with midwives, because it is a model they want to work in. They want to see a woman through that journey. They do not want to not know what happens at the birth, they do not want to not follow the woman post-natally, so there is a lot of enthusiasm. We think, if we can get it right, it might link to our retention strategy as well.

Q220 **Rosie Cooper:** Enthusiasm is absolutely there. I just wonder, has anybody looked at some of the attempts that have gone before and the pitfalls? Sarah-Jane, you also mentioned when you talked about workforce that if there were shortages, that would red-flag to a nursing director and they would want to deal with it. Is it mandatory, or are chief executives and nursing directors able just to ignore that? Do they have to report it to anyone?

Sarah-Jane Marsh: You do need to report it. It has to be reported to your board, and it also has to be put on your website if you have had any breaches of your own safe staffing guidance.

You would want to empower people in the organisation to resolve issues for themselves. Actually, where you have local leaders in the teams that know they can move staff around, they are perfectly empowered to put the resources in the places they need to be. The idea of the red flag is that there are not people in the individual units just struggling on without awareness at board level of what is happening. I do think it is a positive step. I do not think it is a sign that there are loads of red flags that have not been around for a very long time; there is just that greater level of awareness.

Q221 **Rosie Cooper:** And looking at the past?

Sarah-Jane Marsh: Definitely looking at the past. Jacqui Dunkley-Bent, head of midwifery at NHS England, is leading on continuity of carer on behalf of the maternity transformation board. She has already done some work on pulling together the areas that have tried this before. Either they have tried it universally, for all women or, more likely, a lot of places that

have tried it have targeted vulnerable women for the reasons discussed previously, where we know continuity brings a greater benefit for those women who may not have been able to articulate their choices as well and who are vulnerable for a whole lot of different reasons.

We are delighted that some of our choice and personalisation pioneers are focusing, going forward, on those vulnerable women. So yes, we have got a really good sense of who has tried what, where and where we can learn from. But there isn't anybody who has done it in the way that is described in "Better Births" in totality, so we recognise that we have got a big challenge in implementation.

Q222 **Heidi Alexander:** To go back to one of the questions Andrew was asking you about the number of occasions on which women are being turned away from maternity departments to give birth. I know you said you do not have access to national information, but I would be interested in your perspective in Birmingham and Sussex about whether this is happening less or more often than in the past. I would have thought that if you are going to improve the experience of women giving birth, that could be one of the most upsetting things to be thinking you are going to give birth somewhere and then to be told, "I'm sorry, the doors are closed: you can't come in." Just from your own perspectives, in your own hospitals.

Sarah-Jane Marsh: I totally agree with you. It is a horrendous situation and one that we would never want for any woman not only from a safety perspective, but because we have got that relationship built with them. I am only aware of one incident in Birmingham over recent months where, for safety reasons, it was felt that we should ask for help from a neighbouring unit and transfer a woman, because we were really at the limits of the level of care we could provide with the staff who were on duty at that time. I do not think I would categorise that as a closure; we made an assessment at that point that for that woman at that particular stage of labour it was better to transfer. When things moved along over the next few hours we were able to take the next woman. So I am not aware of instances where we have been closing down for whole periods of time.

Q223 **Heidi Alexander:** Do you think the problem in Birmingham though, if it is a problem, is getting worse or better over the past couple of years?

Sarah-Jane Marsh: I do not think it's any different.

Q224 **Heidi Alexander:** Matthew, what is your experience?

Matthew Jolly: My hospital, my trust, has two consultant-led units some two miles apart. We work as a team, cross-covering, so if we get particular peaks of work, women will be offered the opportunity. Often it will be someone who is going to have an induction of labour. Rather than delaying them, they will be given the option of going to the other unit instead. It is very rare for the unit to say, "Nobody is coming in". We have an escalation policy; occasionally that clicks in, usually for an hour or two, and then it is back to normal again. It is really hard, because it is a relatively rare event, to say whether there have been more in the past 12 months than in the previous 12 months. It is difficult to say. Possibly, but

it is fairly subtle. We try to be proactive, to get things set up before we actually hit crisis point, to communicate, to talk to each other.

