HOUSE OF COMMONS

Health and Social Care Committee

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

Tuesday 29 September 2020

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Watch the meeting

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

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Witnesses

I: Miss Michelle Hemmington, Expert Patient and Campaigner.

II: Dr Bill Kirkup CBE, Chair of Morecambe Bay and East Kent maternity investigations; and Professor Ted Baker, Chief Inspector of Hospitals, Care Quality Commission.

III: Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer, NHS England and NHS Improvement; and Dr Matthew Jolly, National Clinical Director for the Maternity Review and Women's Health, NHS England.

Examination of witness

Witness: Michelle Hemmington.

Chair: Good morning, and welcome to the House of Commons Health and Social Care Committee. Today, we are opening our inquiry into the safety of NHS maternity units following the serious issues that are being investigated at the moment in Shrewsbury and Telford, East Kent and other hospitals.

We are delighted to welcome a very distinguished set of witnesses this morning. Dr Bill Kirkup did the investigation into baby deaths at Morecambe Bay and is now doing another investigation for NHS England into what has been happening at East Kent and other hospitals. Professor Ted Baker is the chief inspector of hospitals and a paediatrician himself. His job is to report publicly without fear or favour about the safety standards in all our hospitals. Professor Jacqueline Dunkley-Bent is the chief midwife, and with her is Dr Matthew Jolly. They lead the NHS in its ambition to halve baby deaths and brain injuries by 2025.

Before we hear from those experts, we are going to hear from a mother about her experience. Michelle Hemmington had a very traumatic experience with the loss of her son, Louie. We are incredibly grateful to her for being prepared to talk to us publicly. She is also a campaigner to help stop the tragedy of baby deaths. We are very grateful to you, Michelle, for joining us this morning.

Before we talk to Michelle, it is important to say that nearly 700,000 women give birth with the NHS every year in England and the vast majority are completely safe. But that does not mean that things cannot improve, as we are sadly going to hear this morning.

Committee member Laura Trott is going to talk to Michelle. Once again, Michelle, thank you very much for joining us.

Q1 **Laura Trott:** Michelle, thank you so much for coming in today. Can we start by you taking us through what happened to you and your son Louie?

Michelle Hemmington: Thank you for inviting me to speak today. I will go through what happened up until the present day. On 17 May 2011, I went into labour at 41 weeks and two days with our first child, Louie. I had had a happy and healthy pregnancy.

Arriving at my local hospital at 9 am, I was told that I had picked a bad day to have a baby as the unit was really busy. I was told that there was not a bed available for me. It was suggested that I have a bath to help with the pain while I waited for a bed. I was then left in the bath for two hours, at which point I said I could not stay in the bath any longer. I was moved to a triage area. I was there for five hours without any monitoring of myself or Louie.

When I was finally examined, I was 8 centimetres dilated and then I was moved to the labour ward. I remember thinking at the time, "I've waited so long for a bed. How come there is a bed suddenly available for me?" By 8 pm that evening I was still in labour. As the evening went on, my son showed signs of distress and a registrar was called as there was no consultant at the hospital.

The registrar was in surgery, and it was decided to wait for him rather than call in the consultant. When the registrar finally arrived, there seemed to be some conflict between the midwife and the registrar, and he left without giving any real instruction. At this point, I became concerned as I could hear my son's heart rate and I felt that something was wrong.

I raised it with the midwife and asked for a C-section because I knew I could not deliver my son without help or intervention. I was told not to worry, and that it was too late for a caesarean section. At around 11 pm, the midwife performed an episiotomy and at 11.12 my son was born.

There were happy cheers from my sister and my partner, Paul, who were with me. He was placed on my chest as I wanted skin to skin, and his cord was cut, but at this point he was taken from me. He was taken behind a curtain but in the same room as us. The curtain was pulled across so we could not see anything that was going on.

We then heard alarms ringing and people shouting for help. The commotion went on for some time. After 30 minutes, a man came from behind the curtain. He did not introduce himself. He just told us that our son had died. He then walked away.

No one came to explain what had happened. The next few hours were spent holding our son in complete shock and disbelief, not wanting to accept that this had happened to us. The hospital bereavement room was already taken that night, which meant we had to stay on the labour ward. Hearing babies being born and crying after losing our son was truly horrendous.

Around a week later, we were given paperwork to register the death of our son. I had assumed that as resuscitation had taken place and been attempted that Louie would be a neonatal death, but the paperwork said stillbirth. I disputed this with the bereavement midwife, but she told me that that was the case and that if I did not register Louie as stillborn he would not be registered anywhere and we would not be able to hold a funeral. We had no option but to register his death as a stillbirth, which also meant we would not receive a birth certificate for him.

At around the same time, we received a letter from the hospital informing us that there would be an internal investigation into the death of our son. It was only after I contacted the hospital to find out more about this investigation that we were invited to participate. I think if I had not contacted the hospital we would not have been involved at all.

Weeks and months were filled with trying to work out why and how this could have happened, and desperately wanting answers. The investigation findings were completed in September 2011, four months after Louie's death, and concluded that there had been many failings in the duty of care. Some of the failings were failure to monitor foetal wellbeing, failure to escalate to a consultant obstetrician when urgent review was required and failure to conduct initial resuscitation as per guidelines. There was actually a four-and-a-half-minute delay in resuscitating Louie.

Despite those failings, the hospital concluded that they had not caused Louie's death. We received Louie's post-mortem results, which stated that his death was caused by hypoxia. This only left us with more questions of how he received this brain injury; surely, the failings in care had contributed to it.

I contacted our local police department as Louie's death was unexpected and potentially negligent, but I was told there was no criminal act against stillbirth. I then contacted my local coroner, at which point I learned that coroners have no jurisdiction to investigate or inquest a stillbirth, even though I did not believe our son was stillborn. This only added to the feelings of isolation and that our son's death was of no importance. How could a hospital be allowed to investigate themselves? I could not understand.

We felt that it was down to us to fully investigate our son's death, the only option open to us being litigation. After a long and really stressful four and a half years, the hospital admitted causing the death of our son. We received a small out-of-court settlement but no formal apology. All we wanted was an independent investigation into the death of our son to find out how and why he died, and to stop it happening again.

Losing Louie is something I will never fully recover from. I feel his loss every day. I also see the impact his death has had on my parents and my sister. They have not just had their own grief to deal with, but they have had to see someone they love completely heartbroken and devastated.

Through losing Louie, I have found that deaths like this are not as uncommon as I would have thought. This led me to campaign for rights around stillbirth and improvements for parents who have found themselves in this situation. Through campaigning, I met Nicky Lyon, whose son Harry died as a result of poor care during his birth. Together in 2013, we co-founded the Campaign for Safer Births and have been working ever since to try to achieve our goals. Thank you.

Q2 **Laura Trott:** Michelle, thank you so much. That was incredibly powerful. I am sure I share the thoughts of the whole Committee when I say that you are incredibly brave to come and talk about this today. Well done for all the stuff that you have done since to make sure that no one else has to go through what you went through.

Michelle Hemmington: Thank you.

Laura Trott: It is obvious from your story that a number of failings were involved in Louie's birth and death. Can you talk us through some things that you think need to change to make sure that this does not happen to anyone else?

Michelle Hemmington: We really need independent investigations. Stillbirths that are during full-term labour must be reported to the coroner for full independent investigation. It must be in the public domain to be able to issue prevention of future deaths. I truly think that only then will these types of deaths stop.

I also think that there need to be more staff involved. There need to be more staff on labour wards and in maternity. Consultants, registrars and midwives all need to be working together and to be joined up. At the end of the day, the outcome is to have a safe, healthy, positive experience of birth and to come home with a baby. They should all be working together to achieve that.

Q3 **Laura Trott:** Can you talk us through what your experience was of the midwives on that particular occasion? How many did you see? Was there continuity at all in your care?

Michelle Hemmington: There was throughout my pregnancy. When I went into labour I had eight midwives looking after me, but I did not see eight because obviously I was not monitored for five hours; I only saw two. The midwife I saw when I got to the labour ward I had started to build a good relationship with in that short amount of time, but her shift finished at 8 and a new midwife took over. I had no relationship with her at all. She hardly spoke to me.

Sorry, I've lost the question.

Q4 **Laura Trott:** It was about midwives and whether you had continuity of care with midwives during the birth, but you did not.

Michelle Hemmington: No, but I did during my pregnancy.

Q5 **Laura Trott:** That makes sense entirely. I have a final question. You have been involved with the Department of Health and Social Care subsequently in the brilliant campaigning that you have been doing. Do you feel that things have changed or got better in that time?

Michelle Hemmington: Thinks are improving, yes. We are seeing improvements, but it seems like there are some failings happening over and over again. There seems to be a group of failings that continue to appear in these investigations and in these deaths. There is still much more work to do, but, yes, it has improved over time.

Laura Trott: Thank you; again, I am so sorry.

Q6 **Chair:** Michelle, thank you again for that incredibly powerful testimony. Could you explain the reasons why they said that you had to register it as

a stillbirth? I was quite puzzled when I heard some of those reasons. I might ask some of our later witnesses whether the hospital was correct to tell you the things they did.

Michelle Hemmington: When I tried to push as to why he was registered as stillborn, that is all I was told. I was told that that was the case and if I did not register him as stillborn he would not be registered anywhere, and I would not be able to hold a funeral. We had to register it as a stillbirth.

Q7 **Chair:** I am so sorry. I find it a very odd thing to say that, if you do not register him as a stillborn, you cannot have a funeral. I find that very shocking. Let me ask the question straight up. Do you think there was a motive behind the hospital asking you to register it as a stillbirth?

Michelle Hemmington: Yes, I do. If he was stillborn, at the time there wasn't any investigation process, only an internal investigation. It meant that his death would not be reported to the coroner or the child death overview panel or any of the avenues that you would have with any other child death. I definitely think that there was a motive, and still to this day I do not believe that he was stillborn.

Q8 **Chair:** One final question from me, and then my colleague Paul Bristow wants to ask you a question. In terms of the processes that were followed by the hospital, do you think that we now have new processes in place that mean that should not happen, or is it still work in progress?

Michelle Hemmington: I think what we have in place now is a lot better than what we had, but it still does not go far enough. I feel that stillbirths are not treated seriously, especially for full term, when negligence and failings are probably part of why the baby died. They are not taken seriously. It should still go to a coroner, as any other unexpected sudden death would be. With stillbirth, if he took that one breath—which they said he hadn't and there were no signs of life—that would have been the difference between going to a coroner and not. That should not really exist in these types of deaths.

Q9 **Paul Bristow:** I find your courage humbling. You said that you had received some compensation. Have you ever received a simple apology at all from the hospital?

Michelle Hemmington: No. It was part of our request that we had a formal apology. We didn't receive that.

Q10 **Paul Bristow:** Why do you feel that the hospital were not able to offer a simple apology or answer basic questions? How comforting and cathartic would that apology be for you and your family?

