Health and Social Care Committee: Safety of Maternity Services in England Inquiry
Transcript from roundtable with maternity clinicians
Thursday 7th January 2021, 10:30-12:00

Transcript for group 1

Jeremy Hunt: Thank you all very much for joining us, it's really appreciated. I gave you an outline of some of the things we're likely to be recommending and I'd be really interested to go through everyone and just ask your reactions to whether those recommendations feel on target or whether there's something we should be adding to those. But in the end it's really about: 'do you think your team is able to deliver safe care, what are the things that make that possible, what are the things that make it difficult, what have your own experiences been, and if you have been in a situation where something's gone wrong, do you think that the unit has got the training in place to respond in the right way so that lessons are learned and not repeated, and is the culture right? Those are the kinds of things that ministers don't tend to feel they can focus on because there's so much firefighting, and I know from my own experience that as a select committee we want to step back and ask those more long-term questions as to what we need to do. So really love to hear from all of you about that. Why don't we start with O&G Doctor (Senior) and hear your thoughts?

O&G Doctor (Senior) A: Thank you Jeremy. There's a lot of talking points there so perhaps I could start by talking about the recommendations that you're suggesting, many of which I welcome greatly. I just had a few questions about two of them in particular, and that's with regards to the realities or the practicalities of implementing recommendations relating to safe staffing. It's my understanding that there already were recommendations in place for the number of midwives per unit compared to the number of births in the unit. My particular comment is that in obstetrics we have a huge problem with people leaving the specialty at the moment and so actually we need to be looking at how to retain members of staff once they're in the specialty. My second comment was about the continuity of care, which I welcome very much, but practically speaking my understanding from midwives is that it can be a difficult model to work in. But I'm sure we have some midwifery colleagues here who might be able to speak to that better… I am speaking in terms of lifestyle rather than being on call, struggling to get away. Working patterns can be quite tricky in the continuity of care model.

Jeremy Hunt: I'll tell you where I think we're at on those. There may be some recommended numbers but I'm not sure how much they are adhered to, and I'm not sure of the extent to which they extend to doctors as well as midwives. We would obviously look into that before we made the recommendation. But it's quite a thing because once NHS England agrees then with that comes a funding commitment to maternity units. So if you say that you've got to have this many doctors and this many midwives and this many nurses – that's why it's a significant one. On continuity of care, my understanding is we do have a way of making it work which means that you don't have to be permanently on call for your mums, but that's why you have a team of midwives… But there may be some midwives in our group this morning that have experienced that. Can I ask you, have you had any experience of things going wrong? I'd just be interested to know your experience of whether or not we have the right learning culture.

O&G Doctor (Senior) A: Yes, I'm sure any of us who've been in the specialty for long enough have had experience of things going wrong. I have been involved in a maternal death where I provided care for a lady who unfortunately died within 24 hours of me providing care to her, and of course I've also been involved in many instances of stillbirth in particular, but also unplanned admissions of babies to neonatal units. I would say that in all of these cases I have experienced support; there have

always been team meetings following incidents in which team members have been able to reflect and share their experiences and their concerns. I feel in many of these instances I haven't always been actively involved in the investigations and haven't been fully kept up to date with ongoing investigations and findings, which is something I think is really important as someone who has been involved in these instances and is constantly worried about the outcome of the investigation. It's very useful to be kept constantly up to date with where things are. I think generally though I'm lucky to have worked in units where these systems work well.

Jeremy Hunt: Do you feel that when something goes wrong – it's not always preventable, but sometimes might have been – that we do enough to spread the lessons across the whole NHS, not just things that have happened in your unit; things that might have happened in another hospital in similar situations. What's your opinion about how good we are at that side of things?

O&G Doctor (Senior) A: I think we're getting better, and I think one of the great things in the UK is the MBRRACE group who are involved in investigating both perinatal deaths and maternal deaths in particular, and I'm concentrating on deaths as the worst thing that can go wrong. The MBRRACE group do of course look for common repeated themes in incidents leading to adverse outcomes and share those – the problem of course being it can take 18 months to 2 years for those findings to be shared, so I think it's about timeliness rather than a lack of sharing. As we've seen with Shrewsbury and Telford recently, but other trusts prior to that, these systems only work if there's transparency within the local system itself and reporting on the local system externally. I suppose in conclusion I think the national systems are in place, but they rely on identification of a problem and sharing of the problem from the local system which clearly doesn't always happen.

Jeremy Hunt: Thanks very much indeed, very helpful. Let's move on to **Anaesthetist (Senior)** with your thoughts

Anaesthetist (Senior): Hello and thanks very much for having me today. As an anaesthetist, some of the recommendations you suggested I wouldn't be an expert to comment on, but one of the things you have been discussing is about patient safety and lessons learnt which is something I feel I can bring something to the table with. The reason being that as an anaesthetist I work across the whole hospital, so kind of watching the culture within the delivery suite is say very different to what you'd see in an orthopaedic centre or in paediatrics. The biggest observation I have of the delivery suite is it's a very tribal culture and it's a very defensive culture as well, and it's very siloed. So with regards to patient safety and lessons learnt you do tend to find that the external teams such as anaesthetics, theatres and ODPs are often left out of the de-brief and of the training. For instance, in my last rotation they were doing a training simulation day on maternal haemorrhage, and because I hadn't been properly inducted to the unit I was fifteen minutes late because I didn't know where room 11 was. So it's kind of simple, basic things like that which are done across the whole hospital but actually is implemented in the delivery suite. Reflecting on what **O&G Doctor (Senior)** said for real critical incidents that do happen, I don't think junior clinicians are brought in well enough to voice their opinions for the de-brief, but also being involved in the process, because actually we need to be involved to learn how to deal with this when we're a consultant. I had a significant critical incident on my last rotation where the woman arrested from a major haemorrhage but luckily we managed to bring her back, and I never had a formal de-brief and it was incredibly traumatising. I wasn't particularly satisfied that it was being investigated properly either. I spoke to the consultant as I was leaving who said that there was going to be a root cause analysis about it, but personally as a clinician I didn't feel satisfied that the right steps had been taken to address the fact that this was a very near miss.

Jeremy Hunt: Could you just explain a bit more what you mean when you say the culture is a bit tribal and defensive and siloed in delivery units – that's interesting just to understand what your sense is… I'm not a doctor but just from a layman's point of view what it feels like to me is that to even to admit even to yourself that you were responsible for harm coming to a mother or baby is about the most difficult challenge for anyone in healthcare, and so people find that really hard and you have to try 25 times harder to make it easy for people to be open in these situations. I'd be really interested in your thoughts.

Anaesthetist (Senior): When I say tribal, I mean the midwives tend to stick together, theatre staff tend to stick together, and the obstetrics team tend to stick together, and I think the communication between all three teams is not always effective. I think there's a difficulty especially with visiting teams like anaesthetists and theatre teams – we don't do as much training with each other, so we don't necessarily understand each other's roles and responsibilities. I think it goes back to being kind of defensive as well – sometimes it can be a bit jarring between different groups, so for instance midwives with anaesthetists and analgesia options, there can be more conflict in delivery suite than for the same kind of pain issue you would find on a ward.

Jeremy Hunt: Ok, thank you. What would your solution be – sorry, impossible questions to ask – but if you were to break down those barriers what would the solution be?

Anaesthetist (Senior): I think there needs to be more training with each other. I think that people need to understand what the roles and responsibilities of each other are, what we can and can't do, and improve the respect for each other's professions. One of the big things we did in our unit was basic teaching for the midwives about what an epidural was, to explain about why we need to look at clotting, what the complications of an epidural are, all those kind of things, and actually what you found was the relationship between the anaesthetists and midwives following that was greatly improved and the midwives had a lot more understanding about epidurals which provides a much better service for the patients.

Jeremy Hunt: Fascinating, thank you very much indeed. Let's move on to **Midwife**.

Midwife: Good morning, thank you very much for this opportunity. I'm not going to repeat what's gone before so I'll try to focus on a couple of other things. The first thing I'd like to pick up on is the safe staffing levels and the idea of creating some sort of algorithm based on birth numbers. My anxiety about that – as we know at the moment, it isn't just about the number of women giving birth but it's about the complexity of the care they're having, and that's a much more difficult thing to measure and to outline but it is something that often gets missed when we talk about numbers of births and when we look at the amount of activity in a maternity unit. It isn't just about the numbers of doctors and midwives that you have in that unit – we know from some of the work we've done there are nurses working in the unit, there are healthcare assistants, there is a whole range of other people including anaesthetists who are involved in that care. And so yes, generally speaking the idea of having some sort of a standard would be very welcome, but we need to be cautious of it being a minimum standard as we know in the past there have been issues when you give out a number and say you should have X number of midwives for Y number of births – that doesn't necessarily translate into the quality of service that we like to have. Another thing I'd like to pick up on is the idea of training, and I would go back to the point that interdisciplinary training is really important. One of the challenges we've had in the past is that different groups of people are trained in different ways. We have a current situation where a lot of the training now is online so there is no opportunity for interaction and quite often that's where the knob of the problem is. It isn't necessarily about the knowledge of how to deal with a particular situation or condition, it's actually

how you understand each other's role and who should be doing what and when. Alongside the training… you mentioned ring-fencing training, I'd be interested to know what you meant by that because we certainly know there are huge issues in practice about access to training, especially for midwives and nurses where there's mandatory training put on, but because they're busy or short of staff they don't necessarily have the opportunities to actually attend. So I'd be interested to hear about that.