We have had that for neonatal services sometimes as well. One of our big tertiary units will be really struggling with cots and we will take people across, or people who are going to be induced whose baby might need special care. So there is a working system that does that. It is certainly no better; I am not sure that it is significantly worse.

Q225 **Rosie Cooper:** Is this recorded anywhere centrally?

Matthew Jolly: I don't know. I'm not sure it is. I think it is more to do with what happens with the contract between the provider and the commissioner, but I'm not sure that it is nationally collected. NHS Digital don't collect it, so it's not in a national dataset at present that I'm aware of.

Heidi Alexander: The information is certainly obtainable under FOI, if you request it.

Matthew Jolly: Yes, but I'm not sure that there is a mechanism for collecting it nationally at present.

Q226 **Chair:** I have one more supplementary question before you move on to perinatal mental health. While I completely accept, Sarah-Jane Marsh, that you are not responsible for current practice, given that implementation would require a review of how things are going, would it be possible next year for you to bring those data with you? It would be very helpful for us to be able to look at them.

Sarah-Jane Marsh: Yes. I would not want to leave you with the impression that we are not very aware that there is huge pressure in our units. One of the drivers for "Better Births" is to make sure that that obstetric-led care is delivered to all the women who need it and, as part of that, we can also respond to women's choices and get those that are appropriate into midwifery-led care. We know there is huge pressure, we know that these things happen and we talk about them in board meetings. What we do not do is sit down with a report that says "14 were closed last month," or that type of information.

Chair: I appreciate that, but it is surprising to think that you are not appraising what is actually going on in a detailed manner. It would be helpful to have that when you come next year.

Q227 **Rosie Cooper:** To follow on, I am struggling. If the whole purpose is to get to personalised care, where you know your midwife, if you are then, on occasion, not delivering your baby in the hospital where that midwife is, for that mum the hospital is closed.

Sarah-Jane Marsh: It is awful.

Matthew Jolly: But actually, the personalised care model may create more flexibility in your workforce. Because those peaks and troughs change. There are always a lot more deliveries in September, nine months after Christmas, in most units, and we have another peak nine months

after the summer holidays. So if you can create a workforce that is more able to meet the peaks and troughs, that will help. I accept your points about how we need to collect the data, and there just is not a data mechanism in place at the moment, but I think that implementing the maternity transformation plan may help to address some of those problems.

Q228 **Rosie Cooper:** If you need to know four or six midwives who would be looking after you, that flies in the face of that. That is all I am saying. It is really interesting to have that information.

Matthew Jolly: You will know the due dates and booking under your four to six midwives, which will help as well.

Q229 **Heidi Alexander:** On perinatal mental health, can you set out how many areas of the country do not have access to specialist perinatal mental health services either in the community or in in-patient facilities?

Sarah-Jane Marsh: This is a service organised on a national footprint, like many of the more specialist mental health services. It is commonplace to move women around between different geographical areas to access the services. An assessment was done as part of the mental health work stream about what we needed to do to have more mother-and-baby units absolutely to align the demand for those services with the amount of capacity that we need for the future. A decision was made that we need to invest in a further four of those mother-and-baby units.

Q230 **Heidi Alexander:** Let me stop you there. Does that mean that at the moment four areas do not have access to mother-and-baby units within region, or is it more than that?

Sarah-Jane Marsh: When you say "region", I am not sure exactly what you mean. There are certainly four areas of the country where we felt that there was not a facility within a reasonable distance's travel for a woman. Within that region, there will still be a need to travel some distance to access the unit, because it is a specialised service.