Michelle Hemmington: It was more about them accepting what had happened. In those four and a half years, we had our legal case. If a hospital cannot admit what they have done wrong, how can they learn from it? How can anyone learn from something that they do not accept they have done? It is more about accepting it and apologising for what

they have done, and being sorry for what had happened. We did not receive that because we had no contact with the hospital after we started the litigation process, which I understand is quite normal. It was all through solicitors.

Q11 **Neale Hanvey:** Thank you so much, Michelle. That was deeply moving, and I am so sorry for your loss. I want to ask about the start of the journey that you described, when you were left in a bath for two hours and then on a trolley for five hours. You also mentioned the staffing levels having been part of the investigation.

I want to get a sense from you as to whether you felt that the staff were rushed off their feet and overly busy, or whether there was a lack of compassion and care, to make sure that you were okay and to initiate foetal heart monitoring and the like.

Michelle Hemmington: I didn't see anyone for so long. I saw a midwife when I entered the hospital and was first examined. Then I did not really see anyone else until I was placed on the labour ward. Then I was given a midwife. If it appeared busy, I did not really see any of that because I was left. We were told as soon as we entered the hospital that we had picked a bad day. The words they used were, "You've picked a bad day to have a baby," because they were busy. Since then, obviously, I have learned of all the things that happened behind the scenes that I would not have known.

When Louie died, all the staff who were with us were taken away, and we were given new staff. We did not know who they were. We were told that we would have to go to the labour ward because the bereavement suite had been taken. There was not much compassion. I asked if there was anywhere else we could go, and we were told that we could go home or stay there. I didn't want to leave Louie. I didn't want to be without him, so we stayed.

Q12 **Neale Hanvey:** You mentioned that you found out what was happening in the background afterwards. Are you able to give us a sense of your understanding of that?

Michelle Hemmington: Through the serious incident report, there were roughly around 19 failings. There were quite a few. There were things like the labour ward co-ordinator getting mixed up with all the beds, so she had given the bed that should have been allocated to me to a woman who was not in established labour. That is where the delay came. I had been put on a ward with women who were due to be induced. They were monitoring those women for that. There were lots of things that I know now that I would not have known then, and also through the legal case because I read all the reports. Again, it should not be down to parents to read cold medical reports, but I needed to understand what had happened.

Q13 **Neale Hanvey:** The very last thing I want to touch on—I appreciate this is incredibly difficult, but it is so important—was the way that Louie's

death was communicated to you. That felt really difficult. I do not necessarily want you to speak about that but clearly it is something that should never be blurted out in the way that it was. There is well-established practice for breaking bad news. I am so sorry that happened; it is very upsetting.

Michelle Hemmington: Thank you.

Q14 **Chair:** Michelle, you are welcome to stay and, indeed, to ask some questions of our other witnesses if you would like later on. I know that you have set up the campaign and you speak for many other bereaved mums and dads who have had similar experiences. On the panel this morning, we have the chief inspector of hospitals, the person who is doing the inquiry into East Kent and the two clinicians who are leading the NHS's campaign to halve baby deaths and brain injury. Do you have a message for them?

Michelle Hemmington: To keep parents involved. Parents are the ones who have gone through it. They have been there from the beginning all the way through to the end. It is really important to take their views into account. When Louie died, we were made out to be just angry and wanting blame. That was not the case at all. We wanted to know what had happened with our child and his death. It is focusing on the parents' experience and what they have been through, and a full and proper investigation of that.

Chair: Thank you so much for joining us. As I say, please stay online for as long as you are able, and let me know if you would like to ask a question of any of our other witnesses.

Examination of witnesses

Witnesses: Dr Kirkup and Professor Baker.

Q15 **Chair:** We now move to the second stage. I welcome Dr Bill Kirkup, who is doing the East Kent inquiry, and Professor Ted Baker, who is chief inspector of hospitals at the Care Quality Commission. Thank you both for joining us.

Dr Kirkup, I was Health Secretary when I asked you to do the Morecambe Bay inquiry, and you published that in 2015. You are now doing the same thing all over again for East Kent. Do you think things have got better since 2015, but could I ask first of all what your reaction is to the story we have just heard from Michelle?

Dr Kirkup: It was incredibly powerful. Thank you, Michelle. It absolutely illustrates things that I have heard too often and that I wish I hadn't heard too often. It is dreadfully disappointing that we are still getting problems like this cropping up when they should not.

My work over the past five years or so has been with units that are on the end of a spectrum. I am sure there is a spectrum of performance. There are some brilliant units. There are some good and some not quite

so good units, but generally speaking they are the ones that are doing well; they are learning and clearly improving in response to all the initiatives that there have been since round about the time of the Morecambe Bay investigation.

My problem is that there are a few in the left-hand tail of that distribution of performance that are not able to, or will not, learn and improve. My concern is that we understand those—I am sure there are all sorts of reasons to do with clinical isolation, leadership, organisational culture and so on—but to do that we have to learn to spot them. I do not think we are very good at spotting the small number of units that are in serious difficulties and perhaps do not even recognise it themselves. I would like to see us do much more on that front.

Q16 **Chair:** Can I explore that for a moment? In the UK, we have some of the safest and best maternity hospitals in the world. At places like Southmead in Bristol, led by Tim Draycott, they do an extraordinary job and have one of the safest records in Europe. When you have one organisation and lots of instructions coming from people like Matthew Jolly and Jacqui Dunkley-Bent, whom we are about to hear from, why do we have that lack of consistency?

Dr Kirkup: Variation in the health service has been a feature ever since 1948. There has been a lot of work gone into trying to understand, but I am not sure that we are very much further forward on that. The messages that are coming from Matthew, Jacqui and others are great for the great majority of units. They are very helpful and they clearly make a difference, but they are not reaching a small proportion, for reasons that we do not fully understand.

My view is that a lot of it lies in the leadership of those units and the fact that they become isolated, and nobody can quite spot what is happening. Part of the reason for that—this is difficult territory—is that some units actively conceal what they are doing. When they get into sufficient trouble, their response is to stop communicating with the outside world and to disguise their failings. I think they do that with the intention of sorting it all out themselves before they have to tell anybody, but it is quite difficult to get past that barrier when units get on to the slippery slope of declining standards.

Q17 **Chair:** Professor Baker, in your role as chief inspector of hospitals, when it comes to that variation, could you give some examples of the best and worst practice that you have seen in maternity units as you have been around the country, to give us some sense of the issues we are dealing with?

Professor Baker: Thank you, Chair, for inviting me this morning. This is really an important issue for us—safety in maternity services—so I very much welcome the Committee's interest.

I don't know if Michelle is still on the line, but can I express my admiration for her presenting her story here today? As she told the story, she talked about a man coming and telling her that her baby had died. That man was probably a paediatrician like me. If she is on the line, I would like to apologise on behalf of my specialty that someone behaved like that. At the root of it all is an issue of culture, which perhaps I can come back to in a few minutes once I have answered your question.

Bill Kirkup is right. There is a spectrum of quality that we see across maternity units in England. We have inspected all 200 of them several times. When we first reported on maternity units in the first round of inspections, in our report in about 2017, we identified that in a proportion of units we were finding problems that were very similar to the problems that Dr Kirkup had described at Morecambe Bay. Those problems are of dysfunction, of poor leadership, of poor culture and of parts of the service not working well together. Midwives and obstetricians often do not. Sometimes, anaesthetists and paediatricians do not. It was interesting that Michelle described some of that in her description of Louie's care.

We find elements of that as we go round inspecting services. At that stage, we said, "This is more prevalent. It is not just a few units. It is a significant cultural issue across maternity services." It is not in all services. There are some services that provide much better care, as you highlighted, Chair.

Earlier this year, we produced a briefing on the up-to-date position on maternity services. It raised concerns, but also drew on the experience we had had from our inspections and from working with clinicians from services that provide good and outstanding care. Interestingly, we identified three areas that had to be good for them to deliver really good care.

The first area was about leadership and culture, which Dr Kirkup mentioned. It is absolutely central to have a culture that is open and transparent and recognises that things can go wrong, is open about them when they do and involves the parents, which Michelle highlighted as important, in understanding what has gone wrong, but investigates thoroughly and builds learning on the back of it. It learns to get better and is constantly driving safety. That is a great example of good practice in units.

The other thing that was really important was training. We still find units where training in core competencies is not adequate. That is really disappointing because it has been highlighted for a long time. Staff in some units do not have the training they need to do the job they are being asked to do. That is a real challenge and it must be put right.

The other training that is important is training around how teams work—team dynamics and human factors. Teams in obstetric units are under great pressure. They have to operate as a good team, supporting one another. The third area of training is around scenario training; preparing

for things going badly wrong, for the major complications, with everyone ready to deal with that. Another area is that good services involve women in the care. They involve women in planning care, in their own care and in investigating when things have gone wrong.

That is a summary of the good things we have seen. It is the absence of those things that leads to poor care.

Q18 **Chair:** On blame culture, is there sometimes an issue around litigation, and the role of lawyers in making people defensive? I say that because Sweden appears to have half the neonatal death rate that we have, and they have not had a legal case, as far as I can tell, for 30 years. It is easier to get compensation. They have a slightly different system. The compensation levels are lower, but it is quicker and does not involve the courts. Do you think that can be a barrier?

Professor Baker: The defensiveness culture is important. It is an issue for healthcare generally, not just the NHS and not just maternity services. It is important that we do not see it as distinct for maternity services, but it is particularly important for maternity services. Defensiveness leads to services not being transparent, and to not sharing and not admitting when things are going wrong. It leads to not apologising when things have gone wrong; not being willing to apologise and recognise they have got something wrong.

The defensive culture that is so prevalent in healthcare is really difficult to deal with. In order to defend themselves, if they have to admit that something has gone wrong, it is easier to blame someone than to accept that there is a systematic problem. It is often a systematic problem, but finding someone to blame excuses them from investigating and finding the systematic issues. Anything that drives defensiveness and blame is dangerous for services. It is against providing safe care.

I strongly believe that we need to do everything to try to eradicate blame from the system, and all parts of the system need to understand that. Sometimes I despair because I hear people being blamed for blaming others, if you see the point. Blame can become infectious in that way. We have to accept the fact that humans are fallible. They will make mistakes. The important thing is that they learn from those mistakes and improve. The legal framework certainly helps to drive that.

Q19 **Chair:** One of the issues raised is the totally understandable desire for some mothers to have what is sometimes called a normal birth. There has been a lot of campaigning around that which has encouraged many mothers to avoid interventional surgery if at all possible. Has that had consequences for maternity safety?

Professor Baker: It has in some cases. Dr Kirkup identified it at Morecambe Bay as a big issue, and we have seen it in other maternity services. We have taken action where we have found it.