Jeremy Hunt: That came because when I was Health Secretary I announced an £8,000,000 maternity safety training fund which was allocated between all the maternity units in England, and what actually happened was that a lot of hospitals in financial difficulties managed to tick a box to get the money but actually there wasn't an increase in training. Some used it to tremendous effect and it was very powerful but other people basically did financial jiggery-pokery and it didn't lead to the increase we wanted. So that's where the suggestion came from – to try and find a way of ring-fencing training which relates back to the point about trying to make sure on an ongoing basis we're continually learning the lessons from what's happening across the NHS so that processes are being changed. That was the thinking behind it

Midwife: I think it's a valiant point but the other issue you have in practice is that because of the staffing levels and the issue of practice areas, quite often ring-fencing and providing funding is obviously really important but it's also about providing back-fill so that actually nurses and doctors and midwives can all have the opportunity to do the training. Quite often the intention is good, it's paid for, everything's going well, and all of a sudden we have a pandemic, or less, and there isn't capacity, and we know certainly over the last year training and education across the NHS has been seriously challenged with the current situation. The third point I'd like to bring up – you mentioned maternity bereavement midwives, which I think would be really good, and we've been supporting the National Bereavement Care Pathway. I think as part of that you mentioned about perinatal mental health – are the two in the one issue? Because I think perinatal mental health is again something we know is a massive issue that is grossly underfunded and under-supported, and it doesn't get the same airplay as physical health and wellbeing.

Jeremy Hunt: They are distinct issues. I'm very aware actually of how important perinatal mental health is but I think there was a particular issue about access to mental health support for bereaved mothers, which is the context we were talking about here. I know that there is a broader issue as well.

Midwife: It would be useful to maybe strengthen that in terms of the messaging coming out. The other thing was continuity of care, and I think **O&G Doctor (Senior)** touched on some of the concerns around continuity of care and there's a lot of evidence to say how valuable it is for women. But there is something about supporting the needs of the doctors and midwives who would actually be delivering that, and it would be interesting to see some modelling around how that would be managed to support the needs of a lot of women who are in the service who can't work full-time, who need to work part-time, or have particular issues themselves, and it's how you get that balance to provide the best care for everybody.

Jeremy Hunt: Ok, very good point. On the issue of how good we are when things go wrong, any thoughts on that?

Midwife: More or less what you've heard already, so I won't waste this valuable opportunity by repeating those. I think a lot of it can be down to culture. In my experience of working across lots of different units, if the culture is positive - and we haven't stopped to define what we mean by culture

- but if there is a good working relationship between the different teams, whether it's medical teams and midwifery teams or antenatal and labour and post-natal teams, and in some units that relationship is really positive, whereas in others there is this concern around tribalism and a lack of confidence to be able to talk about issues. There is an innate fear that somebody is going to be blamed and absolutely we need to try to get away from that blame culture because that is something that prevents us from learning and moving forward. In the wider context, I think MBRRACE have helped a lot in terms of sharing best practice around the really difficult cases. I think we have less clear standards around how we share near-misses because sometimes they are quite often not investigated as thoroughly as they could be because we move on to other things, and there isn't necessarily an easy pathway for sharing that information across different units and different trusts.

Jeremy Hunt: Thank you very much. I see that we've got **Rosie Cooper** with us, my colleague in the select committee, so Rosie feel free to jump in.

Rosie Cooper: Hello and thank you very much. I'd like to ask you all a question – continuity of care, I was the Chair of Liverpool Women's Hospital when Baroness Cumberlege brought in this idea in the late 90s. It cost a lot of money. The question I pose to you is: if you have a list of priorities and things like training, more posts, etc., where would continuity of care come in that list, what's its priority for you as nurses (I know it's different as a patient and a mother) but for you as nurses – how important is continuity of care? Would you sacrifice that for other things, because there isn't a small pot of money, it would take a huge amount of money to deliver.

Midwife: I was saying that we had some concerns about the practicalities of managing it, but going back to another point that you (Jeremy Hunt) made in the introduction was around the normal birth ideology and how that's been managed, and I actually think continuity of care is a positive move in terms of enabling women to have to opportunity to talk about what they want. The great advantage, and a lot of the evidence around continuity of care, has been that if the midwives know the women throughout their pregnancy, throughout the labour, then they're much more likely to have a satisfied and safer experience, and that's the great positive. There is a cost attached to it and I think we've already touched on that in terms of the issues around the numbers that might be required in a team where you've got people working part-time and full-time and we know a very large percentage of midwives in particular work part-time these days, so there are real issues around cost. I'm not an economist so I'm not in a position to say where I would put that in a list of priorities for cost, but I would say that it is really important, and it also lends itself to the issue we touched on about tribalism. I have seen some units in the past where you've had groups of midwives and groups of doctors not necessarily working together. If you have a team approach which includes medics, nurses, midwives, anaesthetists and everybody else, then that has to lend itself to a more positive culture.

Jeremy Hunt: Thank you very much indeed. Let's move on to **O&G Doctor (Junior).**

O&G Doctor (Junior) A: I just wanted to talk a little bit more about culture with particular reference to leadership. I think a lot of the cultural norms in every aspect of medicine are derived from good leadership or bad leadership, and I think there's an element of confusion over ownership of women and their care in maternity in particular. Maternity is quite unique in a lot of women because pregnancy is a normal state and birth is a normal process, this will just be under midwifery-led care; conversely there will be a lot of women who are on obstetric care. It's that kind of crossover when things change and when women are a bit higher-risk or develop complications, and that kind of ownership, and passing on that ownership baton or leadership baton can be a little bit challenging. I

think that if there is good leadership to promote a culture where this transfer of the ownership baton is better, then that ultimately delivers better care. I think leadership is quite a difficult topic to discuss with trainees in particular because it's something that develops in the background, but you're expected as soon as you're a consultant to be leading a unit, developing guidelines and protocols and cultures which promote safety. But it's not something that's really taught. You can't go through any kind of job or skill without training, yet leadership and managing a unit – suddenly, you've got 10 years of obstetric training, so you can manage all the clinical things but you can't manage all the other things which come with being a consultant and being in charge of a very complex system which requires quite a lot of thought and working together with different groups, which we do but probably not in that kind of frame of mind.

Jeremy Hunt: Fascinating. So is it clearer guidelines when someone should be transferred from the care of midwives to the care of obstetricians, or are you saying sometimes there's a bit of a muddle when that happens?

O&G Doctor (Junior) A: Yeah, I think there is good guidance as to when a women should be low-risk or high-risk – there's a lot of evidence from the RCOG and the RCM about that kind of thing. But it's the culture, it's moving, it's the transfer of that ownership of that woman and her care. For example, say you have a woman who is low-risk having a nice, normal birth in the birth centre and everything's gone to plan, she's had her baby and everything is wonderful, and then suddenly she starts bleeding and she has a haemorrhage and then emergency buzzers go off. At that point, that's the critical moment, so who should be in charge, who needs to take charge of that situation? Realistically, that ownership of the patient's care should then move on to the next person, maybe the obstetrician, or if the obstetrician isn't available maybe the midwife. It's that kind of culture of recognising when there's a problem, escalating it – which I guess is one of the things in the Ockenden report – and then being able to hand that back when everything's resolved.

Jeremy Hunt: Okay, and can I ask about your experience of how easy it is to be open when things go wrong?

O&G Doctor (Junior) A: My experience has actually been quite poor. When things have gone wrong, particularly when I was an SHO, so quite junior in my training, a lot of the time juniors are excluded from debriefs and the investigative process. I very specifically remember an intrapartum stillbirth when I was a first-year O&G trainee and I was traumatised. Absolutely traumatised. There was a whole debrief but it was expected that I carried on with my job because I still had patients to review and I wasn't invited. Actually, that comes back to the element of attrition with O&G trainees, we have a huge attrition rate and a lot of that happens in the early years. Some of it happens in the later years… but I think that's quite a big factor. It's quite traumatic. It is a difficult specialty both physically and emotionally. The level of training that is required – it's a long training program, yet there doesn't seem to be enough support for these extra-curricula issues that arise. Similarly with incident reporting, I think: a) there's a culture of not reporting incidents; and b) I think that incidents, even though they may be investigated, there's not enough learning, and particularly there's not enough communication from risk teams and senior consultants to trainees who are on the front line doing their day-to-day jobs, and as a result change is slow to happen.

Rosie Cooper: May I ask a question? You just said there's not enough learning – this goes to the core of so many issues right through the health service so could you describe in maternity care, which is particularly relevant today. How would you improve that learning? When you say there's not enough learning, how do you recognise that? How would we fix it?