So that was the assessment made, that we needed to have an additional four mother-and-baby units to ensure that all the women needing access at any one time would get it. As with all specialised services, we would never be able to guarantee that people will necessarily be in their home unit—if one came up to capacity, we might need to divert to different areas—but we are confident that, once implemented and opened, we will have a match between the capacity and the demand for the service.

Q231 **Heidi Alexander:** When will they open?

Sarah-Jane Marsh: I think there is a phased opening. The decision on which of them was to be designated was made only about two months ago. Implementation is over the next one to two years—to see them developed, essentially. In some, we need to recruit extra staff and so on.

Q232 **Heidi Alexander:** So it could take another two years before the additional in-patient capacity is available.

Sarah-Jane Marsh: Yes.

Q233 **Heidi Alexander:** That is quite a long time, isn't it?

Sarah-Jane Marsh: Yes. It is sometimes difficult when developing a service from scratch. As ever, it is the workforce, isn't it? But again, it is something that we recognise as absolutely critical. We will do everything we can to get them implemented and opened as soon as possible. They are, though, very much supplemented by the community teams—

Q234 **Heidi Alexander:** How many additional beds will they provide? I am interested because the number of in-patient beds in that service was falling between 2010 and 2015. I do not know what has happened in the past couple of years. I think my colleague, Luciana Berger, has tabled parliamentary questions about this, to ascertain what has happened to the number of beds in the past year or so. I am interested to know how much extra capacity the mother-and-baby units will offer, and whether you know what the current number of perinatal in-patient beds is.

Sarah-Jane Marsh: I cannot give you a specific number. I do know that no beds have been closed down for purely financial reasons, as in, "You need to reduce this service", because there is no suitable alternative for these women. It is not that you can replace a bed-based service with a community-based service. We know absolutely that these women need to be in mother-and-baby units. That is one of the reasons why, when we have got some money for investment, that was the absolute No. 1 priority, because we know that investment needs to be made. I do not know the exact size of each unit—do you?

Matthew Jolly: No, I do not know the precise numbers. I do know that the mental health team are working really closely with the Mental Health Alliance, which has done some fantastic work producing the data showing the gaps. It really feels like there is a good working relationship between the mental health team and the Mental Health Alliance. We have got the implementation of perinatal mental health networks and the development of perinatal psychiatry. There is also work with the RCOG and Health Education England about how we develop the role of those frontline obstetricians to a point, supporting the lower grade mental health problems, because there is obviously a huge range from mood disorders right through to acute psychotic episodes, which are the really scary ones associated with high mortality. Part of that £365 million over the next five years is really focused on the acute psychosis mother-and-baby unit end of that. There is a lot of resource going in, but I would have to turn to my mental health experts about the real detailed stuff about implementation, timelines and beds. It is not something that I am hands-on now.

Q235 **Heidi Alexander:** I think it would be useful just to know and have that information, because there is such an urgent need for it—

Matthew Jolly: If we had the right person up here from the mental health work stream, they would probably give you the numbers straight off.

Q236 **Heidi Alexander:** If you could provide us with that in writing, that would

be helpful.

Matthew Jolly: The overall feeling is one of excitement and optimism that actually we are really going to start making improvements on this. It is a good news story, I believe.

Q237 **Maggie Throup:** I want to come on to postnatal care now. We heard from our earlier witnesses that when it comes to postnatal care, individual needs do not seem to be taken into consideration—it is a "one size fits all" approach. What improvements does the National Maternity Review plan to make to postnatal care?

Sarah-Jane Marsh: One of the cornerstones of the implementation of "Better Births" is the community hub. The community hub's philosophy is to get as much care as possible delivered out there in the community, including the midwifery-led care, and also, where possible, to locate some of that care with children's centres, health visitors, breastfeeding support—with a whole range of things that a woman might need on a maternity journey. So the community hub will not just be something that a woman would be in contact with antenatally, but also postnatally.