There is sometimes tension between those who are proponents of what they call normal birth and those who are proponents of a more interventionist approach. The danger is that while many women can have a straightforward birth with relatively little intervention—they are low risk—occasionally they develop serious risks, and the service needs to be able to respond to those risks. It needs to recognise the risks and escalate care appropriately, and not delay the escalation of care.

When it becomes a tension between different members of staff—someone who wants to promote a normal delivery and someone who wants to be more interventionist—it becomes a cultural issue within the team, rather than people working together to do the right thing for the woman and her baby. This is really important. There is a real issue out there. If you talk about maternity safety, there tend to be factions between those who want to promote normal care and those who want to promote interventionist care. The answer is that both are important and both need to be available, but the judgment needs to be made appropriately to escalate care, where necessary, to protect the safety of the mother and the baby.

Q20 **Barbara Keeley:** Professor Baker, you talked earlier about a small number of units that do not know they have a problem. If we look at the figures, nearly two fifths of maternity services are rated as requiring improvement for safety. That seems far too high, and it does not quite tie in with a small number of units.

You have talked us through a lot of factors, and that is very helpful, but can you explain why maternity services perform so poorly on that metric? Is it an issue specific to maternity services or is it a concern across the health system?

Professor Baker: For us, it is a particular concern for maternity services. That is not to say that it is not an issue in other services, but maternity services are where we have not seen safety improve as rapidly as we have in many other services. That is why I think this is so important.

I think it was Dr Kirkup who talked about a small number. I agree with you that 38% of our current ratings for maternity services are that they require improvement for safety. That is a significant number, and larger than in any other specialty. It is a reflection of the cultural issues in maternity services nationally.

Some services are outstanding for safety, so it can be achieved. Why do those services not learn from the services that are outstanding? That is the challenge we want. The work that Dr Jolly and Jacqueline Dunkley-Bent are doing and leading is really important in bringing that support to bear, and to make sure that services that are not assuming high levels of safety do so.

In the three years since we produced our report in 2017 up to the current day, we have identified eight services that were inadequate for safety and we have had to take action on those services. We have identified a further nine services that were inadequate for well-led, so they had major cultural issues.

My reflection on that is that a significant number of services are not achieving the level of safety that they should, and there is a recurrent theme. There are services having serious problems, as Dr Kirkup identified. There is a real concern that, if we do not turn the cultural issues around, we will have a constant stream of services running into difficulties because of the extra pressures they face. That is the challenge. We know we can do it if we can change the culture. That is the challenge that we have to get right.

Q21 **Barbara Keeley:** What lessons did the CQC specifically learn from Morecambe Bay, and what changes were made as a result? Given that failures in maternity safety have persisted—Shrewsbury and Telford and East Kent—do you think that the CQC and other organisations are working effectively enough to detect problems at an early stage? There seems to be the sense that we picked up from Dr Kirkup of an organisation just folding in on itself and ignoring what was going on. Given your role in investigations, do you think that you are detecting such problems at an early stage?

Professor Baker: The Morecambe Bay report in 2015 was very important. That to some extent has informed our view of safety in maternity services going forward. It is a key measure, and of course it talked about the defensive culture. It talked about dysfunctional teams. It talked about midwives and obstetricians not working effectively together, and poor investigations without learning taking place, with poor risk management and safety lessons not learned. Those elements are what we still find in other services. I said publicly earlier this year that five years on from the Morecambe Bay report we still had not learned all the lessons. All units have not learned the lessons, so I feel very strongly that we still need to build on that learning going forward.

To come to your point about picking up services that are in difficulty, if 38% of services require improvement for safety, there is always concern that some service is going to deteriorate because of staffing pressures or whatever. There is real worry and concern in terms of services deteriorating at times, and that is what generates the pressures.

At the CQC, we rely very heavily on the intelligence we get from women using services, from staff and from the data we analyse. We look at outcome measures from maternity services on a regular basis, and we follow them up very clearly. We are very vigilant about services that are having problems. We go out and inspect them. Some services have achieved a lot of publicity around problems, but equally there are other services that we inspect and take action on that are not so prominent. It is important that we emphasise that this is more widespread than just a

few services, which is why we have to address it as a systemic cultural issue. We cannot address it one service at a time.

Q22 **Barbara Keeley:** Given the importance of maternal health, and of avoiding complications in the latter stages of pregnancy, what work are you doing at CQC to monitor and report on early intervention and prevention work—those aspects of maternity services—as well as the work being done on labour wards?

Professor Baker: We take our lead there from the work that Jacqueline Dunkley-Bent is doing. She has produced some guidance for services on safety built around the needs of individual women. We are incorporating that in our inspection framework going forward. We will be building that aspect of care into our assessment framework for maternity services. Part of our response to what we see as the problem is to launch a new series of risk-based, focused inspections on safety for maternity services over the next six months or so. We will begin the work we are doing jointly with NHSE&I and other bodies centrally to make sure that it is a co-ordinated approach, and it will include that aspect of care.

Q23 **Rosie Cooper:** Professor Baker, how do you identify the people who do not learn from their mistakes? To go on from the comment Barbara made, everyone talks about organisations folding in on themselves, but we have lots and lots of data. Everybody says they are tired of all the reports they have to do. Isn't it the whole system that is passing the problem on, and just ignoring it?

In Morecambe Bay, we had a list that included the strategic health authority. That exists, but Monitor has now gone into NHSE&I. You have the CQC and the ombudsman. There are also auditors. There is a huge failure of regulation, but at the core of it isn't it that nobody actually wants to see the problem? How can it be so pervasive and nobody notices until it is a crisis?

Professor Baker: That is a very important challenge. One of the reasons that I am championing the problem and have spoken publicly about it several times and published briefings on it, and am working very closely with other parts of the system, is that it is a challenge, as you say, for the whole system. There are significant cultural issues in maternity services that we need to address, and I do not think we can address them with just one part of the system. All the regulators, but also the other parts of the system, such as the royal colleges, need to work together to drive the cultural change we need to improve maternity services and make sure that they do not run into these problems.

I think your challenge is right. It is a whole-system challenge. We are identifying the problem at the CQC, and we are very clear that the whole system needs to come together to help resolve the issues.

Q24 **Rosie Cooper:** Absolutely. It might be that the Secretary of State or your good selves would be considered to be the backstop. But why is it acceptable for people not to accept that things are going wrong? If we go

down the line of the no-blame culture, in my history in the NHS we have gone from blame to fair blame, to just and learning, and all the rest of it. Each system has its failings, including the just and learning system that we seem to be operating now.

Part of it is that nobody is actually owning the problem right from the lowest level to the top. They pass it on, hoping to get away with it. I am often struck by Bishop Jones's report, "The patronising disposition of unaccountable power"; everybody defends the system and it just carries on. It is all right for the CQC or Professor Kirkup dealing with it when it is a crisis, but my question to you is, on a labour ward tomorrow how do you ensure that people are really learning?

Professor Baker: We have to promote local leadership both in the clinical team and in the organisation, and it has to focus on driving the right culture in that organisation. Of course, we hold those organisations to account for that, but equally we recognise that they are facing a big problem and we need to give them support. The whole system needs to give them support. That involves us, of course, identifying problems and making sure that they are transparently identified, and pointing where action is necessary. It also involves bodies such as NHSE&I, as you will be hearing later, setting the guidance and driving forward the agenda. The work they are doing is very important. We have been building up collaborations with other parts of the system, such as the HSIB, the NMC and the GMC, to make sure that we are all co-ordinating what we are doing to make sure that we are all supporting the system to drive the right culture.

Maternity services are improving. It is important to emphasise that. We said at the beginning that they are improving, and we should not forget that they are improving. My perception is that they are not improving fast enough. They can improve faster. If you compare this country with some other countries in Europe, you see that we are not improving as fast as we should. There are also, of course, too many cases like the one we heard from Michelle, where tragedy strikes because services are not doing their job well enough. Those are all reasons why we have to deal with the issue head-on. That must mean that the whole system has to come together.

It is not about blame. If we make it about blame, the system becomes defensive. Dr Kirkup described the defensive behaviour of services trying to hide problems because they are afraid of exposing them. I want those problems to be exposed, not because I want to blame anyone for them but because I want to make sure they get the support they need to improve. The work that Jacqueline Dunkley-Bent is leading on the maternity safety support programme is very important. Where we identify a problem, we talk to them and they go in and provide support on the ground for that service. That has developed over the last few months, and it is important in taking things forward.

Q25 **Rosie Cooper:** I appreciate all of that, but in the face of the fact that we

are not learning fast enough—in my history in the health services I have heard this over and over for 30 years—and in the face of tragedy, don't you think that mums and dads out there will just think, "Same old, same old. We're not really making any progress"?

Professor Baker: We have to prove them wrong. I think that is the challenge to us. Don't you? What we must not do is get into the mindset where we think it is too difficult to solve the problem. That is why I have raised the problem. That is why I am determined to keep on raising the problem until we have solved it.

Q26 **Dr Evans:** I am keen on the concept of defensive medicine, but from the other angle, in terms of clinicians particularly, being a clinician myself. Practising defensively means thinking, "Am I going to get sued? Am I going to make a mistake?" That leads potentially, in some places, to taking on more tests and more interventions than you might necessarily need to.

I would be interested, Dr Kirkup, in your position on that. Does it add particular weight in the maternity sector specifically? Professor Baker, could you comment on that as well? It has a big burden in weight; we have heard about the litigation being high in maternity. There is great responsibility and risk in dealing with pregnant women. I wondered what your thoughts are and how this fits into the puzzle.

Dr Kirkup: I certainly think it is a part of the puzzle. It is slightly secondary, if you do not mind me saying so, to the notion of the unspoken professional culture that there is among clinicians, which is that we are all brought up in the specialities that we do to think that we have to be perfect. We are all conditioned to think that mistakes are unacceptable. There are obvious reasons for that, in that nobody likes to have made a mistake. If people have been harmed as a result of it, even more so.

If we are to change that culture, we have to start absolutely with the training of medical students. I have often said that I wished that somebody had sat me down when I was about to qualify and said, "Look, you are going to make mistakes and people will be harmed as a result. You will feel terrible, but being defensive about it, not admitting it and trying to explain it away is absolutely not the best response."

We have to be open and we have to say that these things happen. We all have to accept that, but we absolutely have to learn from them and not keep doing the same thing over and over. I have tested that with an awful lot of clinicians I have come across in the last 10 years. I have not found anybody yet who disagrees with that notion.

Q27 **Dr Evans:** Professor, could you comment?

Professor Baker: I entirely agree with what Dr Kirkup said. It is really important that we all accept our own fallibility and accept others' fallibility. If we get to the mindset that mistakes must mean that

someone is incompetent or in some way malevolent, I think that is entirely wrong. We have to accept the fact that humans are fallible, and that the professional response is to investigate thoroughly, openly and honestly and to learn from that to try to prevent a similar mistake being made by others.