O&G Doctor (Junior) A: Ok. For example if there is an incident, what I would be doing is trying to be very open and honest about it, identifying the factors that could have contributed to that problem, just like a root-cause analysis, but then disseminating the learning from it. So maybe holding sessions with multi-disciplinary teams in order to disseminate what can be learnt from that particular incident. It seems very basic but these kinds of things don't happen and that's a result of culture, staffing, rotas… there's so many different factors. Other than strong encouragement, I don't know what else can be done to improve on that.

Rosie Cooper: Thank you. I think we'd expect some of that to be normal practice so it's quite enlightening to hear. Thank you very much.

Jeremy Hunt: Thanks Rosie. Thanks very much, let's move on to **Senior Midwife A**.

Senior Midwife A: I think everybody's made some really valid points. I just wanted to add in regard to the staffing and the acuity levels, it is obviously individualised and [tied to] the personal needs of families and the women you are caring for and the pregnant ladies. But what also needs to be taken into account for any state of staffing is sickness. We can well say we have acuity of 1-25, which the current birth rate acuity level is, but how many of those people are off sick, especially right now due to the coronavirus? We may on paper look like we are adequately staffed, however in reality it's a completely different standard. The attrition rate in midwifery is also extremely poor. Often the early years can make or break a midwife… it's really difficult to transition from being a student and having support all the time to then being a fully fledged midwife having your own responsibility with practically no support. I know when I qualified I was pretty much thrown into the deep end because there was just no support around. I think I got 6 hours of supernumerary time on my first labour ward shift back. There is a lack of support – not because people didn't want to support me, but because people are just not able to support me because of what was happening on the wards and units at that time. In regards to the training, I absolutely agree that it needs to be MDT. The learning from governance needs to be mandatory. I run a safety bias workshop for maternity staff, and it is MDT processed and what you find when you're running through a case study and breaking it down - and unpicking it, because I'm not unpicking it for them, I go through all the documentation on the screen and they unpick everything – and then at the end after revisiting it 3 times with everybody we then hear the other side, we hear the woman's experience. So we have a holistic breakdown of that case study to actually see what we're seeing as a midwife, what we're seeing as a doctor, what we're seeing as an anaesthetist, what the HCA is seen feeling and doing in that process in that documentation that led up to an adverse effect that happened to someone from a BAME background, and then at the end, what the woman's experience was. The sad reality is, when you are black, Asian, or from a diverse ethnic background you are less likely to complain, you are more likely to take the first review given to you, and all you need to do is look at your local PALS complaint procedure to see that they're not representative of the communities we care for, which shows that we've potentially got a huge number of blanketed near-misses which we're not even aware of. That's a whole other thing to unpick another time… In regards to continuity of care, it is extremely important, and as Marmot says, 'proportional universalism is something that needs to happen.' So Rosie, I understand your concerns regarding the costing of it. It's a very costly thing but if you need to do it, it needs to prioritise more vulnerable people to begin with because the barriers and the trust that needs to be built up there is extremely important. But the staff also need to be completely competent and be trained to the level where they can give it. They need to understand the biases that they carry and also their lack of knowledge around informed consent, and the fact that the medical curriculum, as many medical curricula are, is a Eurocentric curriculum. We're taught how to pick up jaundice, we're taught to pick up mastitis and certain things in fairer skin tones – one of the

first things we're taught to look for is redness but if black and brown skin is going red you should be quite worried, especially if black skin is going red. Jaundice in a black or brown baby… by the time you recognise it their eyes are yellow and again, they're a lot further down that spectrum and therefore we're picking things up later. That's just a couple of things around those. In regards to outcomes, when things have gone wrong even midwives aren't invited to debriefs because they're expected to carry on. I've been in situations where I've had extremely traumatic experiences and I've had to go and look after the next person because you know it's just a normal day, you carry on. So I haven't been invited to debriefs and I've been told later on that an incident is now a police case and you've got to go and give a statement. And I've never been updated. I think that is standard across all the work that we do… I think I'll stop there.

Jeremy Hunt: I think that's a very, very powerful theme that's come across which is that basically when something goes wrong what it feels like – what the prevailing culture is – is that the senior people get together and discuss it, and they just want everyone else to carry on as normal when actually we know that the way that you correct mistakes is actually by working out every single person in the chain of events and understanding better. So that's really helpful, and I must admit a completely new recommendation, but I think it's a very, very powerful one so we'll definitely take that away, but thank you very much for being so candid. Let's move on to **Paediatrician (Senior) A** with your thoughts.

Paediatrician (Senior) A: Hi Jeremy and thank you. Thank you to everyone else - some really powerful and interesting points have been made and it's always good to hear from my colleagues in other areas. So I feel like I'm advocating for the baby here, I'm a neonatal trainee and I'm coming at it from a slightly different angle but with similar themes. I think where I work – I work in a big teaching hospital that's probably not comparable to many places in the UK with the care that we deliver – but one of the key things in being able to deliver safe care is staffing, like everywhere else, and obstetrics and midwifery by the sounds of it. Our attrition rates are absolutely terrible in paediatrics and with our neonatal nurses, and that's what really impacts the care that we can provide for our patients and would mean that babies have to be shipped out to different areas of the country and those kinds of things. So staffing is a common theme and I'm not really sure there's a quick fix for that. With regards to when things go wrong – I think this is something we do really well where I work, how the team responds. It's really upsetting to hear that other people aren't involved in debriefs or have that pastoral support afterwards. It's traumatic when anyone dies, but especially when children or babies die actually. It's really devastating and I think it's been recognised early on in paediatrics. We use a lot of debriefs, so we have hot debriefs that happen immediately after the event, and it's not attributing blame to anyone, it's kind of going through how people feel, if there's anything that they want to say, and just providing a space for people to decompress because often, like everyone else is saying, you have to just unfortunately crack on and get on with the job because the next patient is waiting and there's another family and things like that. After we have a hot debrief we have a cold debrief, so we get a psychologist involved and they facilitate a space and we invite all members that were involved, so we've had paramedics before, A&E crew, the midwifery team, and obstetric team are invited if it's something happening in theatre. We do try to involve as many teams as possible, but hearing what I'm hearing today this is actually something I try to advocate for better in remembering midwifery, obstetrics and anaesthetics colleagues. When we have things like this, because we're such a big centre at *[redacted]* every death kind of goes through 3 or 4 reviews. We have local reviews, so I'm part of a mortality review board where the cases go through critically with the consultant body and other people, then we obviously have regional reviews in the *[redacted]* neonatal network where the cases are presented and discussed with neonatologists from different areas and we grade the category of the incident in A, B, C, D and see

how it fits with that. Then there's also talk of us getting graded or having our cases reviewed with external cases that are more comparable in other places . . . There's not many we can use but we're looking at ways to better our services. Whilst we're not perfect at it I think we do try our best to at least respond to things better and remember human factors. The other thing that again has been mentioned by my colleagues here, and it's really nice to hear that they all think it's important, is simulation and involving all the teams in it as well. We run a lot of simulations on the neonatal unit and I'm sure my colleagues do on the obstetrics side, but actually involving everybody, I just think that makes us better. So that's my thoughts at the moment.

Jeremy Hunt: Thank you. It's really good to hear there are places that do these things really well because I think that's one of the things we have to think about, the variation across the NHS and how we get the best standards adopted across the piece. It's been very helpful to hear that, thank you very much indeed. Let's move on to **Student Midwife**.

Student Midwife: Hi everyone, thanks for having me, everything's been so interesting. The place that I come from is quite a small trust – to my mind there's been quite a lot of benefits with that on terms of the environment as a very open culture, there's a big emphasis and encouragement to Datix anything that is untoward. The training that we're involved in – there's an emphasis on being able to escalate things if needed. At the prompt training that I've attended they talk a lot about pilots and the way that within the pilot business… if they do anything wrong, so long as they speak up about what went wrong, there is no retribution. So they use that as an example of how it should work in a maternity service, that so long as you come forward and say…

Jeremy Hunt: Sorry, can I just put you on the spot? Would you say that happens in the units that you've worked in?

Student Midwife: I've only worked in *[redacted]* and I would say yes, I think it probably does there *[redacted]* I do hear about other trusts as well and it doesn't happen everywhere. Also at my university people are placed within 4 different trusts in *[redacted]* and I know that it doesn't happen everywhere. But I think it's a really powerful message for people to work within to be able to do that, and that's being pushed quite heavily at the moment actually within my trust, that you speak about things. So I'm very happy with that but I do feel there are improvements that could be made. I'm not just talking specifically about my trust, but for example risk assessment within care was something that came up in the Ockenden report and I think for that to continually happen throughout a women's maternity journey, I think better systems could do with being in place. I think there's a bit of a hurly-burly, a hotch-potch of different paperwork, different computer systems, and it's like that's just administration but it's not just administration. If you've got a form here that you need to fill in, and another form here that's almost the same but not quite, and then you've got to put all that on the computer as well, then things get missed. If there's a page with actually one salient point that needs to be filled in then the rest is just chatter, that page doesn't get filled in, for example. I think there needs to be a streamlining of documentation and things so that nothing gets missed. There's too much extraneous chatter, really, and I think that impacts safety and the continual risk assessment that should be done.