The continuity of carer model is again very much focused on the same team and the same midwife being able to look after a woman during that postnatal phase. Having built that relationship in the antenatal care they will be in a better place to understand each individual woman—"I know this woman is going to need a bit more and I know this woman is going to need a bit less"—and flex that personalised care to give that woman exactly what it is felt is needed for her and also to bring in other services, if they are required. We envisage that some of the mental health workers that we were talking about will be either placed in or linked with these community hubs. If a midwife feels that he or she needs to get some extra support, there should be somebody as part of that community hub team that they can bring in to provide some mental health support. There is a whole range of other services as well, and hopefully some of the voluntary sector organisations that also do a great role in supporting women post-natally. We think there are lots of things about the model that will help.

We recognise from listening to the first panel that clearly people want some more explicit statements as part of what we are doing in the implementation of "Better Births". We will go back and look at that as a board. It is our intention and very much something that our early adopters are doing, but for some reason our communication isn't as clear as it might be.

We are also asking the payment work stream to look at this carefully for us, because a lot of the payment is frontloaded towards the antenatal and the birth. There is very little of the tariff that actually goes into post-natal care. If we are going to be asking the local maternity systems to invest in post-natal care and have a better infrastructure in place, we are going to have to make sure that that is reflected better in the tariff.

We are doing lots of things already. I do think we can do some more and it is something that we are very much aware that we need to really sort out the funding streams for.

Matthew Jolly: I think there is something also about clarity of commissioning—when maternity-provided services stop and when health visiting or GP-provided services or perinatal or routine mental health services start. If we can really tighten up those gaps and not let there be gaps between one sort of provision of service and the next provision of service, we will make a difference with the limited budget that we've got in the post-natal side of things. That ties in very much with the work that the NHS payments team are doing on this.

Q238 **Maggie Throup:** I think the ambitions are great but, if we have got so far behind with continuity of carer, I am worried that it will take years and years before it is actually all joined up and this more individual post-natal care is provided. Also, you talk about the payment work stream; are there any other work streams that it should be in? It just seems if it is all about money, rather than actually about—

Sarah-Jane Marsh: Oh no, not at all. It is very much part of the local delivery work streams, because, again, we are asking people to come up with a model that makes sense for them in their area. I agree with you, it is frustrating. I would love to be able to sit here and say, "I can do continuity of carer in three months' time." I think we need to be realistic about how long it is going to take. We feel that it is best to get it right in a small number of areas first, and be able to describe what that looks like, and how we can roll it out quickly. So, yes, it is going to take a bit of time to get it right; but once we have got those lessons we will be able to ensure that that is rolled out across the country as quickly as possible.

In the meantime, as Cathy said in the earlier session, there is no rule, there is no reason, that actually within our current systems we cannot be more adaptive; and I believe that many systems are—that they do give more care where it is needed and discharge women much more quickly if they feel that everything is going well, and stay with women on the journey where they feel that more support is needed before handing over to a health visitor. So I think there are things we can do this afternoon and tomorrow, as well as the things that are going to need to wait for the community hub and the continuity of carer.

Q239 **Maggie Throup:** So in 12 months' time, hopefully we will be getting more positive feedback with regard to that.

Sarah-Jane Marsh: Yes, in 12 months' time I would be describing what the early adopters have been able to achieve both on the continuity of carer—what that has meant antenatally and post-natally, in terms of experience—and then, connected with that, the impact where we have introduced the personalised budgets: has that actually made an impact on the outcomes that women themselves are saying about their experience of pregnancy and birth?

Matthew Jolly: There is a time lag to collect the data as well.

Sarah-Jane Marsh: There always is.

Matthew Jolly: The report you have just heard about is 2014, 2015 and a little bit of 2016—for them to rerun the report after we have implemented the change, the timescales are quite tight for actually getting those data.

Q240 **Maggie Throup:** We would rather hear it from you directly next year.

Matthew Jolly: Fine, okay—well, hopefully Twitter and everyone else will be telling you how much better things are.