There is a big issue that goes beyond just that. It is about the wellbeing of people working on the frontline in healthcare. There is a tension between the healthcare self-image, which is that it is very safe and that when things go wrong it is because there has been incompetence, and the reality of clinicians' lives. As you described, Dr Evans, clinicians often end up working defensively because they are so worried about making a mistake, yet to some extent that puts you in a position where you are disconnected from the culture in which you are working. We need to change that culture to one that accepts everyone's fallibility. That would improve the wellbeing of frontline staff.

Q28 **Dr Evans:** I am glad you picked up on that, Professor, because that is the next line of it. Where do you see the role of CQC in doing that? As the body that goes in and, effectively, checks up on services, it creates a lot of concern, certainly on the GP side, about people trying to perform, and to get in the right place. As you rightly point out, a lot of the medical profession are perfectionists and like to do that. With the anxiety that comes with it, rather than seeing it as a collaborative chance to learn and highlight good care, there is concern that the spotlight is being shone: "I am under an exam situation and I need to make sure that everything is watertight."

What do you perceive your role is as the CQC in trying to be the facilitator, and bringing that strength forward, rather than being the heavy-handed enforcer? What is the balance between the two?

Professor Baker: We are often characterised as the heavy-handed enforcer. I do not manage the regulation of general practice, so I will not comment on that, Dr Evans.

Sometimes, I am held up to be the heavy-handed enforcer on hospitals. If I do not get that right I totally accept that I am fallible like everyone else, but what I am trying to do is create transparency so that people have to face up to the real issues. When I was in clinical practice—I was in clinical practice on the frontline for 35 years—the external reviews of my practice and my service were very helpful to me, provided I put away the pride that said, "I don't want any criticism."

You have to accept the fact that a review that tells you that you are perfect is actually not much use. It may make you feel better but it is not much use. A review that tells you that there are things you can do to make your service better is really helpful. That is what we try to do at CQC. It is not always received in that way, and I totally accept that. We are absolutely clear that we will not do anything other than tell the reality about what we find. That will sometimes be uncomfortable, particularly

with services that have real problems with safety. I accept that it is uncomfortable, but if we do not face up to the issues, we will not solve them.

Q29 **Dr Evans:** I really appreciate that. Thank you for your honesty. Stepping slightly further away from that and moving the subject on a little bit, though it is still relevant, would CQC pass comment on the way in which we structure our maternity services? Do you feel that it is structured in the right way, with the levels we have for our tertiary units and our midwife-led care? Is it the right structure, and is there a better one out there?

Professor Baker: The CQC is not there to determine the structure of services. I need to be careful. It is up to us to regulate the services as they are, not tell them what they ought to be. There is a general argument about all services, including midwifery services, that there tend to be relatively rigid frameworks in how we organise them. You have to accept the fact that what works in a big metropolitan area, because of the closeness of tertiary units, and so on, may not work as well in a rural area. Dr Kirkup mentioned this earlier when he was talking about it. Sometimes, maternity services and others in rural areas, a long way away from main centres, do not have the critical mass around care. They try to some extent to model the metropolitan unit and think they have to be like metropolitan units. There may be other models.

Before I was at the CQC, I was looking after a small maternity unit in a rural setting that had 1,500 deliveries a year. I was told it was not viable and could not work. I said, "Where have you gone to find out about this?" Essentially, they had just asked people at the royal colleges in London. I said, "Have you looked at models from abroad?" and people had not. There must be models of high-quality maternity care in other countries in that kind of setting. I wish the NHS would be more open to that learning.

Q30 **Dr Evans:** Dr Kirkup, would you be prepared to answer that question as well, with your experience from what you have seen? Do we have the structures correct in the NHS currently, and what other addition would you like to see? Can you answer that professionally or in your personal capacity?

Dr Kirkup: Maternity is one of the specialties that is particularly affected by the notion of critical mass at the moment. I am absolutely with Professor Baker on this one; there is a real danger in having a single model that is based on metropolitan practice. If you look at the evidence—I was involved in looking at the evidence in relation to North Cumbria not too long ago—there is actually very scanty evidence that small units are not viable, provided they are prepared to look at being innovative, and provided that they are prepared to look at co-operating properly with surrounding units and dealing with the things that they need to deal with. Where they do not do that, there are serious dangers of becoming clinically isolated.

It is not just geographical, but it may certainly be geographical as well. When you get very little interchange of ideas with people, with the outside world, your practice can deviate quite a lot before anybody is aware of it. That was one of the features that we found at Morecambe Bay. When you are prepared to use a different model and co-operate fully with the units round about you, there is every evidence that you can provide safe services, even in relatively small and isolated units.

Q31 **Dr Davies:** I have a couple of questions to either or both witnesses. To what extent do staff recruitment and retention issues impact on the quality and safety of maternity services, in your experience?

Dr Kirkup: That was certainly a feature at Morecambe Bay, and it has been a feature of other investigations I have been involved with, not necessarily in maternity services. It is one of the products of the thing I have been loosely calling clinical isolation. There are locations where it is very difficult to recruit staff. That can become a serious factor in their standards slipping and that not being spotted outside, in my experience. I am sure that Professor Baker has a view on that too.

Professor Baker: I agree with what Dr Kirkup said. The recruitment and the number of staff is better than it was. Certainly after Morecambe Bay, when Dr Kirkup identified those problems, we were very assertive in insisting that units have the right level of staffing. They have improved, but we still see elements of that.

There is a background. There is a big attrition rate in trainee obstetrics and midwifery. If you look at the statistics and staff feedback, those specialties have a lot of bullying, and that is partly linked to the culture and the safety problems we are talking about. That creates tensions in teams that make it very difficult to work. I suspect that we lose a lot of good people from some units, and from the profession entirely, because of the way we look after them in the culture in which we make them work.

Managing high-risk obstetrics is very stressful. People need to be supported and accepted as they are. It comes back to this issue: if we say to an obstetrician, "You've got to be infallible," clearly when something goes wrong they lose a lot of their self-worth at that stage, and asking them to stay in the profession is difficult. If we support them and their fallibility, and help them learn and improve over their professional lifetime, I think we can keep them in the profession. There is an issue of staff numbers, but there is also an issue of how we look after the staff we have.

Q32 **Dr Davies:** That is very helpful. Dr Kirkup, to expand on an issue that Dr Luke Evans was raising just now in terms of the structure of services, I am interested, as an MP representing a relatively rural area, in the ratio of midwifery-led units versus doctor-led obstetric units and the distances between those for access of care. Have you come across situations where women find that the distances involved are too great and pose a risk?

Dr Kirkup: That is exactly the issue we looked at in North Cumbria, which is a relatively spread population, with a couple of urban centres and a large rural hinterland in between. It seems to me that where you can provide an obstetrics service and a midwife-led service so that women have choice, you have the best of both worlds. That is what they manage to achieve in North Cumbria.

One of the key points in making that sustainable in areas like that in the future is how we train junior clinicians. The more we tend to centralise their training in the metropolitan areas, the less attractive the rural places seem. We do that because royal colleges, by and large, like training to be in large centres with big rotas of doctors, and do not like them trained in smaller units. If we were able to be more flexible about that and train people in places like that—I had the great good fortune to be trained in a couple of them, including Hexham, which is quite a small unit—the experience would be fantastic and would give much more likelihood that you would practise in places like that in the future and keep them sustainable.

Q33 **Neale Hanvey:** Thank you, gentlemen, for your contribution. I want to try to pull a couple of strands together. It comes back to the argument about fallibility and the ability to be self-aware of your own practice as a clinician, but, as an organisation, being able to reflect on the systems and processes that are in place, and whether they are safe either for clinical delivery of services or the management culture. Could you comment on whether you feel it is safe for people to whistleblow and to raise concerns, and whether that precipitates blame and targeting of the whistleblower, or if there are any changes that need to be made that would enable concerns to be listened to in a balanced and helpful way?

Professor Baker: We have not mentioned the freedom to speak up agenda as yet. It is really important, so thank you for raising it. We at the CQC rely very heavily, as I said a while back, on patients and service users raising concerns, and staff raising concerns and telling us about their real lived experience of working in services. That is very important to our understanding of those services.

The reason why people are frightened to raise concerns is the culture in the units in which they work. A healthy culture would mean that people routinely raised concerns and were expected to do so. If you talk to safety-critical industries, they say, "Actually, we expect people to raise concerns. We're concerned about people who don't raise concerns." Healthcare is completely different from that. Raising concerns is regarded as being a difficult member of the team. It is often not so much fear of retribution as fear of letting the team down that stops people doing it. We need to recognise that.

Good training about team dynamics would tell you that good teams are teams where people are always raising concerns. That is really important. The culture in organisations and in teams is very important. I have spoken before of my concern about the hierarchies in healthcare, where it

is very clear who is in charge and where you sit within the hierarchy. We need to start breaking that down. Again, if you speak to safety-critical industries, they say that inappropriate hierarchies are detrimental to safety because it means that people cannot speak up about things they are worried about.

It is important and we are not seeing a good, internal speak-up culture in many maternity units we look at. A lot of work has been done recently with trusts appointing freedom to speak up guardians. We welcome that, but a lot more work needs to be done on it. That has to be central to driving the right culture.

Q34 **Neale Hanvey:** Do you have any comments, Dr Kirkup?

Dr Kirkup: I agree with all of that, of course. One of the striking features of doing some of the visits for the "Better Births" report was the extent to which you could tell how teamwork functioned in a unit within half an hour of meeting them. I think Professor Baker has had very similar experiences. In one kind of unit, you walk in and it is all terribly formal; people are sitting on different sides of the room not relating to each other, and you know that their teamwork is suspect from the start. In other places, you walk in and they are all mingling and joking with each other, clearly seeing themselves as able to raise any issues they want, and you think those are the units that will find themselves able to be open about things, own up to them and tackle them.

Q35 **Neale Hanvey:** In units where there is an endemic cultural issue that prevents the free flow of concern, of information, support and all the things that you would like to see in a healthy clinical culture, what impact do you think training on its own would have? If there is endemic resistance to change, in its broader sense, could some form of role modelling from one of the exceptional units and one of the ones where there is a cultural challenge be facilitated, and how? That might have more gravitas than a slideshow. I am not denigrating the training in any way, but do you know what I mean?

Dr Kirkup: Absolutely. Training is the root of the answer in the longer term. We have to start making sure that people have the right knowledge, attitudes and behaviours from the outset. In the short term, I fully agree with you. It is not going to have an impact. It is no good lecturing people about being better.

A lot of us have wrestled with the notion that we should be better at learning from the good units, and if we just pull together some sort of osmosis will happen and the poor unit will improve. What has happened in a lot of instances that I have seen is, unfortunately, not that. A barrier goes up between the two; the good unit is reluctant to get involved because it sees itself being dragged down, if anything, and the poor unit is reluctant to open up to somebody being held up as being better than them. I do not welcome that. I do not condone it, but I think it is a part

of human nature. We have to work a bit harder at it than just linking units together in most instances.