Jeremy Hunt: So even if people are supported if they speak out – it's great to hear that happens at *[redacted]* – we're not structured enough on the way that we spread that learning across the whole NHS. It's that what you're saying?

Student Midwife: I guess what I'm saying is every trust is doing something different and using a different computer system and using different paperwork. Somebody comes to one trust, they're

booked in at another trust, things don't automatically transfer over, you can't necessarily have access to the information about that particular women. But just on a day-to-day practical community midwife or continuity midwife day-to-day work, there's so much paperwork and so much duplication that I think things get missed.

Jeremy Hunt: Ok, thank you very much indeed. And finally **Junior Midwife A**… do you want to give us your thoughts on what you've been hearing from other people?

Junior Midwife A: I agree with what **Student Midwife** said – the fact that everybody's work uses different systems. I'm in community at the moment and I've not long qualified with my first placement being community. Throughout my training I worked at other trusts as a support worker as well. I've noticed that documentation causes massive problems and the breakdown of communication with the documentation because everybody uses such different systems. Some people use paper notes, for some it's online, and it causes massive problems I think, not just between midwives and doctors but also between health visitors, GPs… everybody's on a different system. I suppose it would be a massive job changing that. And about culture as well… I think there's a massive blame culture in the NHS. I've only worked in maternity services for 4 or 5 years but what I've experienced is that people are frightened to speak up because they're frightened of what's going to happen, and also because of all the litigation around maternity care I think people practise quite defensively because of that. I think that changes how people would normally practise so it leads to people receiving over-medicalised care or the wrong care because people are practising defensively

Jeremy Hunt: Thank you very much indeed and very powerful comments about the blame culture… Did anyone have any final points they wanted to mention before we go back?

Senior Midwife: I think if we're going to be sharing learning from poor outcomes we also need to be sharing good practice and it needs to be on a national platform so we can see what other people are doing, and learn, and grow, and talk to each other more, because I think that communication is something that's massively important.

Student Midwife: I just wanted to advocate for the student in all of this with regards to training. I'm not too backwards in coming forwards, so I have said 'please can I do the prompt training' or things like that which other students don't necessarily put themselves forward for and they're certainly not invited to emergency training or the in-house training that trusts provide. I think that they should be – it's really benefitted me going on the in-trust training and I think it should probably be mandatory and they should be invited.

O&G Doctor (Junior) A: I just wanted to mention health inequalities because I think there are significant health inequalities in maternity. I really think that maternity is quite poor in engaging populations and communities and I think we need to be a bit more innovative in our approach to getting to these hard to reach groups. For example in my area we have a large Indian community and there are midwives who have specifically learned Hindi to be able to communicate better and make those women feel much more relaxed and at ease to talk about the health problems they may have. I think this is something transferrable to other areas and there's certainly a lot that can be done to promote health education, awareness and improve the health of these women.

O&G Doctor (Senior) A: Just two points, I'm afraid the second is perhaps a bit longer but the first point is about debriefing. I have been invited to good quality debriefs but I've also been invited to debriefs for events that I've been heavily involved in but invited on a day when I'm not on shift. I think that's quite frequent and unfortunately, I don't think debriefing can be a single box ticking

exercise, I think it needs to repeated and to ensure that everybody involved in an event has been provided with a cold debrief. Hopefully digital technology may help with that – if I was invited to a debrief on an off-day via video conference I'd be happy to join versus travelling an hour into the workplace to do that. My second point is actually… from your recommendations perhaps this outside your scope, but I'm quite surprised there's no recommendation related to intrapartum foetal monitoring. This is a major issue in maternity that leads to lots of intrapartum stillbirths, neonatal deaths and long-term neonatal disability from hypoxic episodes. Intrapartum monitoring in the NHS is quite tricky because there are about 4 different methods of interpreting intrapartum foetal monitoring and every unit that I've worked at does it in a different way. There are national guideline for this but there's no national consensus, and many clinicians disagree with the national guidelines. This is largely because of a lack of an evidence base about the right thing to do, but I think until we can agree nationally about how to monitor foetuses I don't see any way forward in improving training on this.

Jeremy Hunt: Ok, I wonder if you could possibly drop me an email on that one, it's slightly out of my clinical comfort zone but that sounds like a very important issue. I wondered finally if I could just ask the midwives here – any thoughts about an issue that came up in the Ockenden initial report that mums were being pressured into giving natural or normal births even when it would have been safer if they had been transferred over for a C section. Do you feel that there is still a culture of encouraging so-called normal births?

Junior Midwife A: In my experience in the trust I've been in, it's actually quite the opposite. People aren't encouraged to have caesarean sections but… yeah, I've not found that at all. It's usually the women pushing for the normal births in a lot of circumstances and it's the staff – not that they push for caesareans but… it kind of comes into the defensive practise thing, they're frightened of things going wrong with vaginal births in what is probably outside of their comfort zone so they try and get the women to have a caesarean.

Senior Midwife A: I've worked in 5 different trusts and in the UAE and I can say that actually most midwives are advocating for the women, and they are trying their best sometimes to support women in whichever choice they can make. So this normal birth discussion is actually something that most midwives have felt that they're being criticised about for something they're not actually doing. I think there's a narrative around that and actually if you were to make a recommendation around the normal birth ideology I would probably re-word it to 'individualised care and informed consent' and something around those rather than a normal birth ideology, because it would extremely affect the morale that the midwives are already going through which is extremely poor, because they feel like they are being blamed when all they're trying to do is their best for the people they care for.

Midwife: I think actually that **Senior Midwife** said it better than I could. I did mention when I spoke earlier about my concern about the language and the danger of a normal birth ideology. I haven't come across it; I haven't seen it exist. I think there is pressure put on by women for a particular birth experience. I think that we have to look at the wider community and in particular social media to look at what images are produced across that and the impact that has on women's expectations. I think there's a big expectation around normality, there's an expectation that it will all go well, and going back to the role that the midwife has to play in the antenatal period in terms of managing expectations and being clear about what the women wants. But I've not come across this and I would absolutely support what **Senior Midwife** said about changing the language on that because I think there is a real danger that people will misunderstand the notion of what we mean about normal birth.

Jeremy Hunt: Ok, we've run out of time but it's such an important topic and I can still see a few hands up, so just very quick answers if we could…

Anaesthetist (Senior): Just a quick point really. As an anaesthetist dealing with labour analgesia, I have seen that there has been coercion into different form of analgesia which haven't been previously expressed by women. In particular Remifentanil PCA, because it's more labour intensive and difficult to deliver because it's labour intensive, is sometimes the right option for a women but is discouraged.

Paediatrician (Senior) A: It was basically just echoing what everyone else has said, and I think social media and all of that has a lot to do with this normal birth thing. I look after a lot of very sick and unfortunate babies that eventually die from horrific events during labour. So actually if you can get that baby out safely without the stigma or whatever they seem to feel about having to have a C-section or forceps or anything like that, I think that goes beyond midwifery, I think it's a wider issue. I think it also links a bit to the idea of breastfeeding which… I'm very pro-breastfeeding, but ultimately if you have a baby that needs to be fed by formula then it needs to be fed by formula. Often mums go home, especially because of the Coronavirus. We're seeing a lot of first time mums after a day or two with very jaundiced babies, loads of weight loss, sick, because they haven't had the proper support in hospital, they've had to get them out, which is no reflection on the obstetric or midwifery team, it's just Covid times have affected what services we can deliver. But we are seeing really sick children coming back in, mums coming in that are really upset and families that are really upset. So actually it all links to peoples' attitudes to pregnancy, childbirth, how you feed, how you look after your baby.

Transcript for group 2

Laura Trott MP: I just want to reiterate Jeremy's comments right at the beginning and thank you all so much for taking the time to do this today, I know how incredibly busy you all are at the moment. This is something that we think is incredibly important. We hope it will make a real difference in terms of what the Government decide to do and we want to make sure that the focus is on the brilliant work that you are doing, and are trying to do, and that we are doing all we can to try and support you to do that work in a safe environment which is safe for you and the mothers, fathers and babies involved. Just to introduce myself, I'm Laura Trott and I'm the MP for Sevenoaks. I've been interested in this policy area for a long period of time and so I'm delighted we've managed to get this going as a select committee inquiry. I'm here with my colleague Neale Hanvey**,** who I will get to introduce himself in a second, and what we're going to do is run through a number of questions, which are direct to individuals, but if people have comments on specifics or want to raise anything then please do use the chat function, or raise your hand, and we'll come straight to you. We'll do our best to bring everyone in and get everyone's comments. I'll just hand over to Neale briefly to just introduce himself.