Sarah-Jane Marsh: It may be interesting to actually invite one or two of the leaders of some of the systems that have done some of this implementation to hear very directly from one or two areas in the country what they have achieved and where they have gone up to, as well as the overall.

Q241 **Chair:** The final section of questions is around personalisation and choice. Could you perhaps start by saying, Sarah-Jane Marsh, where we are now on that? How far have we progressed on implementing that?

Sarah-Jane Marsh: We have progressed on personalisation and choice since we were last here. I think at that time we had identified seven pioneers that were going to be launching the personalised budget, but it hadn't actually happened. It now has, in several of those areas. People have been launching since November time, and slowly but surely each of the seven is coming on stream. They are all doing things slightly differently, so some of our pioneers are offering the personalised budget to every woman who is going through that maternity system. Others have decided to focus on vulnerable women; so the south-west London pioneer is solely focused on how we can use the personalised budget to improve the experience and outcomes for vulnerable women. As I say, that is now under way. We are very conscious of the need to evaluate the impact that that has. We recognise some of the concerns that people have raised about it; so we have got an NHS England team that sits separately to maternity, that is tracking not only, "Did choice happen?" but, "As a result of choice, what different outcomes did we see?" both in terms of some of those harder sort of safety outcomes but also women's experience of care.

We have also asked that that has got some academic rigour to it; so it is not just NHS England saying, "Did NHS England do it well?" but we have actually got somebody alongside that, from an academic perspective, absolutely evaluating, "Has this truly made an impact?"

Q242 **Chair:** So it would be evidence-based.

Sarah-Jane Marsh: Yes: what is the evidence base that this has actually made an impact? Until that evaluation is undertaken we will not be rolling out beyond the seven pioneers that we have got.

Q243 **Chair:** You will have heard the concern from the earlier panel about the risk of widening health inequalities. You have got one area looking specifically at rolling out with disadvantaged women.

Sarah-Jane Marsh: Absolutely.

Chair: Can you assure us that that issue of health inequality will be built into the evaluation?

Sarah-Jane Marsh: Yes. That is one of the areas on which we challenged all the people who wanted to do the pioneering. In Birmingham, 122 languages are spoken, so we very much challenged them about how they were going to get this information in the right way for people to understand it and be able to process it, particularly for vulnerable women across a whole range of areas. We know that they will need, for example, longer appointment times to be able to have some of these conversations and make meaningful choices, so that is what some of the pioneers are looking to do.

Q244 **Chair:** On a couple of other aspects of choice, there was a report in the *Health Service Journal* a couple of weeks ago that you were planning to close free-standing birth centres in Birmingham. Is that the case?

Sarah-Jane Marsh: No. The discussion that we have had is that as we empower women to make more and more choices based on the evidence available to them, we do not know at the moment exactly what that is going to mean in terms of who chooses to go where.

The point I was making in that interview is that we envisage that more women, with continuity of carer and with information available to them, may choose to have second, third or fourth babies at home. I was asked what a shift towards home birth means for free-standing midwifery units. The answer is that only a certain amount of women are suitable to give birth not in an obstetric-led unit, because we know that the majority of women will need to be in one. It may lead to different choices about where we put the investment in future for midwifery-led units, but I know that free-standing units are very popular and I have no plans to—

Q245 **Chair:** So in other words, we could end up increasing the ability for women to choose home birth, but cutting off another popular choice because there isn't enough workforce to go around. Does that summarise the position?

Sarah-Jane Marsh: I think it is very much going to depend on what women choose, and also on what is available—

Q246 **Chair:** But they would like to be able to have both, I think.

Sarah-Jane Marsh: Yes, and we would like to be able to offer the choice of both. "Better Births" itself said that women should have three choices available to them: the obstetric-led unit, an alongside midwifery unit and either free-standing midwifery care or a home birth. The level of care is broadly similar.