Q36 **Taiwo Owatemi:** Professor Baker, the 2019 MBRRACE-UK report noted that ethnicity increased the risk for women, specifically black women, who were five times more likely to die as a result of complications in their pregnancy. Neonatal mortality is also considerably higher in babies of black or Asian ethnicity. What steps is the CQC taking to mitigate that or to understand those statistics? How can it be addressed effectively?

Professor Baker: We need to understand it much better. You have raised a very important statistic. It is a measure of how little we understand the issues behind safety in some of these services that there can be such disparities in different groups in terms of outcomes.

One of the things that frustrates me when I go to maternity units and ask them about their outcomes that are not in line with the national average is that they sometimes say, "Well, it is because we have particular kinds of patients. We have a difficult socioeconomic group." What they are not doing is saying, "Actually, our challenge is to address those issues and try to make sure that these people get the best outcomes we can achieve." I do not think those challenges are going on enough in maternity units in terms of outcomes.

As we go forward with our new inspections, we are building looking at ethnic differences in outcomes into our inspections because we recognise that is an important aspect of safety. Not only is it about the safety of individual women; it is also about the safety culture of the organisation that it does not allow such disparities to occur. We think it is very important to focus on that going forward, and to see it as an important measure of the overall safety of the unit and the leadership culture of the unit. We will be focused on that going forward. For too long, we have seen major disparities, particularly in maternal mortality for black and minority ethnic women, but also, as you say, neonatal mortality. It has been going on for too long and we want to address it.

Q37 **Taiwo Owatemi:** I want to follow up on previous questions about training. How important is training, and do you think you are getting the right funding and instructors in place to deliver training? I am aware that we had a maternity training fund that only lasted a year. What do you think needs to be done to address that? That question is to both Professor Baker and Dr Kirkup.

Professor Baker: I may not be able to answer that directly. Training is very important. We emphasise and have emphasised in our briefings the importance of training. It has to be high-quality training and not just PowerPoint slides. I do not know if Dr Kirkup can answer more on that.

Dr Kirkup: The funding that was earmarked for that kind of training was withdrawn after a year. That is disappointing because there was evidence accumulating that it was effective. Part of the reason it was effective was

that it was done in a multidisciplinary way. In other words, you did not train different professional disciplines in isolation; you trained them as teams, which I think is fundamental to improvement in the areas we have been talking about.

Q38 **Taiwo Owatemi:** Would you say that removing the funding reduced the quality of training being offered? How do you think in the long term we can improve it and ensure that the training being offered is adequate but broad enough to deliver the quality of care that we need to deliver?

Dr Kirkup: The evidence was that the training was effective. We could do with accumulating more of that evidence. I certainly think it was disappointing that it was stopped when there was evidence accumulating. If it is as effective as it was looking at that point, it would certainly have had a net negative cost in terms of the birth injuries, litigation and all of that, as well as the human loss that we would have avoided.

Q39 **Sarah Owen:** I have two questions. One is around the change of culture, and I want to dig a little further, Professor Ted Baker, around staff pressures and shortages.

Last year, the Royal College of Midwives said it was short of 2,500 full-time midwives. Are you picking up any impact from the pandemic? We have seen reports that Homerton, for example, had stopped home births because they could not guarantee that ambulance services would be able to get to people in time, should they need them. There were reports of midwifery staff being pulled from services to go elsewhere in hospitals.

There was a promise in 2018 to train 3,000 more midwives. How far along are we with that? If we are not necessarily retaining the number of midwives we need, how many are we looking at in terms of shortages now and the impact on services long term?

Professor Baker: Thank you for the question. The number of midwives has been a constant issue over the last few years. During the pandemic, one of the unheralded things that has been very positive is the way that information has been shared by the various national bodies. NHS England/Improvement has been sharing with us its weekly situation report on services. There have been some services, as you say, where they have limited access for a while, but most of their services are now back up and running at this stage. There was an impact. It has varied over time. It changes from week to week but services have largely been restored. There are a few services that are still not accessible nationally, but they are very few.

On the overall complement of midwives, could I ask you to take that to Dr Jolly rather than me? It is probably within his remit rather than mine. Our perspective at the CQC is that we expect providers to have adequate staff to provide safe care. Where they do not, we will insist that they find those staff, but we recognise that many units have difficulty recruiting.

As I said a bit earlier, not enough is done about maintaining the wellbeing of the staff they have and attracting qualified staff back to work by providing them with a good working environment. We need to value and look after our staff better and retain them, rather than always look to recruit and train new staff all the time to fill vacancies.

Q40 **Sarah Owen:** Dr Kirkup, you are nodding. Is there anything you want to add?

Dr Kirkup: I think Professor Dunkley-Bent would have the numbers. Certainly, I am very taken with the notion that we need to do more to protect and retain the staff we have. The turnover in some units is very high indeed. If we could do anything to make them more attractive places to work, I am sure we would reap the rewards.

Q41 **Sarah Owen:** Both of you have said that we need to retain staff and make it a more attractive and healthier place to work in terms of staff wellbeing. Is there anything specifically that would help retain members of staff?

Professor Baker: I strongly believe that the culture we are talking about to keep patients safe is the same culture that will keep staff working. If you talk to frontline staff, the thing that motivates them is the belief that they are providing high-quality care. If they think the care they are providing is not good enough, it is very demotivating and many of them will look to work elsewhere. The way you retain staff is to give them the support to provide high-quality care, and to deal with the cultural issues that they face to make sure that they are confident they will get the support they need when things go wrong, but also that learning will take place and they will be part of driving improvements on the back of it.

Q42 **Sarah Owen:** My second question is a little left field, but it is important to raise. Do you think there is a role for the trade unions in tackling the blame culture and protecting whistleblowers? They are very used to changing cultures within organisations but also protecting whistleblowers. Do you think there is room for some other form of safeguarding people, particularly those at the lower end of providing hospital care and lower-paid staff members, when they whistleblow or raise concerns?

Professor Baker: There is a role for everyone in addressing the blame culture. I do not think anyone should be outside that. It is too pervasive. If everyone does not get on board to address it, we will not get it right. As I say, so often people say they are tackling the blame culture, but really they are trying to find people to blame for the blame culture. That does not work. We have to accept the fact that no one is to blame and we all have to work together to solve the problems. We have to accept that we are all part of the solution as well as part of the problem. Everyone needs to be involved in that.

It is a real challenge because the system is driven by a lot of defensive behaviour that Dr Kirkup described earlier on. That defensive behaviour tends to drive a blame culture. People want to find someone or some

organisation or group of people to blame when things go wrong so that they can free themselves of concern. Trade unions, with the right approach, can be really positive in this regard.

Q43 **Laura Trott:** I have two questions. The first is around culture and the second is around investigations. First, I want to pick up the Chair's earlier line of questioning around Dr Kirkup's finding that there is a growing move among midwives to pursue normal childbirth at any cost. I think it is extraordinary that an ideological viewpoint is affecting women's safety. We heard earlier from Michelle that when she asked for a C-section she was routinely dismissed.

When we are thinking about our recommendations as a Committee, what can we do to stamp that out and make sure that women's safety is not affected by the way some people perceive they should or should not give birth?

Dr Kirkup: I do not have any evidence as to whether that is a general trend that is of concern. I am referring to what I have seen in some of the units that have got into end stage failure, where it has certainly been a factor. We have to be careful about extrapolating from those; part of my point earlier was that they are not so much like other units.

Having said that, I think there is a slightly simplistic view that there is only one lever we can pull: either lots of intervention and it is safe, or much less intervention and it is a normal birth but it is not safe. I do not think there is one lever. That is too much of an oversimplification. People sometimes describe the debate, and try to frame the debate, in those terms. I think there are multiple levers; we can have lots of appropriate normal births, and we can also have a safe service provided that we do the right things to maintain surveillance of the service and make sure that we give safe care as well as appropriate care.

Q44 **Laura Trott:** Professor Baker, do you have any views on that?

Professor Baker: Yes, I do. I think the point you make is a really important one. Care needs to be individualised for the individual woman, taking into account her needs and her risks. She needs to be given the advice to make the right decisions for herself. She should not be told, "You have to do it this way or that way." She should be given the choice and understanding how to do it.

In the latest national maternity survey, we surveyed 17,000 women across the country—it was published not long ago—and one in six women said that they raised concerns during labour that they did not think were taken seriously. Michelle mentioned that as well. It is just not acceptable. Women's concerns need to be taken seriously.

One of the things that will change safety is when patients and service users—women in this case—are equal partners in safety. They are not receivers of safety; they are partners in safety. They help drive their own safety and the safety of the service. That is an important element. The

sense of normality against intervention, as if you have to choose one or the other, is nonsense. You have to have what is right for you under the circumstances. When the risk changes, the service needs to be able to escalate care rapidly to make sure that you get consistent and safe care.

Q45 **Laura Trott:** Thank you both. This is a different question around investigations. We heard from Michelle that she felt it was extremely unusual and not proper that the hospital was investigating what happened to her in her individual instance. Obviously, things have changed since then. Do you think that the procedure and regulation when individual instances have gone wrong is correct now, or do you think there should be changes made?

Professor Baker: Of course, now the HSIB undertakes investigations in many of those cases. That independent investigation is very valuable. They have already produced some really interesting results. Their overarching view is important. Of course, it reinforces some of the discussion we have had. It is interesting that the problems that emerge from these investigations are often the same problems that we have known about for a while. That is the frustrating thing about it.

If we are to do it well and if we get the culture right, the hospital should be able to do the investigation in a fair, honest and open way, with the support of the family themselves. If we get to a point where we cannot trust hospitals to do the investigation, we have not got the culture right. I think that is a fundamental issue. If the hospital is doing it well, it will want to do a thorough investigation because a thorough investigation will lead to the best learning and the best improvement in care. That is where we need to get to. The fact that people do not have confidence in investigations is a feature of the culture not being where it should be.

Q46 **Laura Trott:** Thank you, Professor Baker. Dr Kirkup, do you have any thoughts on that?

Dr Kirkup: I fully agree. It is important that investigations are proportionate and that in the great majority of cases it should be the local hospital that is doing the investigation because that is where the richness of the learning lies.

The converse is that, where they are failing and not doing proper investigations, there has to be some way of ensuring that there is then a proper investigation, a stage higher, which is independent and probably crosses different organisations where multiple systems are failing in different organisations. It is proportionality. It is getting the right investigation for the right circumstances. The majority of the time local investigations should be the way to go. You have to have the right capabilities and the right culture for that to work. Where you do not, there then has to be recourse to something that can step in and put that right, which would be with the independent investigation.

Q47 **Rosie Cooper:** I disagree very strongly about hospitals being the first

and only point of contact to get an investigation done. Professor Baker, you talked about "if". Well, so many families around the country have gone to the hospital, and it is like the police investigating themselves. They are supposed to accept what they are given.