Neale Hanvey MP: My name is Neale Hanvey. I'm the MP for Kirkcaldy and Cowdenbeath in Scotland. My background is in the NHS, I was a cancer nurse, so I know very little about midwifery so I will be suitably interested in hearing what you have to say. This is such an important area of practice to get right so we really welcome your contributions, so thank you very much for coming along.

Laura Trott MP: We're going to start with a very open question which is whether you feel like your team is able to deliver safe care.

Senior Midwife B: I think that the key to safe care is communication to be honest, and continuity which Mr Hunt mentioned. I feel that if members of a team, and whether that's just a midwifery team if it's a low risk case, or whether it includes a whole range of clinicians and staff in the case of a high-risk woman, the communication is key. And when things break down is when the communication is bad. The continuity part of this is important, because once people have a relationship with a woman- a professional relationship of course- then they are invested in that woman as an individual. They see her as an individual, they see her holistically within a whole paradigm of care and they have that sort of motivation, you know it's a very human thing isn't it to give that relational care which means that they're communicating with colleagues to dot i's and cross t's to ensure that things are followed up and that things happen in a timely manner.

Laura Trott MP: And do you think there are barriers in the way of you communicating with obstetricians and other members of staff in the hospital. Is there anything that can be done to facilitate and to make communication better?

Senior Midwife B: I think it's happening. I think it is happening in in places. I think possibly there has to be a breakdown of the sort of hierarchical model which has existed in healthcare for decades, from the inception of the NHS and before that, so that the most, let's say senior and most junior people in the hierarchy feel equally able to say what they feel and what they think. And there shouldn't be a culture of fear about speaking out, that people shouldn't be fearful, or feel that their contribution is less valuable perhaps because they're less experienced or lower in the hierarchy. Sometimes a relative outsider sees things that an insider doesn't so this is really, really important. And a breakdown in this hierarchy should also include parents and families, very much so. I should have introduced myself in the beginning I'm a midwife in the NHS working in a birth centre and in the community primarily. I'm also an independent midwife.

Laura Trott MP: Thank you. ***Senior Midwife C*** can I go to you with the same question: Do you believe that your team is always able to deliver safe care?

Senior Midwife C: Not always, no. I would echo exactly what has just been said. I feel, I mean it's the same stuff that we hear all the time, but equipment, working equipment, is a huge barrier. Staffing levels is a huge barrier.

Laura Trott MP: Can I just ask, when you say working equipment is there anything specific that you'd like to highlight?

Senior Midwife C: CTG machines are often broken, and then we have a system in place where we can take them to be fixed but they can take weeks/months for them to come back and then there is no replacement in the meantime, so for a department that would usually… I work in a Maternal Assessment Unit which is a very busy, kind of like a mini A&E for obstetrics, so the turnover of how many people we can see is obviously reduced, and then what happens is we have very vulnerable women who are sitting in the waiting room simply just waiting for a monitor and that's when we can see problems. And there's nothing we can do about it. It's such a simple barrier really isn't it, but it has such huge consequences for the safety of delivering care.

Laura Trott MP: Thank you that was really helpful.

Junior Midwife B: I'm a newly qualified midwife doing my first rotation on a busy labour ward and I would echo really what's been said. Staffing is a major issue. When we're fully staffed yes, it's fine, but how often we're full staffed is very hit and miss, particularly at the moment.

Laura Trott MP: And so I can understand, just from people who aren't in hospital every single day, is it because there aren't enough people on the rota, or is it because there aren't enough staff available and there are vacancies. What's the main driver behind some of the staffing shortages?

Junior Midwife B: I think it's a bit of both in our trust to be honest. There is a rolling programme of recruitment, because the Head of Midwifery was saying we've got 1.8 full time equivalent midwives that leave every month and that's retirement or just leaving and going elsewhere. But obviously if you've got one intake of newly qualified midwives a year, and our local universities sort of work like that then, you've potential to have massive gaps across the year when you're trying to recruit people. I think the rotas are generally mostly fully staffed, but we do have quite a lot of agency having said that, and NHS professionals shifts that go out. I think at the moment obviously COVID is not helping, because we've got people who are off isolating and having to take time to look after children and things like that. But it absolutely does make a massive difference. Just on the other point about equipment, the amount of running up and down the corridor that you do in an average shift trying to find a thermometer, I mean it's ridiculous we're in a hospital why have we not got thermometers, but there aren't enough thermometers. There aren't enough sort of pumps for fluids and syringe drivers and things like that. And it is all just time wasted and potentially a risk to safety if you've got people who are desperately in need of a CTG and there are not CTG belts anywhere because they've all be sent to the laundry. I've been in that position before.

Senior Paediatrician B: I'm a neonatal ST7 trainee working in *[redacted]*. From a maternity perspective which is what I obviously observe happening while I'm stood in the corner next to a resuscitator, or whether it's from a neonatal perspective, the universal themes apply. Which is staffing which is not just stretched during COVID times, it just happens to particularly be. But the fact that staffing numbers are poor across the board which leads to gaps, which leads to people covering those gaps, either internal or external candidates, which then leads to people working over their hours to try and help, to try and help fill those gaps which then leads to people getting worn out which then leads to illness. And there's also kind of predictable vacancies which is the fact that this is a mostly female workforce and we will get pregnant and we will need time off so there's always going to be quite a predictable gap in the workforce from the maternity leave perspective as well as there will be some ill health and those things are very predictable, they're quite static.

Laura Trott MP: And from your perspective, I know you're talking from a paediatric side of things so this might not be something you can comment, on but the staffing shortages are they driven primarily, same question I asked to ***Junior Midwife B***, is it through the rota not being right, the number of people being scheduled not correct, or is it because there aren't the people to fill the schedule that needs to take place.

Senior Paediatrician B: I would say both. I would say the optimal numbers to fill shifts would be more than there currently are, but that's what they're funded for. They staff what they're funded for, they're funded for that number of staff. So if there's a challenging maternal situation which requires a second set of eyes on a CTG, or potentially there could have done with being two midwives in that room instead of one, I know loads of midwives who just don't even get their breaks because they're stuck in a room because things just get challenging. Funding is definitely an issue and I think staffing standards dependent on flow of numbers of births for a unit would definitely be handy.

Neale Hanvey MP: Can I just ask an additional question point on that? That's really helpful, can you just expand a little bit about that. I understand this very well from a nursing perspective, that establishments are establishments are establishments. Certainly, something that we were able to do

in some of the areas that I worked was that we did a clinical assessment of what the establishment needed to be. And I just wondered what piece of work has ever been done to your knowledge and is that something that you feel would be helpful, so you look at the clinical need, you think about the establishment that is required. Has that ever been considered or is it just the funding?

Senior Paediatrician B: I'm not aware of that, probably primarily because it's outside of my realm of expertise being a neonatologist, but I'm sure it will be a piece of work very easily achievable that if we instead of looking at what can we do with the numbers we have instead going for blue sky thinking, what would be the optimal care that we could offer these women. I think would be a very interesting piece of work. I think that would go together with examining the themes of where cases have gone wrong in the past and led to litigation, and I very much believe that that's an issue as well, the fact that that it is litigation or nothing

Neale Hanvey MP: Is there any assessment of junior staff in the medical teams and the training places allocation, is that based on clinical need or is that more academic opportunity and funding.

Senior Paediatrician B: It's definitely… I mean a unit does not have trainees if it has not shown that it can provide them with a training environment and that is reviewed regularly. In terms of funding, yes, it's definitely very funding limited and in fact the number of trainees provided by the college is funding limited. Even though there are so many gaps, again it's a situation where there are…it's very predictable that people will leave the programme, it's very predictable that people will need sick leave, get pregnant what have you, but we just don't have the funding in the form of training numbers to be able to fill the gaps that we have, from a doctors perspective anyway.

Laura Trott MP: Thank you that has been really helpful. I'm going to move onto ***O&G Senior Doctor B*** and ask the same question: do you feel that your team is always able to deliver safe care?

O&G Senior Doctor B: I think a direct answer to that would be no, not always. It kind of depends on the basics. I'm an ST7 in obstetrics in *[redacted]*. The way I kind of see it is about having systems, processes and behaviours, and the systems need to be right before you can start building on those things. So, for example I think everyone has alluded to the staffing and that is the main cog usually in all of this when thing start to unravel at the seams. So you can put all these clever interventions in place about taking team working to the next level, about culture, about lots of things but actually if there's just not enough bodies in the system to be able to aspire to those kind of goals, then you're doing lots of clever things for no reasons really. And spending a lot of time, a lot of money. But actually, what you need to get right is the equipment, the staff, the way the systems work, the way the processes work, the way the guidance, the pathways and then build on that. So actually, the number on thing is staff I would say, from experience, from looking at lots of different units. And if we're looking at things like vacancy levels, sickness levels that's usually red flags for us as a regulator for example, but also lots of local units use that as like a determinant of culture and working environments. So, it's one thing recruiting the number of people, it's another thing keeping them. So if you're not kind to them, if you're kind of a blamey kind of unit, if you're hunting people down every time something goes wrong, then very quickly people will start to leave, or start going off sick if they're not treated well. There's a really nice paper by Michael West, where if people feel they work in well-structured teams and well supported environments actually their job satisfaction levels are much higher, patient safety goes up and sickness levels come down.