Q247 **Chair:** So it's either/or, you think?

Sarah-Jane Marsh: No, it isn't. We just said that all three of those should be available in a local maternity system.

Q248 **Chair:** What about four?

Sarah-Jane Marsh: Four can be available—that is fine as well—but there must be three.

Q249 **Chair:** At least three?

Sarah-Jane Marsh: There must be at least three.

Q250 **Chair:** So there is no guarantee, and there is a potential unintended consequence that you could close a free-standing unit. I am still not clear whether you are saying that is likely to happen, or—

Sarah-Jane Marsh: That certainly is not the strategy. There isn't a hidden agenda or strategy that says we do not want to have free-standing midwifery units, but we know that if more and more women were to choose a home birth, it would probably reduce the amount of women in the free-standing midwifery units, and then we would have to look at whether we have the resources and staff in the place that women want them to be. But I am very aware they are popular, so actually, it may be that with the evidence, more women want to move from alongside to free-standing. We need to see what happens.

Q251 **Chair:** So is that something that you could bring along the data for when you come next year, to see how it is progressing over the next few years? Another area that I raised with the previous panel was the situation for independent midwives, which is a choice that some women wish to make. Is there anything that you are doing at your level to be involved in the current situation that has arisen with the NMC and the ability for independent midwives to access insurance? We have heard about the suggestion of honorary contracts, for example. Is that something that you are going to be involved with as part of the choice agenda?

Sarah-Jane Marsh: Not directly in the current situation; that is very much a decision for the NMC. We at NHS England are obviously working to support—first and foremost, I know the independent midwives themselves are working to support—any women who now, as a result of this decision, might not have the support they need over the next months. Where that is unable to happen, NHS England are very much looking at ensuring that each of those women can get the care they need and that if any do choose to go forward and give birth without any midwife at all present, we know who they are and can be on standby to respond if that is needed.

Q252 **Chair:** It has been raised with me that they are a high-risk group, potentially. Is that something that concerns you?

Sarah-Jane Marsh: We at NHS England need to ensure that all women get a service now—that if, for whatever reason, they now cannot go forward with their independent midwife, there is a service available to them from the NHS, and if they choose not to progress with the NHS service, we will still be aware of who they are and able to respond if they need us to. Going forward, we absolutely value the work that independent midwives do and, actually, one of our early adopters has chosen to

contract with Neighbourhood Midwives as part of their overall local maternity system. That is the sort of the thing that, again, is different in different areas. We support that move to include independent midwives more in the NHS family and allow them to be one of the choices available for women to access through local maternity systems. So again, we look with keen interest at what will happen with one of our early adopters and Neighbourhood Midwives.

Q253 **Chair:** Thank you. Finally, Professor Bayliss-Pratt, did you manage to find the data?

Professor Bayliss-Pratt: Yes. We will write to you to formalise this, but we have been able to identify that there were 1,100 vacancies across England in 2015, which is a 0.5% vacancy rate, and we anticipate, based on what we know now, that the number of new posts planned to be created by 2020 is about 1,001. Based on the supply that is available, depending on the retention and uptake of the people who are available and out there to be midwives, between 3,000 and 6,000 midwives would be available to work in the system. Indications thus far are not telling us that we will have a shortage of midwives, moving forward.

Q254 **Chair:** Is an effort being made to match where those vacancies are with the training places?

Professor Bayliss-Pratt: That is more work that we need to do, that we can formalise and bring back to you. We very much look at it from a national perspective, but there will be local variations and we can work to get that information to you.

Q255 **Chair:** Within other specialities what we hear repeatedly as a Committee is that the vacancy rates are highest in the most disadvantaged communities, so it would be very helpful to know that that is something you will be able to bring back next year.

Professor Bayliss-Pratt: Absolutely.

Chair: If there is nothing else that any member of the panel would like to say that they haven't been asked about before we finish, let me say thank you all very much for coming.