The hospital investigates. NHSE&I will not. Then you are left with the original hospital that technically the query is about. The only avenue after that is the ombudsman. As we know, they do very little investigation; they do not have the capacity. Ergo, I actually believe we have now reached a point where we do not have a complaints system.

Professor Baker, you talked earlier about a report that tells you what is wrong being the best thing because you can improve on it, so why don't we value complaints? Why don't we really learn from them? Please. After all these inquiries that we have had—Morecambe Bay—nobody has learned because we are now looking at this current inquiry in Shrewsbury and Telford.

The reality is that there is not a real independent system, which is why, for LCH, I have had to push and we have now got so many inquiries. Dr Kirkup is now doing the third one. The reality is that you do not have a complaints system. When hospitals investigate themselves, it feels to families like the police investigating themselves. It is not real; it is not open; it is not honest; and they do not trust it.

You also said that when you have looked at things there is loyalty to the team, and the culture is that the loyalty is to the team. Patients believe that the Hippocratic oath says that the doctor's loyalty should be first to the patient and not the team. My final question is, should Bishop Jones's report be compulsory reading for every member of the NHS?

Chair: There is a matter of fact I want to bring to everyone's attention. Since Michelle's evidence, the Healthcare Safety Investigation Branch now does an independent investigation of every serious maternity incident. Whether that is working as well as it should or not is an open question, but I wanted to put that issue of fact on the table. Over to you, Professor Baker.

Professor Baker: We have had a whole series of reports recently into failures in the NHS. They identified a common theme around culture, defensive behaviour, around investigations not being done and around patients and patients' families being fobbed off without support. It is exactly what you have described in terms of poor investigations. Yes, those reports should be compulsory reading. I absolutely agree in that regard because I think they are really important, but we have to make the changes that stop us having to have reports like that. That has to be by addressing the culture in healthcare that is defensive and is not willing to learn when things go wrong.

When things go wrong, we need to learn. It may be a complaint. It may be a serious incident or whatever. We need investigations that are effective in delivering learning, and that involve and have the confidence

of patients and their families. If we cannot achieve that, we are not in the right place on this. I think that is absolutely fundamental.

Q48 **Rosie Cooper:** But you are not in the right place, are you?

Professor Baker: We are not in the right place, which is why I have raised this as an issue and why it is so important that we focus on the issue. It is important that all the organisations in the NHS leading on this come together to provide the leadership necessary to make the change.

Q49 **Rosie Cooper:** On that basis, Hillsborough never happened. It is crazy. Let me explain. All those organisations did not investigate things properly. The fans were blamed and people died. Here, what you are saying is that the whole system needs to look at it, but when individuals collide with the NHS and have a complaint, they feel exactly the same way—that the hospital and the authorities work together. All the regulators fail and they do not get a proper answer. It has taken me six years to get to where we are with LCH. If you are just an ordinary member of the public, be it in a maternity setting or wherever, how do you get justice? That was my real question.

Chair: Professor Baker, why don't you address that briefly? Then I am afraid we have to move on to the next panel.

Professor Baker: I go back to what I said before. It is important that we get to the point where people can have confidence in the organisations investigating when things go wrong, and confidence that lessons will be learned and they will be told the truth about what has happened. That is why we are here today—to drive the cultural change that can drive that confidence.

Chair: Thank you very much indeed, Professor Baker and Dr Bill Kirkup. The best of luck to you in your continuing work with the CQC and in the East Kent inquiry. Those were very important answers and some very important questions as well.

Examination of witnesses

Witnesses: Professor Dunkley-Bent and Dr Jolly.

Q50 **Chair:** We now move to our final panel this morning. We turn to Professor Jacqueline Dunkley-Bent and Dr Matthew Jolly, who are leading the NHS's campaign to halve neonatal deaths, stillbirths, maternal deaths and brain injury by 2025. It is a really important campaign.

I know that you have been thinking about all these issues. You will have lots to say about what you have heard this morning. Thank you for joining us. Could I start by asking Professor Dunkley-Bent about your reaction to what you heard from Michelle right at the start?

Professor Dunkley-Bent: Thank you, Jeremy. I was exceptionally saddened to hear Michelle's account from real lived experience about the care that she received and the fact that she felt alone. I have been a

midwife for 32 years. I pride myself in the midwife/woman relationship. It should be, and for most is, a unique and special relationship. I feel really saddened that Michelle had that experience and that her family had to experience it, and that she continues to seek answers.

Q51 **Chair:** Thank you. I will ask Dr Jolly for his reaction in a moment. While I am with you, Professor Dunkley-Bent, I want to ask you about the national maternity safety ambition, which I know you have been working really hard on. The deadline is to try to halve these terrible incidents by 2025, which is a very bold ambition. Sands, the neonatal deaths and stillbirth charity, is worried that we are not making enough progress to hit that target. It points out that still every day about 14 babies die before, during or soon after birth. Do you think we are on track as things stand today?

Professor Dunkley-Bent: First of all, the safety of pregnant women, their babies and their families has been, and will always be, an absolute priority. We are working really hard to ensure that we achieve that ambition.

In relation to the stillbirth rate, for example, there was a 21% fall between 2010 and 2018, meaning that the NHS in England has met the 2020 20% reduction ambition two years ahead of schedule. That means in terms of numbers 2,900 fewer stillbirths. In recent times, we have data that tells us that there is a 25% fall in the stillbirth rate. That was in 2019, but I recognise that we still have a long way to go. That is just an illustration of some of the progress that is being made.

Q52 **Chair:** Thank you. Let me go to Dr Jolly, if I may, first of all, for your reaction to Michelle's story.

Dr Jolly: I would like to start by thanking Michelle for being so brave in sharing what was such a sad and tragic series of events. I also thank you, Michelle, for all the campaigning you have done since, along with Nicky Lyon. Getting those messages out is making a difference. When you describe some of the events that have happened, I can think of interventions we are putting in place that will stop those experiences happening. It is about embracing the theme that Professor Baker and Bill mentioned. We need to learn by our mistakes. We need to embrace the mistakes, understand them and use that as evidence for how we drive improvement. That is exactly what we are doing.

Thank you for your bravery. Thank you for sharing your story. You are making a difference, and you are helping us make a difference.

Q53 **Chair:** Could I ask you about Sands's concern about progress? I think everyone agrees that we are making progress, which is particularly impressive on stillbirths, as Jacqui just mentioned. The neonatal death rate has gone down but appears to have slightly ticked up since 2014. That might be a reporting issue and the way the stats are collected. Maternal mortality rates are going down, but the one that does not seem

to be budging is brain injuries. Do you have a view, or is it in fact moving and that is wrong? Why is it that we seem to have an issue with brain injuries?

Dr Jolly: There are some technical challenges about brain injuries. We only developed the definition that we are using for brain injury back in 2015, and the data are not brilliant before then. We are getting better at collecting data about brain injuries. Part of the rise is because we are better at recognising them.

The definition of brain injury was quite broad because our neonatologists were determined to try to address every source of brain injury, not just the ones that are due to hypoxia in labour. They want to stop brain injury for any baby because each baby matters for the parents.

We focus more on hypoxic injury. It seems there is starting to be a fall in those injuries related to birth injury, so that is heartening to see. There are delays in publishing the brain injury data. We are working with Imperial College, who have all the data on it, to try to get the data published quicker so that we can understand our progress. We have interventions in place to try to further drive down the brain injury rate. There is some very exciting work with the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and THIS Institute in Cambridge about how we understand a lot of the dynamics that have been raised by various witnesses during this meeting: how we understand and can address those issues and further drive down brain injury. I think we are going to see improvements in brain injury. There are interventions in the pipeline that will start to shift the dial in that area.

Q54 **Chair:** I want briefly to ask you both about some of the things that arose earlier in this morning's hearing. First of all, on the data issue, how good is the data that you are working from? I understand the data from MMBRACE is presented as a ranking and not a funnel plot, so people cannot automatically see from that whether they are within the expected safety range. Are you generally happy with the data and the way it is presented?

Dr Jolly: I would always like better data. We have changed the way we collect data with the new version of the maternity services dataset that has recently been published. Getting that working properly has been challenged by Covid. It is a very complex process about trusts getting the right maternity information systems in place to collect the data and pass it up centrally. There is a plan in place; it is starting to be rolled out and data is definitely being improved.

Beyond data, the exciting development is that we no longer use just data for the quality surveillance of our maternity services. We have merged it with an intelligence-led approach to monitoring maternity services so that we can identify units where things are going wrong much earlier. That is a collaboration with HSIB, with NHS Resolution—the early notification

scheme—with CQC and with the deaneries, with the colleges. It is intelligence about what it is like to work in the unit and what the culture in the unit is like. That is being funnelled up through our regional chief midwives. We are putting a whole escalation process in place so that Jacqui and I can really have our finger on the pulse of what is happening in maternity services. The data needs to get better, but the gamechanger is that we are now introducing intelligence-led surveillance as well as data-led surveillance.

Q55 **Chair:** We heard a very heartfelt plea from Rosie Cooper about the way people feel shut out when a tragedy happens and feel that the system is conspiring against them. Obviously, one of the changes that has happened recently is that HSIB is doing independent investigations into every incident. Is that working in the way it should? Are you happy that that is a positive step forward?

Dr Jolly: I really recognise what Rosie Cooper said, but I want to reassure her that there are changes happening. HSIB has really progressed well. There is much more maturity about it. It has gained the confidence of lots of clinicians who work in the health service who were, understandably, a bit intimidated by the thought of being investigated by a safety investigation team. It is becoming obvious that HSIB really wants to make our services better. It is a comprehensive deep dive into what goes wrong. It has objectivity. It has external independence, and the involvement of parents in the process.

We are seeing themes emerge with HSIB reports that would not have emerged before. It did a report on skin to skin, and deaths related to that. In the past, those individual deaths would have been put down to isolated tragedies. Now we are getting learning, and we are sharing the learning across the system so that it makes a difference.

It complements the work that is going on with the perinatal mortality review tool, which is more for the internally led investigations. It is very structured, with objectivity in it as well. It helps individual clinicians feel that they can change and improve their services. My dream would be that we do not need whistleblowers in the future because we have such an open, objective and aspirational service where people can raise issues and rapidly improve the care that they are providing, very much in the way that Ted and Bill described.

I accept the challenge from Rosie Cooper. I suspect it will take me a little while to present all the evidence to convince her that we are making a change, but I genuinely think that the objectivity of our investigations is improving. They can be trusted because of the external HSIB approach.

Q56 **Chair:** I have a quick question for Jacqui before I hand over to colleagues. I want to ask you, Jacqui, about Bill Kirkup's comment about training. He said something that was fascinating to me, that coping with mistakes should be a mandatory part of training for all doctors and midwives—in other words, learning the process of being open and

transparent, and helping people to cope better. Is that something you have a view on?