Laura Trott MP: That's really interesting, because we've been talking a little bit on the Committee and talking to witnesses about early warning sides for whether there are problems in units, and a lot of the things that we've been talking about is not picking up neonatal maternity levels. We've seen

that consistently that has not been picked up by people and action has not been taken earlier, but what we haven't really considered to date is looking at exactly what you're just pointed out here, and I think that's a really interesting proposal in terms of looking at…seeing if we can find indicators of the culture within a unit and trying to identify problems early before they come to a head.

O&G Senior Doctor B: Some units do it really well actually. There's a unit down south who does this really, really well, it uses cultural indicators. But it's a really fine balance, as soon as the exec board gets sight of 'oh there's a dashboard' and you know it's red, it's orange, it's green, let's put performance markers on this, and culture, teamworking is such a sensitive, personal area that as soon as you start treating it as a performance dashboard, it loses the emphasis it's trying to make. It's really sensitive, but it's so important that we need to find ways of getting it right. That's what I genuinely believe.

Laura Trott MP: Exactly, and you're totally right that where trusts are good, and it's working really well, actually they will be really sensitive to this and they'll be on it and they'll be monitoring it. But the problem is the areas where they're not it's how we do make sure that we are, in a way that is not very top-down and targeted, making sure that we are giving them the help and support that they need, and that's what we're trying to come to. That was really helpful so thank you.

O&G Junior Doctor B: I'm an ST2 obstetrician and gynaecology trainee, so still on SHO and as such probably the most junior person around. I think in general yes. I've worked in three hospitals so far, and they've all been in London and I'm aware that things vary depending on where you are in the country. Of course staffing is an issue. I think from the doctors side on a maternity unit, or specifically an obs and gynae doctors side, yes we're all female, many people have babies, everyone's kid now has a fever so they have to self-isolate. But also there's a 33% plus rate of attrition in our specialty because it's a tough job, and I don't know if there is much you can really do about that without really expanding the funding to train more and more people. If there are rota gaps you then end up with people taking locum, so you tend to come to a night shift as a junior person and have never met the person you're working with, who in order to practise safely you need to have a really good level of communication with so you can call them to say I've just seen 5 people in triage, these are my plans, are these correct. And actually, if you're doing that with someone you work with day to day that's much easier than with essentially a random stranger so of course staffing is going to have an impact. I completely agree with the point as well about the importance of culture, but I do think that is something really difficult to apply in terms of the system. Because it is just about when you turn up and it's a fantastic coordinator who you know will be doing all the right things before anyone says that they should do them, you're filled with joy and you think brilliant the next 13 hours is going to be fine, and that's the story of the whole NHS isn't it. It's about people working over time and being brilliant and caring and that's how the NHS functions and I don't know you can really necessarily have a systems based way of ensuring all of those people exist. But I do agree that actually as a marker, in terms of reporting and detecting problems, it probably is a really good marker. The other thing about safe maternity care I think, and again it's a theme across the NHS, and it ties in with the thing about communication is notes, medical notes. People come in and they're randomly in labour, or bleeding, and they have ten pages of coffee stained notes and you have no idea really anything about them. Where I work at the moment we have a huge, it's in a very deprived borough and most people don't speak English, and we have an amazing system in the day where we have three interpreters that work full time that interpret for the languages that the community we serve speak. And quite honestly, they could just be the midwives and the doctors because they know everything you're going to tell the women. That's fantastic and that's an example of really, really good practice and a trust locally putting in some funding to do something

that is going to improve safety in our area. But in terms of notes, I think it's a huge issues. I've worked in two trusts with electric records and it is truly the absolute ivory tower of medical practice, you know if someone comes in in the middle of the night and you can click Control-F and find the last time their haematologist saw them and what their plan was for labour that is pretty great. And in contrast to that if you have to spend 15 minutes logging on to an IT system to find that a review someone had was thrown away and never found, there is a huge discrepancy there between the level of safety there that could be provided. I appreciate that that's an NHS wide thing and something that…

Laura Trott MP: We're going to try to fix this. Before I hand over to Neale who has some questions on training, I'm going to hand over to ***ODP***: do you feel your team is always able to deliver safe care?

ODP: I work in an operating theatre, I'm a clinical lead so probably speaking from a different perspective. Theatres are impacted greatly by factors outside of our control and a lot of that is shortage of midwives, and that impacts on the effectiveness of our lists. I feel quite fortunate, because our staffing levels is always what is required in theatre, we would never proceed with an elective list without the amount of staff that we would need. I think what **O&G Doctor Junior B** said about a good coordinator, I think that's absolutely paramount. So, we have a supernumerary coordinator and we also have myself available and I would be expected to help out clinically if we had an emergency situation. I feel quite fortunate, listening, because theatres as I say we are fully staffed.

Laura Trott MP: And that's centrally decreed right, you're not allowed to go ahead which completely makes sense and is something that we perhaps need to model more widely withing the NHS.

ODP: So why would other areas be allowed to, as I say we wouldn't. I know obviously a birth has to happen, you can't stop it, but as I say we would just pull from other departments, from gynaecology theatres because maternity is obviously our priority. I think listening about equipment again I feel very fortunate because again in theatres we are never in that situation. We've got enough equipment and we've got enough staff. But for me it's very difficult watching the midwives, not getting breaks, and we can't do anything to help them obviously because we haven't got that skill. So everybody is saying the same about staffing levels.

Laura Trott MP: Thank you all there are some really strong messages that have come up there about staffing and I think some particular points that we can take forward.

O&G Junior Doctor C: I've been a trainee in *[redacted]* for six and a half years and I think there's been some extremely good points. For me the most important thing is adequate staffing, familiarity of teams and the problems with turnover. But I also just wanted to briefly mention about how a lot of problems often start in the antenatal period. [In] our antenatal clinics we sometimes have 60 plus patients per antenatal clinic and you only have five or six minutes per patient to actually see them and that's often when a lot of problems can start. And often a lot of misunderstanding can happen as well during the antenatal period. I know that pre-pregnancy counselling is not also funded as well, so this is counselling for people with complex medical problems, such as diabetes, hearts problems etc. before they're even pregnant so you optimise them before they fall pregnant and that service isn't currently funded. I think we also need to look at the amount of time that people have with women during their antenatal time.

Laura Trott MP: That's really helpful. I think we'll move on now to some questions around training. We're about halfway through our time so I'm keen to make sure we cover everything that you want to talk about. I'll hand over to Neale to ask some questions about your training.

Neale Hanvey MP: Thanks very much Laura. In terms of your experience of training within maternity services if we could just go around in the same order and if you could just outline what aspects of training has worked well and are there any barriers to achieving your training objectives in the workplace. I would just ask is you could mention if you've had any experience of how establishments may have impacted on that. I know we've spoken about that earlier, whether the establishment is conducive to a good learning experience, whether that's the medical team or whether that's the midwifery team or indeed the allied health professionals such as ODPs.

Senior Midwife B: I think aside from the present time, obviously COVID has caused huge problems for student midwives certainly and they missed a whole six months last year in terms of clinical experience, because they were just sent home really in March and then didn't come back until September in our area. But aside from that I think on the whole that goes quite well, except that it can be difficult to get a fairly consistent experience and again if staffing is poor it's very difficult to accommodate the number of students because obviously they have to be supported by appropriate supervisors so that's all really I'd like to say about training.

Neale Hanvey MP: And do you have time in the clinical sessions or in the morning/afternoon for training to take place or does the volume of work interfere in that.

Senior Midwife B: Yes. I would imagine that most people who are supervising students or mentoring students would be doing an awful lot of the paperwork and the things that are required by the university in terms of assessments and things and filling in records, that probably happens outside clinical shifts quite often because there isn't much time. It's difficult to fit in.

Neale Hanvey MP: That's really helpful, thank-you.

Senior Midwife C: So ***Senior Midwife B*** talked nicely there about student midwives and practical training, so what I wanted to talk about was more training of midwives, the continuity of professional development. The best training in my eyes is the multi-disciplinary training when we have, focusing on our mandatory training, every year we have mandatory training, depending on what ever trust your at- ours is a couple of days- and we have a whole timetable of different specialists talking to us about whatever topic, consultants from all different areas, midwives and doctors and nurses. When it runs smoothly, in an ideal world, then it's fab, but the problem is it all, just echoing about staffing, they're often working clinically on that day and they're called into an emergency, they can't get free so they send their junior who hasn't seen the slides before….so it spirals. It's difficult to get the experts to come and facilitate those training sessions and I think they're often, the time that they have is not safeguarded, probably because there is no time and they're short on the ground and clinical care has to take priority, it's down on the hierarchy of needs I guess.

