Written evidence submitted by the National Childbirth Trust (MSE0049)

NCT's written evidence to the Health and Social Care Select Committee's Inquiry into Maternity Safety

1. what the impact has been of the work which has already taken place aimed at improving maternity safety, and the extent to which the recommendations of past work on maternity safety by Trusts, Government and its arm's-length bodies, and reviews of previous maternity safety incidents, are being consistently and rigorously implemented across the country	• NCT had representation on the most recent maternity policy review in England (Better Births) and we therefore commend the focus on safety in the NHS England Maternity Transformation Programme. However we note that 'personalisation' is also a high priority in the implementation work and a quality service must integrate this individualised approach to care along with continuity of caregiver, evidence-based recommendations to women to assist their choices and multidisciplinary care when needed. • While we understand that reducing levels of maternal and infant mortality is an extremely important aspect of safety, it should never be the sole aim of safe care. Suboptimal maternity care can lead to severe morbidity in terms of both physical and mental illness, at worst leaving women in pain and fear through subsequent pregnancies and sometimes the rest of their lives. Understanding of women's values and plans before the birth, and follow-up of any complications afterwards, are both essential elements of safe care. • Successive reports from MBRRACE-UK have highlighted the greater risk of maternal death among women from black and Asian backgrounds, as well as those in families living on a low income. Future research should determine more exactly the components of this unacceptable inequality, whether due to systemic racism or differences in clinical, cultural or socio-economic situations. But while this further evidence is sought, all caregivers must be aware of the experiences of black and Asian women and, above all, listen and respond to their wishes and concerns. • MBRRACE-UK reports also make clear that the majority of both deaths and severe morbidities occur in the postnatal period. This phase of care has been grossly underfunded and persistently eroded for decades, resulting in many avoidable tragedies. The cause is overwhelmingly the fragmentation and lack of clear leadership in postnatal care. Even after birth complications and surgical procedures, mothers may be: cared for only briefly in a hospital ward; sent home after one day to receive sometimes only one visit from a maternity care worker (not a midwife); discharged at 10 days via a phone call; one family in an 800+ caseload of the local health visitor; and have to rely on healthcare from a GP who may or may not offer the required specific appointment for a 6-week maternal check-up. Notes and crucial information often do not reach the appropriate professional in a timely fashion. Where social workers or other healthcare staff are involved, relevant communication may be absent. This is where safety is lacking, above all other phases in maternity care.
2. the contribution of clinical negligence and litigation processes to maternity safety, and what changes could be made to clinical	• For families who have been affected by a death or other adverse event, the essential key is keeping them involved and informed as much as they wish throughout any such processes. Bereavement support should be provided by trained staff. • For professionals involved, speed of completion of processes is of importance so that lessons are genuinely learned before staff move on.

	negligence and litigation processes to improve the safety of maternity services	
3.	advice, guidance and practice on the choices available to pregnant women about natural births, home births and interventions such as C-sections, and the extent to which medical advice and decision-making is affected by a fear of the "blame culture"	• There is now a plethora of information and guidance about supporting women's choices, including a number of 'decision-aids' designed to help women and their partners make plans about place and mode of birth. • It is essential that these offer balanced information, e.g. adverse outcomes of hospital birth as well as potential risks of community settings. Clarity about areas where evidence is sparse is also important. • Despite this availability of support, feedback from women indicates that plans are frequently either disregarded or overtaken by events, perceived to be emergencies, that require different decisions. Inadequate midwifery staffing that fails to enable time for support and discussion may leave women feeling uninformed and 'having things done to them' or 'part of a production line'. Lack of involvement in decisions is a factor that increases the risk of postnatal mental health issues, including post-traumatic stress disorder (PTSD). • Many experiences reported by black and Asian women would indicate that such absence of information, involvement and consent to interventions affects them to a greater extent. This inequality of outcome and the lack of safety for women from black and Asian backgrounds should be key points in this Inquiry.
4.	how effective the training and support offered to maternity staff is, and what improvements could be made to them to improve the safety of maternity services	• Where there have been repeated incidences of poorer outcomes for women, workplace culture has often been identified as a cause. This includes a lack of good multidisciplinary teamwork, and issues such as bullying or discrimination amongst staff. It is rarely the content of professional education or training that is at fault but deficient management, poor communication and lack of respect for others' views and experiences. • NCT urges service leaders and educators to understand the importance of cultural awareness and competence of professionals and the need to create culturally safe environments, to help improve outcomes for BAME women. • Senior staff who are supportive of less experienced colleagues can engender a safer culture by promoting their confidence, in turn enabling midwives and doctors to care for women and babies in the same way: listening to their voices; responding to concerns; encouraging their endeavours; and emphasising the positive aspects of the maternity journey. This style of care is especially important for women from black and Asian backgrounds some of whom have reported being ignored when they raise questions about their own care and conditions.
5.	the role and work of the HSIB in improving the safety of maternity services, and the adequacy and appropriateness of the collection and analysis of data on maternity safety.	We do not have direct experience or data about the work of the HSIB so have no comment about their results. We have previously asked why eligibility for such investigations is limited to 'term babies born following labour' and suggest that many other babies and their families have suffered from the same sorts of suboptimal care sometimes identified by the HSIB. It would be good to hear who carries out the investigations for these other bereaved families.

11 September 2020