Professor Dunkley-Bent: I absolutely agree with Bill Kirkup's view in that regard. To ensure that we support an honest and open culture, we have to provide the infrastructure for that to happen, so that people are accountable. Of course, they should be accountable for their actions but should not feel as though it is a blame culture, where they are less likely to speak freely about the mistakes or the things that they have observed.

The maternity safety training fund—the £8.1 million that was given to us under your tenure, Jeremy—was exceptionally well received. We had in excess of 30,000 training places; I think 30,945 training places were delivered through that fund. The evaluation that was undertaken by Health Education England demonstrated that on the whole the programmes were successful. Many services pulled those training initiatives into their baseline positions. I take the point that colleagues are concerned that the funds are not recurring, but I understand that the intention was to kickstart the service with that training support.

In addition, we have been working to address the variation in training and competency assurance. That was mentioned previously in relation to the variation in education provision and assessments across England in our maternity services. We have been working with a group of clinical professionals and experts, with NHS Resolution colleagues, to develop a competency framework that will ensure that we reduce the variation in what is provided, how it is assessed and what happens afterwards across our maternity services. That is in train at the moment. We are hoping to launch part of it on Thursday with an abridged version of the CNST, and then the full version next year when we launch CNST incentive scheme four.

Q57 **Laura Trott:** Thank you both for all the work you have done on maternity safety. As we have heard today, it has been an historically overlooked part of the NHS. The work that you are taking forward is incredibly important.

You were kind enough to be present for the earlier panel. I want to give you an opportunity to comment on the question that I asked previously about ideology. We heard from Dr Kirkup that there is a growing move among midwives to pursue normal childbirth at any cost. That was in his report for Morecambe Bay. Professor Baker said that he can see the desire for normal birth leading to bad outcomes. Do you accept that? What steps are you taking at the moment to address it?

Dr Jolly: That is a narrative that has been played out for many years. I think we have seen a fundamental change in how it should be addressed thanks to Lady Hale's ruling in the Supreme Court as part of the Montgomery *v.* Lanarkshire case, and also the GMC guidance on consent. Lady Hale said that there is no more room for that paternalistic attitude to women in labour, and I completely agree with her on that.

We are developing a consent tool to help us address the issue by putting women at the centre of decision making in labour. As Ted and Bill said, it is about good assessment of a changing situation, communicating the risks, the pros and cons and the options that a woman has at the time, and listening to what she wants to do. Different women have different agendas about what they want to do, and we should respect their view and respect women's autonomy to make a decision. Some people will have a low threshold for wanting a caesarean section because the safety of the baby is absolutely paramount to them. Other women may be more confident that they can achieve a normal birth without exposing their baby to risk. Our job is to do the best possible risk assessment, communicate clearly and respect women's autonomy.

We are working with Birthrights, a human rights charity, on developing the consent tool. It will be Montgomery *v.* Lanarkshire compliant, GMC consent compliant and woman focused. In that way, I think we can deliver both personalised and safe care, and we can defuse the arguments that you described.

Q58 **Laura Trott:** Will that be rolled out to all trusts, Dr Jolly?

Dr Jolly: We are developing it along with NHSX at the moment, to make it a digital tool that is easier to use. We are hoping in the next few months to start piloting it. Obviously, it depends how well the pilots go. We are very much doing it as a co-development with service users. Women are absolutely involved in how we develop it. We are listening to them. We want to make it so that it works well for them. The sooner we can get it out, the better, but I do not know all the technical challenges. I do not know the feedback we are going to get, but we have absolute determination to deliver it.

Q59 **Laura Trott:** Professor Dunkley-Bent, do you have any further comments on that?

Professor Dunkley-Bent: I wholeheartedly support the IDECIDE tool that Matthew has just referred to. I acknowledge your comment about the ideology. I understand where it came from. Maybe I could share a little bit about training to be a midwife, the undergraduate curriculum and education and training once you have qualified.

Midwife means "with woman". Midwives should advocate for women in supporting them in their choices. It is a unique and special relationship. On the whole, women trust their midwives. I know that there are exceptions. The ethos of how a midwife practises should not, and must not, be to take choice away from a woman. Midwives do what is right in terms of what is right for the woman. There is an appropriate risk assessment that every midwife undertakes so that, when a woman makes a choice, she can be given truly informed information to help her choice to be supported, whichever way she chooses to go.

It is not in a midwife's DNA on the whole to support normal birth at any cost. We want to ensure that women have a good experience, good outcomes, and that the family have a rich experience and their choices are supported.

Q60 **Laura Trott:** Thank you both. I have a loosely related question concerning choice. With neonatal provision, at the moment parents do not have a choice over where their baby, if it requires neonatal care, is placed. Is that something you are looking at? Do you think it in any way affects health outcomes? We have heard of instances where mothers and fathers have been separated from their baby at hospitals. Surely, that will have an impact on how the baby does.

Dr Jolly: A lot of the time, admission to a neonatal unit occurs because of prematurity. We are working with the British Association of Perinatal Medicine and our quality improvement team—the MatNeoSIP programme—to optimise care to reduce neonatal deaths and improve outcomes. Part of that is better identification of women at risk of pre-term birth, and timely transfer to the appropriate level neonatal unit to provide the right care.

Neonatal care is incredibly skilled; you need a critical mass of activity to have really skilled doctors and some of the techniques they have available. We cannot have level three—the most advanced neonatal care—in every single obstetric unit. It is a matter of getting ahead of the game, either by preventing pre-term birth or optimising care, and that includes good communication.

In many cases, there will be limited choice about which level three neonatal unit you go to because geography will trump choice, if you see what I mean. If you have a 20-mile journey to one, and a 50-mile journey to the other, you are going to go to the one that is 20 miles away. That is just the pragmatic side of things.

Again, we need good communication. Putting parents at the centre of the decision making is all part of how we can address those issues.

Q61 **Paul Bristow:** I would like to ask Dr Matthew Jolly this question first. You talked a little bit about data and what you are doing to improve the quality of the data you receive. That was reflected in the report "Better Births Four Years on: A review of progress". Why do you feel there have been such issues related to data collection?

Dr Jolly: It is a complex area. Probably the way to think about it is that there is a journey from a clinical event and how those data items are recorded on a maternity information system, to how they are exported up to NHS Digital, processed and then played back to the clinical teams. That is how it works.

The technical complexity of how you record data on maternity information systems is very complex, but we have worked with real experts in NHS Digital, NHSX and the Professional Records Standards bureau to

completely revamp that and we use new coding technology called SNOMED CT. We have created a much better capability to record it. That allows us to publish something called an information standards notice, which is something all trusts must comply with.

A trust has to procure high-quality maternity information systems. That is a challenge. It is an expensive, difficult and challenging procurement process. We have used our CNST incentive scheme, which is the insurance scheme for trusts, whereby if trusts do not work hard in implementing a maternity information system there are financial penalties. We are really putting levers in place to drive the procurement of the best-quality maternity information systems.

We have NHS Digital working hard with the trusts' technical data people to improve the data flow from trusts up to the maternity services dataset that has also been revamped and aligned with the primary data. Those data are now starting to flow. In the next few weeks, we hope to see some of the benefits of those developments. The CNST scheme that Jacqui mentioned earlier is going to be fierce on trusts and drive good-quality data. I fear that some trusts will pay the price this year, but we cannot tolerate people not taking data seriously. I do not apologise for putting financial penalties in place to drive data quality. I am sorry if I was getting a bit technical, but I promise you that was very high level compared with the conversations I have with NHS Digital.

Q62 **Paul Bristow:** You weren't joking when you said it was a complex issue. I can understand the value you place on intelligence-led surveillance as well. The report I mentioned a few moments ago says that there is still significant variability between units in terms of outcomes for women and babies. Why do you think that is, in a nutshell?

Dr Jolly: That is a complicated question to put in a nutshell. To start off with, it is very interesting if you look at the MMBRACE data, where we look at the variation in stillbirth rates. You see a bit of variation between trusts. MMBRACE also has a way of controlling for various issues, such as deprivation, and you see a flattening of the variation between trusts. Some of it is that we have more to do in caring for the more vulnerable mothers. That comes out in what we have seen with the poor outcomes in the black, Asian and mixed ethnicity groups—the poor outcomes related to deprivation.

In order to achieve equity for the women we care for, we need to go the extra mile for those who are the most vulnerable. It is embracing the principle of proportionate universalism. An example would be the saving babies lives' care bundle, where we have designed best practice care and have put in place a way of identifying those who are at greatest risk. In areas where we have worse outcomes, we need to do more, and target those people and give them absolutely the best-quality care to address the disparities between different units.

We recognise the problem, and we are trying to do something about it. There is more that we need to do. Don't think that because I said we have some solutions in place we are not absolutely determined to carry on exploring how else we can improve. We have reduced the stillbirth rate by 25%. That means we have another 25% to go. While that would evidence that we are on the right track, we need to do much more.

Q63 **Sarah Owen:** The first part of my question is to Dr Jolly and the second part to Professor Dunkley-Bent. It relates to the questions that Laura raised around women's choice.

I am interested to hear a bit more about the work that you are doing on the IDECIDE app and whether that work is going to be extended pre giving birth and being in labour, extending the amount of women's informed choice when it comes to different ways of giving birth. I am pleased that you mentioned Birthrights; they had a survey that showed that 74% of respondents said they were given the opportunity to discuss the benefits of a vaginal delivery, but only 42% said that they were given the opportunity to discuss the benefits of a caesarean section. Is the choice—the app that you are developing—going to incorporate decisions for women before they are in labour?

Dr Jolly: Thank you for that question. I agree with you that informed decision making the whole way through pregnancy is important, from 12 weeks, as is the choice you make about screening all the way through that journey. Part of the way to meet the challenge you raise is better information giving. We are working with NHS UK on making sure that the best-quality information is available to women. There are a number of charities trying to integrate best-quality information giving with the electronic patient record that we are also developing.

The reason the IDECIDE tool applies just to labour at present is that that is where the biggest challenge was. We thought that, if we could crack that challenge, we could then roll it out in other ways. There may be a way of using the IDECIDE tool antenatally once we have developed it. In many ways, it is not just a formal consent process. It is about good-quality information sharing and sensible conversations with our incredibly expert and experienced midwives, and personalising that, to put the best-quality information in NHS UK into the context of what works for the individual woman's circumstances. That is why personalisation is such an important part of the maternity transformation programme, and why we think personalisation goes hand in hand with safety.

Q64 **Sarah Owen:** If you have personalisation and it goes hand in hand with safety, people have to be fully informed, and impartially informed, about the decisions that they are going to take.

Dr Jolly: I agree.

Q65 **Sarah Owen:** Professor Dunkley-Bent, one of the things that has jarred personally with me throughout this evidence hearing, and through reading all the evidence, is the term "normal birth". This touches on some

of the ideological issues that Laura raised and some of the problems we talked about with Dr Kirkup around the want for normal birth. Is it time to drop that terminology and just call it what it is, which is unassisted vaginal birth? People can then have a much more informed and probably unbiased or value judgment base when it comes to choosing their carer and birth.