Neale Hanvey MP: In terms of that point you made about being shorthanded, is that a frequent occurrence, is it an intermittent problem or is it something that really needs a lot of attention.

Senior Midwife C: Well I would say every training that I've ever been to this this has been a thing. I'm not saying every single session, but definitely within a training session this is a standard thing to happen.

Neale Hanvey: And so that interferes with I guess the success or otherwise of the training itself.

Senior Midwife C: Yeah of course. The standard of whatever is being delivered is altered. Sometimes they just have to cancel it altogether and they may or may not share some slides later on or something which you may or may not read, because the training day is over by that point. Or you get

someone who is trying to do their best but obviously isn't very inspiring because they've never read it before so people kind of switch off. I think it's a while bunch of things adding to a poor delivery of what could have been a really good training day.

Neale Hanvey MP: So a sense of business impedes that experience.

Junior Midwife B: So staffing definitely impedes on the training. As I said I'm newly qualified on a labour ward and for my preceptorship have got obviously lots of competencies to get signed. And it's incredibly difficult on those shifts, to find time with somebody else, you know for me to have time, for somebody else to have time to oversee me doing things and get things signed off. Simple things like suturing that we need to learn that's part of the job and actually getting to do that is really difficult. Obviously then that impacts you as a professional going forward, some of us will leave these rotations well practised in these things, and other people potentially leave that rotation without them. So I think the level that everyone can achieve is really variable. The other thing is, again echoing about training people, it's not happened to me because I'm newly qualified, but I've seen it time and again while I've been a student midwives pulled off training because the unit's in escalation.

Neale Hanvey MP: And you're in quite a valuable position as far as we're concerned because you've just gone through the pre-registration training and you're now practising under relevant supervision. Do you feel that the experience is similar, and the challenges similar, as a student midwife to a junior midwife? In terms of getting that test to a dedicated person, to take you through- you talked about suturing- identifying the opportunity, giving you the support before, guiding you through the experience and debriefing afterwards. Is that the challenge?

Junior Midwife B: Yes definitely. I feel in my three years of training I've been incredibly lucky to have some really good mentors who have gone out of their way to make sure that I knew what I need to know to be qualified. But equally I know many people who qualified not feeling that way. It's not necessarily the midwives fault or the mentors fault, it just is the fact that they're just purely too stretched, or people are out sick, or there aren't enough mentors and you've got them students just turning up to a shift not knowing who they're going to work with, that mentor doesn't know anything about them, where they're up to in their learning and development. And it's just kind of, you're just here to get your 40 births and that isn't what you're there for. You absolutely need all that learning because once you get there as a qualified midwife you need to know what you're doing because it's crazy and busy.

Neale Hanvey MP: That's really useful. So is that a sense of anxiety that it's really chaotic or it can be chaotic.

Junior Midwife B: I think it does cause people a lot of anxiety. I have been alright, and I work in a unit that has been very supportive of newly qualified midwives. But I didn't get the supernumerary that I should have had, and it was purely because of staffing, not enough staff on the ground.

Neale Hanvey MP: And do you know as a student, has it been discussed on your course, about how to assess the correct establishment based on clinical need in deciding how many people you're able to look after in either antenatal or labour.

Junior Midwife B: Yes, we've sort of learnt about that. But I think ultimately you get to your shift, if you're on your post-natal or antenatal ward, the women are divided up between who's there at the end of the day. Labour ward, it's not uncommon at the moment unfortunately, and this definitely should not be happening, that you've got a woman in labour and a post-natal woman who has not

yet gone to the ward to keep an eye on. And that's no good because these babies are quite often having observations. We have birth centres and we have high-risk labour wards and when they're on labour wards they're there for a reason, because there is other stuff going on, so you are trying to deal with a woman in labour and keeping an eye on your post-natal, something is going to be missed.

Neale Hanvey MP: There's definitely a risk there isn't there.

Senior Paediatrician B: In terms of training, I'd echo what others have said. Staffing is very much an issue, if you don't have adequate staff people don't get released to go on training. Also if you have enough staff it means that staff can go off and do learning. There's a huge amount of being a trainee that is service provision and don't get me wrong you learn quite a lot from doing that service provision but if you cannot consolidate that learning through doing further reading- which shouldn't always have to be on your own time- then you miss out on optimal learning opportunities that can be seen in the way that clinical structures are run in other countries such as Australia. And I think that again what has been said before MDT training is fantastic resource as well as simulation. It's also really important as it improves relationships within a team, and it lowers that hierarchy. And on a slightly similar ilk the fact that what are we teaching midwives or healthcare professionals to tell mothers who are pregnant. Are we teaching them to warn mothers of the symptoms of pre-term labour, are we teaching healthcare professional what to tell mothers what to do when they recognise that they might be in pre-term labour, how quickly they need to seek help. There is a real problem with women identifying when they're in pre-term labour, we've got the Every Kick Counts initiative, but in terms of decreasing of movements and stillbirths but pre-term labour is really an issue. And again the fact that we have this standard of an extremely natural birth being the optimal thing which it definitely is, but it's not a failure if you don't achieve that, especially if something happens like preterm labour, when we really do need to be quite invasive, we do need to give you antibiotics, we might need to give you steroids, you will need to stay in hospital and baby ought to be delivered in the safest way possible.

O&G Senior Doctor B: I think everyone has kind of said about the staffing and being released and I think that's a definite concern. In terms of training, I think there is some kind of future in thinking about how midwives and doctors train together but from an early stage in their career. The reason I say that is I think is our speciality is really unique in terms of there is no other specialty where a women could go through right from booking, right to having a baby without seeing a doctor for example or doing the whole process with a doctor. And sometimes that baton is passed very quickly, and in quite difficult circumstances, and I don't know if we work together enough to allow that to happen as seamlessly as it should do because when things go wrong this is one of the problems that happens. So going forward I guess, yes we need to do the MDT training and all the multi-disciplinary stuff, life skills and drills, human factors all of that needs to be a priority, and it is it's part of the incentive scheme it's something that all trusts need to do, but I think we need to go a little further in trying to understand the relationships that the professionals have in first outcomes and nursing them from a very early stage rather than just in a training setting. That's a one-year tick box if that makes sense.

Neale Hanvey MP: Yes it does. So that inter-disciplinary work, do you feel that would help the culture within the units. That symbiosis.

O&G Senior Doctor B: Yeah definitely. I think it would. I think it would make it easier for people to speak up when they're worried and like I said at the end of all the things, and all of the discussions is

a woman and her baby and it's putting that into focus of what is going on and I think only practise is something that makes something like that perfect.

O&G Junior Doctor C: I was going to say that again it's just down to staffing. The problem with the staffing is that if it's so minimal then actually you can't release people. Study leave requests are often denied so how can we develop if we aren't given the tools to develop. I'd also like to say that the culture of learning does very much come from the top and if you have a very friendly, risk governance lead, the consultants in charge of those investigations and the risk governance team, then it's much easier to admit mistakes and learn from those sort of things. Whereas if there is that sort of cultural blame you also become quite afraid to admit those sorts of things and then self-reflect and what happens is the next time you're faced with that clinical situation then you don't have the confidence to enact those sort of changes.

Neale Hanvey MP: I'll just pick up on the fact that you're now senior, I don't know how long it's been since you've been a junior or a houseman or a senior house officer in my days, but at that level. Are you able to provide your juniors with supervised training that you provide and did you experience that as a junior from your senior?

O&G Junior Doctor C: Sorry just to clarify I'm still a trainee, I've been a trainee for about 6 and half years, there's definitely an increase in the pressure of each individual in the amount of pressure that you feel during clinical sessions. One of the examples I'll use, what the recently qualified midwife said, in that it's very useful for us if midwives are able to perform perineal suturing but it's a lot faster for us to just do it ourselves because we will get it done in 10-15 minutes. Because we're so time pressured, we can't supervise and teach the midwives in order to do their own perineal suturing and then it's a self-reciprocating problem that we always end up having to do it because we can't train other people to do it.

Neale Hanvey MP: And from the perspective that you mentioned around managing risk and being able to speak freely and frankly about error that may have been made or misjudgements, is that something that is a consequence of that pressured learning environment.

O&G Junior Doctor C: I think it can be. But the culture of it very much comes from the top down. And I'm very fortunate I work in one of the busiest units in the country and I'm fortunate that there is quite a flattened hierarchy, the consultants are always there, they're on first name terms with a lot of the midwives and the student midwives so when things do go wrong everyone does sort of know each other and you are able to learn and reflect. I've also worked in units where it is very sort of blamey, every sort of clinical incident that happens everyone seems to pile in and give their opinions and they all seem to have the benefit of hindsight and they tell people 'I could have seen this a mile off, this is terrible" etc.

Neale Hanvey MP: Rather than a reflective, supportive experience. That's interesting.