Professor Dunkley-Bent: I acknowledge some of the concerns around the term normal birth. I have been a part of many discussions and debates about that term: should it be removed or replaced? In speaking to a diverse group of women, many women do not understand what unassisted means. Many women have shared their concerns about why we are making it something that it is not. Is it a normal birth? Is it a vaginal birth? It is really interesting engaging with socioeconomically advantaged women who have a particular view and women whose first language is not English and listening to their views.

I believe that it may warrant further discussion, but my soft intelligence tells me—my intelligence comes from a diverse group of women—that it is not so much the normal birth that is the challenge but what surrounds that concept.

Q66 **Sarah Owen:** What measures could be put in place to better inform women on the choices and options around giving birth?

Professor Dunkley-Bent: I am the national lead for continuity of carer. The evidence tells us that women having a midwife who is with them and who is their named professional during their pregnancy, birth and afterwards have a better pregnancy experience. The evidence tells us that women are more likely to disclose intimate concerns that they have not disclosed to others. I am speaking about domestic violence and other things like that. The evidence tells us that having continuity of carer reduces the pre-term birth rate by 24%. Having somebody you trust and can develop a relationship with, as in continuity of carer, would enable and support a woman to be empowered and have these conversations. What is normal birth? What is a C-section? What are forceps? What will happen if I have an epidural? They would be able to speak candidly in those terms.

Many women tell me that if they do not have such a relationship they feel embarrassed or feel that their questions are silly or not valid. They go to Google or one of the other search engines to have their questions answered. I believe that continuity of carer is one way of ensuring that women can have frank conversations.

Q67 **Barbara Keeley:** Professor Dunkley-Bent, you have talked about an area of progress, with reductions in the number of stillbirths. We have heard from the Chair that progress is still badly needed to reduce brain injuries.

We have heard about staff retention problems and culture problems, particularly in teams, as well as training issues. Do you keep coming back to the same issues? Nearly two fifths of maternity services are rated as

requiring improvement for safety. That is the thing we cannot get away from. What is your view of the biggest issues in maternity safety?

Professor Dunkley-Bent: I have been part of those discussions and debates. Dr Jolly previously mentioned surveillance, and ensuring that we develop intelligence-led data. That is a surveillance process whereby we recognise some of the concerns early. We are upstream, helping services that may well have a problem before it escalates into a CQC warning, or a CQC inadequate or requires improvement rating. We are working on that surveillance piece because we want to use data that is intelligent to help us focus our efforts and support services that are not quite on the radar for regulatory action but are somewhat rumbling beneath the surface.

If I may, I will share with you the maternity safety support programme that we have at present. It is a programme that provides targeted support for trusts most in need. We recently revised the entry criteria to the programme, but it started when Jeremy Hunt was the Health Secretary. He charged us with this surveillance piece: how can we ensure that we have close scrutiny of services that may have some concerns, and what can we do about it?

The maternity safety support programme was birthed at that time. In its first year, we had nine trusts on the programme. How does one get on the programme? In the first year, trusts would arrive on the programme, or be invited to be a part of the programme, because they had a CQC inadequate or required improvement rating.

Since the first year of the programme, with nine trusts on the programme and six trusts successfully moved away from the programme in terms of their success with the CQC—moving up into their improvement journey—we have changed the criteria. It is about being upstream. We have reduced the threshold by which a trust would enter the programme. The CQC will still do their assessment. We have worked very closely with them; I think Professor Baker alluded to it earlier. We have worked very closely with the CQC to lower the threshold when the maternity support programme would go in to support a trust. That means it is not just about "requires improvement" or "inadequate"; it is about another CQC domain. That has lowered the threshold somewhat.

To share with you some interesting statistics, if we stuck to the old criteria that I explained a short while ago, four trusts would be on the programme now. Because we have lowered the threshold, we have 12 trusts on the programme. This means that each trust on the programme will get a maternity improvement adviser. The maternity improvement adviser will go into the organisation and work alongside the leaders, the managers and the clinical staff to support them in their improvement journey. It might take six months or a year, but we are committed to ensuring that we support organisations on their improvement journey.

Q68 **Barbara Keeley:** Thank you. I have a separate question for Dr Jolly. Obviously, the past six months, during the pandemic, have posed unique

challenges to the delivery of maternity services. I know that many of my colleagues in the House of Commons are very concerned about what a bad experience it has been not having partners with you for a scan. Coronavirus is making a big difference.

What steps has NHS England been taking to ensure that the work on maternity safety that we are talking about has not been derailed or is not being set back by the pandemic? Are you also tracking what impact the pandemic is having in itself?

Dr Jolly: Both Jacqui and I still work clinically. We know how important it is to women to have a partner or a loved one with them. Even members of the policy team have been service users of maternity services, so we absolutely understand how upsetting it is not to have someone you love with you at some of the key events on the maternity journey.

It has been a difficult balancing act to maintain services, maintain safety and make sure that we do not have Covid rampant in a unit, and lose the staffing and have to close down a unit. There has been a balancing act, and Jacqui and I have done a lot of work. We have sent letters out to the system. As the risk has reduced, we are doing more and more to improve access for women to maternity services.

In maintaining the safety work, we work very closely with the RCOG, the RCM, the Society of Radiographers, the National Screening Committee and a whole host of key stakeholders to develop guidance. It is very much contingent on how bad the shortages are in a unit. In a unit where there was relatively little Covid, they could continue with the best practice care as described in things like the saving babies' lives care bundle, whereas in a unit where there were severe staff shortages we identified which were the safest things that they could cut back on to maintain services and try to ensure the best safety possible with serious staffing challenges.

There are some specific areas where there have been challenges on the safety side of things—for instance, carbon monoxide testing. There were some concerns that you could theoretically pass Covid on by using carbon monoxide testing machines. We had to pull that. We have been working with the Smokefree team at Public Health England and I think we are very close to reinstating carbon monoxide testing and reintroducing best practice care.

It is a stratified approach, relying on local leadership to assess the risks and trying to keep our safety approach to a minimum.

Q69 **Taiwo Owatemi:** My question has already been asked, but I want to follow up on what I asked the previous panel. How are ethnicity and socioeconomic disparities in maternal and perinatal mortality outcomes and experience, including women from black, Asian and other minority ethnicities, being addressed?

Professor Dunkley-Bent: There are very startling, stark and worrying statistics about mums who are thinking about getting pregnant and mums who are pregnant who are black, Asian or minority or mixed race ethnicity and how they will think about those data and receive those data.

What we have been doing in that space is learning from the MBRRACE improving care rapid report and the UKOSS surveillance data that clearly show that if you are Asian you are four times more likely to be in hospital pregnant with Covid, and if you are black it is eight times more likely. We also have the MBRRACE five times more likely to die in pregnancy data.

We have done a range of things to reach out to our maternity providers. We have key asks. We have a four-point plan that was shared with the system some seven weeks ago. That four-point plan asks maternity services to increase support for at-risk pregnant women—black, Asian and minority ethnic women—making sure that clinicians have a low threshold to review, admit and consider multidisciplinary escalation in women from those backgrounds. That is really important.

I am also pushing for health professionals to listen, and to think about who they listen to. In the four-point plan, we are addressing the communication that our services have with the women they serve and their families in the local community, and to make sure that their communications are tailored to those women. Naturally, different languages and how you pitch the information falls into that space.

Point three is to ensure that hospitals, maternity services, midwives and obstetricians talk about vitamin D deficiency with all women, but, as we know, women with darker skin, non-white women or women who cover their skin when outside may be at particular risk of vitamin D deficiency. They need to consider taking supplementation. We have asked in the four-point plan for our midwives and obstetric colleagues to have that conversation with women and to explain its significance.

The last point in the four-point plan is to ensure that maternity providers record maternity information. I am thinking specifically—it is noted in the four-point plan—of the ethnicity of the woman as well as other risk factors. That needs to be recorded because in the absence of data we cannot be as purposeful as we would like with our interventions.

There are many more things that I could share with you, but I will share one more, if I may. Maternity voices partnerships are groups of user representatives, commissioners, doctors and midwives. The groups are led by users of maternity services, and they look closely at how they can support us. They are the face of our face with women and their families. They have been working with us to support the development of a black, Asian and minority ethnic voices partnership network. I am keen that we hear from everybody and not just from those who have advantage and speak well.

Our MVPs ensure that their MVPs are inclusive of black, Asian and minority ethnic parents and not just white middle-class people. Our MVPs prioritise mentoring schemes for black, Asian and minority ethnic parents. They hold webinars as well. We recognise that "No decision about me, without me" means that we have to step into the context of where communities are to be able to provide purposeful and meaningful care that will drive up outcomes.

Q70 **Taiwo Owatemi:** It is great to see that so much work is being done in this area, but what is actually being done to understand the data that we currently have? I know we are addressing it, but what are we doing to understand why those statistics occur?

Professor Dunkley-Bent: First of all, I will speak from an empirical perspective. The Department of Health and Social Care is funding research through the National Institute of Health Research policy unit. That research will investigate the factors associated with the excess risk of maternal death for black and Asian women, and the excess perinatal mortality rate experienced by black, Asian and minority ethnic babies. We hope that those data will be published before Christmas.

However, right now there is a concept called proportionate universalism, which Matthew alluded to. We have asked, and continue to encourage and support, every maternity service in England to ensure that their care is proportionate at scale and intensity that is equal to the level of need. Everybody can do something right now. I usually substitute scale with pace. I think pace is timely because women are scared.

Matthew alluded to the saving babies' lives care bundle. In saving babies' lives care bundle two, we have a whole focus on pre-term birth. Matthew has led an amazing programme of work that has some great outcomes, but for black, Asian and minority ethnic women the pre-term birth element of saving babies' lives care bundle two focused on pre-term. We know that, if you are black or south Asian, you are more likely to have a very pre-term baby. That is another intervention that will target women who need that care most.

There are many other initiatives, but I think that we can all start with proportionate universalism, knowing our demography, knowing our people and serving them well by applying intervention that is relevant to their need.

Chair: I am afraid we have come to the end of our session this morning. We have overrun because it has been such a fascinating session. On the last issue, Taiwo, Jacqui did a very good presentation to the all-party group on baby loss on ethnicity factors in improving maternity safety. I will make sure you get a copy; it was very encouraging to see the progress that is being made.

I finish by thanking everyone, particularly of course our witnesses, Professor Jacqui Dunkley-Bent, Dr Matthew Jolly, Professor Ted Baker, Dr

Bill Kirkup, and particularly Michelle Hemmington, who opened today's evidence session in exactly the right way, to make us all really understand the seriousness of what can, sadly, go wrong. Thank you, everyone, for participating. This is only the first of a number of hearings that we will be having, so we will be returning in much more detail to many of the issues that we have touched on today. For now that concludes this morning's session.