O&G Junior Doctor B: Just to add to that point about the risk consultant and how they dispel information. One example of very good practice; at one unit I worked at the consultant who was doing the investigation would email the team involved regardless of the outcome- whether it's positive or negative- and say 'hello I'm investigating this because it was an unexpected term admission to NNU, you guys went to the birth centre, did a kiwi, it was timely, well done" as well as the ones that were negative. And actually that's really important for the juniors, because until you're a registrar you're not really on the line for anything that goes wrong, but obviously the first time you understand how HSIB works, and the first time you understand what the process is going to be if something goes wrong, that shouldn't only begin when you are there if that makes sense. So I think

learning about how things are investigated, and indeed the reports on things that have been investigated, whether or not they're particularly significant or whether, they've just kind of been looked at and case closed, that should be filtered down to all of the staff- and the midwives as well- whoever was in the room, should be included in that email and that allows all the staff members to say 'ok I now understand what happened' and that's really valuable learning. I don't think I have anything to add in terms of the training days, there's already systems in place for us to have them, we should have them, sometimes we don't because it's busy.

ODP: So one thing that we used to do that was really effective, obviously before COVID, we used to have live simulation. The staff weren't told in advance, so we'd actually mock-up a category one emergency for cord prolapse. We'd come into the bed, the midwives would be at the end of the bed and that was part of my training, that was really valuable for my training. We didn't know it wasn't real until they came in, but even with the whole team so there was a doctor, an anaesthetist, midwife and it's something I'm keen for us to reintroduce when we get back to normal working. I just think it was really valuable for my experience so when I was in that actual emergency situation for real, I've been there, I've mopped it up, so it wasn't so scary. And one thing that I've done, I've developed a really good working relationship with the midwives, because I think quite often surgery and midwifery units don't work closely together. I've spent a long time building up a good working relationship as a team.

Laura Trott MP: Thank you everyone for that and thank you to Neale. We've got about 10 minutes left, so what I want to spend those last 10 minutes doing is just some very quick reactions from all of you on the recommendations that Jeremy mentioned right at the beginning. I won't repeat them all because of time, I just wanted to get from you anything that you think we're missing, or any of those that you think are wrong or not guided in exactly the right place. We've got about 10 minutes so I'll go around everyone quickly and very interested afterwards if you want to email anything further to clerks and I'm sure details will be circulated round.

Senior Midwife B: I think the seven points that Mr Hunt mentioned are very positive. I have only a large problem with number 3. This idea that there is a normal birth ideology, expressing it in that way is extremely damaging for midwives and for normal birth in general. I think in the media, and in commentary in general, normal birth has been conflated to mean anything that isn't a caesarean section. There is a big, big gaping void and the doctors will agree with me here between a normal physiological birth, where it start spontaneously and continues until the baby is born without any intervention there is a big difference between that and the use of oxytocin and instruments for birth and induction. To conflate all that together is extremely dangerous. There is overwhelming evidence, as I think one of my colleagues here said, that a physiological birth does have the most positive outcomes for women and for babies and the International Confederation of Midwives statement on the role of the midwife state that it is the midwife's role to promote physiological births. I think it's probably better to use the term physiological to distinguish between a vaginal birth with intervention, such as instrumental or inductions, and a birth that has no intervention. They're completely different things, there is overwhelming evidence that a physiological birth benefits women and babies and there isn't as far as I'm aware an ideology that promote this to the detriment of women. There shouldn't be. If women need interventions, we should be there intervening, absolutely straight away, we shouldn't be delaying.

Laura Trott MP: And that's what we've heard in some evidence, in some very difficult and very grave cases is what's happened, and we understand that point. Thank you.

Senior Midwife C: I just wanted to say quickly I do like how he relates it a lot to care given in Sweden, and all their stats. I think it's really good to have a benchmark and I think there is no reason why we shouldn't expect to have the same. You know we're a first world country, we have all of the privileges of living here so I think it's a really good benchmark and I think it's good for everyone clinical, and in administration whatever, to know that it's happening, that it is possible.

Junior Midwife B: I'd echo similar. I liked everything I heard apart from the bit about normal birth. I'd agree the physiological birth is completely different to calling it a normal birth and this is something I've not come across at all in my training is people putting so-called normality above safety.

Laura Trott MP: Well that's a very good thing. Thank you, I appreciate that.

Senior Paediatrician B: I really like the themes. Obviously, something that we're not covering here is the massive difference in difference in outcome that there is for people of colour for people of a Caucasian background.

Laura Trott MP: We've covered that quite extensively in the hearings that have been taking place because you're right it's an incredibly important issue and one that we need to fix urgently.

Senior Paediatrician B: Yes. Otherwise, I know it's really difficult this point about ideology. The difficulties that I've experienced is certainly around parental ideology and expectation around what their birth is going to be. I think there is a benefit to knowing what you would like to have for your birth, and what the options are if you have the choice, but there really needs to be an emphasis on mother and baby coming out of this in the healthiest way possible. If physiological birth is the way, and it can happen, then that's fantastic but it's not a failure if it can't. And that fact that, particularly in ante-natal classes, sometimes there isn't the awareness there of what can go wrong, what will happen if things don't go exactly optimally and actually just having the healthy mother and baby at the end of it is a success.

Laura Trott MP: Amen. Thank you that is very helpful.

O&G Senior Doctor B: I think it's a really good start, in terms of the initiative and recommendations. I do think we need to start steering a little bit away from comparing to Sweden as strongly as we do, because I think the Nordic countries invest really heavily in their public health, their women are healthier, they're slimmer, their diets are better. There are so many differences from a public health point of view in the Nordic countries so we can't just be like 'we need to be like Sweden'. I think that is really quite demoralising to people who are working really hard but with a population that really doesn't mimic that part of the world. But also I do think the blame culture there is a lot better so I think to do the learning we can do, but then try not to mimic something that we are absolutely nowhere near at the minute.

Laura Trott MP: Yes understand that they don't operate in a vacuum.

O&G Senior Doctor B: And in terms of the birth ideology, and those kind of things, again I'm very much of the opinion that women need to have all of the options laid on the table. To try and explain forceps to a woman in the last ten minutes of her labour can be really traumatic sometimes for us, and for them. So to at least go through the options, go for the birth that you really, really want but these are the things that may happen. I think women need to be empowered. The last thing is really more from a board perspective, so I think we need to start thinking about rewarding good teamworking and good cultures because those are the things that boards don't really focus on

because it's not performance target. So when we start making these things a big deal, but it needs to come right from the top, that would hopefully make the services think in a better way as well.

O&G Junior Doctor C: I completely agree with a lot of the points that have been raised. Just one thing that I would say is that I have unfortunately worked in places where there is a little bit of an antagonistic atmosphere between sort of normal physiological births and what is often safest. I've worked in a unit where our ID card didn't allow us into the birth centre because that was what the consultant midwife didn't want us going there without permission so when we were bleeped there we were stood outside waiting. Fortunately it doesn't happen where I currently work but I've worked in a place where that does happen so it does exist out there and I think to not realise that would do a disservice to this review.

O&G Junior Doctor C: I think with respect to normal birth ideology, I think there are very few women who aren't holding out for a completely physiological birth. Almost everyone wants that, and the problem is not I don't think generally midwives, as the two midwives who are with us, of course when things are getting tetchy they would call us. The problem is that the women have read online, and gone to NCT, and been exposed so much about how important a physiological birth is, which doesn't really need to be underlined. Most people know that they don't want to be in hospital, and they don't want drips and these horribly invasive things and that's underlined at the cost of the other things that **O&G Senior Doctor B** mentioned. You know that's what we want but this could happen. So teaching people to be flexible and teaching people what could happen is very important at any stage. I think all the other measures are great, but I think one thing we haven't discussed is that lack of obstetric medicine in this country. Most units will have at least one or two foetal medicine consultants, and obstetric medics are very rare, there actually isn't a medical physician training programme for them but when you do have them they're amazing. And actually they don't just promote intervention, on the contrary because we as obstetricians aren't necessarily great at medicine and we are anxious, so we image everyone for everything and treat them for everything because we're desperate not to let anyone have anything bad happen to them. And obstetrics medics would I think actually protect women from unnecessary intervention because they are more confident in their clinical ability to diagnose and treat medical problems. So more of an interplay between that and access to obstetrics medicine would be really valuable.

ODP: So the one thing that struck me was it's about continuity of care from the start of pregnancy, which I absolutely agree with. My only concern is that we have an elective team of midwives who come to theatre regularly, that's what they do. So would a community midwife be expected to come to theatre and be that midwife which is something she's not familiar with. I know that is something that our trust is looking at, that sort of continuity of care. So I've just got a slight reservation from the theatre perspective.

Laura Trott MP: I think we need to transfer over to the other meeting for the summary, but I just want to thank you all for the work that you're doing and the input that you've given today. These select committee reports are important, they're read by government, and we hope they can make a really big difference and make the brilliant work that you're doing every day better in the way that you described. Thank you so much for you time, I know how busy that you all are and the pressures that you're under and we really appreciate it and we hope it will make a difference.

Neale Hanvey MP: I just want to add my thanks to those of Laura. It's been an incredibly valuable session. You may feel that this is a reflection of your day to day but for us it really is incredibly rich data.