Written evidence submitted by Campaign for Safer Births (MSE0064)

Health & Social Care Committee Submission
Safety of maternity services in England

Campaign for Safer Births
Nicky Lyon and Michelle Hemmington 3/9/20

Background

Campaign for Safer Births (CfSB) was co-founded by Nicky Lyon and Michelle Hemmington in early 2013. Nicky and Michelle were introduced to each other whilst campaigning individually following the deaths of their babies.

Nicky's son, Harry, was left profoundly brain damaged and later died following failings in care during term labour. Following major errors in her care during term labour doctors were unable to resuscitate Michelle's son Louie, he was later registered stillborn.

Michelle and Nicky were shocked that following both these incidents the hospital Trusts concerned were able to investigate themselves with little/no external scrutiny. Both families had to undertake litigation to receive an independent assessment of their treatment.

Compare this to what would happen if a child died in died in other circumstances involving potential negligence – there would be independent investigation from agencies such as the Coroner service, the Health and Safety Executive, the Police.

Campaign for Safer Births as worked for over 7 years to increase awareness of avoidable harm in maternity, to campaign for independent investigations with parent involvement, for Coroner jurisdiction for stillbirth and for improvements in safety in maternity services.

CfSB was instrumental in getting Coroner jurisdiction for stillbirth included in Tim Loughton's Private Members Bill and the subsequent public consultation. Michelle and Nicky are the parent representatives on the Royal College of Obstetricians and Gynaecologists (RCOG) Each Baby Counts project. Nicky has worked with NHS England and Improvement as a user representative for many years and currently is lay Co-chair of the national Maternity Transformation Programme (MTP) Safety Workstream (WS2).

We believe that there has been much activity and improvement over the past years including:

- RCOG Each Baby Counts
- Research work and actions from reports including those from MBRRACE
- NHS England Saving Babies Lives Care Bundle
- NHSE MatNeo Safety Improvement Programme
- Increased user representation at all levels
- Healthcare Safety Investigation Branch (HSIB) national investigations and maternity investigations
- Increased focus from NHS Resolution – in producing reports and recommendations and the CNST scheme

The activity is very safety project based, however safe care/outcomes relies on the whole service working well – for example the correct staffing levels.

The considerable reduction in national rates of stillbirth is testimony to this, however there are still far too many avoidable deaths within maternity and still too many Trusts offering substandard care that require improvement.

We have now 'worked' in the sphere of maternity safety for many years as expert parent representatives and have a clear understanding of the further action needed to improve maternity safety and reduce avoidable harm.

Key Issues, Questions and our Recommendations for the Health Committee Inquiry:

Independent Investigations – Coroner and HSIB Maternity

Where Coroners have been able to conduct inquests following baby deaths due to injury in term labour it has been instrumental in providing answers to families, in uncovering major systemic issues in Trusts, in instigating improvements and in preventing future deaths. The recent case of baby Harry Richford at East Kent Hospitals University NHS Trust is an example of this.

At present, Coroners are not able to investigate/conduct inquests for babies registered stillborn following term labour (who were alive at the start of labour) – even if they or the parents suspect negligence/poor care. Many Coroners are very frustrated at this situation. They feel their hands are tied.

The rollout of HSIB involvement in investigating all term stillbirths and potential brain injuries in labour is very welcomed, however the plans and long term funding for this work are unclear. If HSIB discontinue this work or funding is removed then parents will be back to square one with no avenue for independent review and there will be no independent scrutiny of many deaths.

RECCOMENDATIONS:

For the safety of mothers and babies it is essential that stillborn babies are given equality with other babies to ensure their deaths can be independently investigated by Coroners when required

More clarity is needed to ensure that neonatal deaths are properly referred to the Coroner to ensure awareness and review

The Report into the Morecambe Bay Inquiry (Bill Kirkup) made a key recommendation that Medical Examiners should be involved in stillbirth – this has not yet been implemented

(Please note we have also contributed to the current call for evidence by the Coroner Committee)

Workforce, staffing and tariff

Staffing issues/high demand/issues with capacity has been a recurring theme of many national reports. Lack of capacity/staff has been proven to result in poor outcomes for mothers and babies. This has been highlighted by the following national projects/organisations:

- MBRRACE Reports: *'Concerns identified in this confidential enquiry about staffing and capacity issues in maternity services, particularly around the issues of induction of labour and timely transfer to delivery suite, need to be addressed'.* MBRRACE Perinatal Death Conf Enquiry Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death

- RCOG Each Baby Counts: '*As an urgent priority, maternity units need to be adequately resourced. Without this, trusts, health boards and healthcare professionals will struggle to implement the recommendations from the Each Baby Counts team'*. Each Baby Counts 2015 Full Report

- HSIB Maternity: National reports and individual investigations have highlighted capacity/resource issues

The results of the MatNeo Safety Improvement Programme Score surveys showed that maternity clinicians are regularly missing breaks and lunch. This is bad for professionals and for the safe care of mothers and babies.

It is hard to know if the issue is due to insufficient tariff to fund the service requirements, Trusts utilising money in other areas or recruitment problems – we believe most likely a combination of these factors.

Health Education England (HEE) produced a report Maternity Workforce Strategy in 2019 showing major shortfalls in staff across maternity professions – this is of huge concern.

It is our understanding that the actual situation could be much worse as the resource requirement has not been recently assessed. The actual current resource requirement to run the service safely - based on the care outlined in Better Births, current guidelines, care bundles, patient characteristics - has not been assessed.

Often money is given to Trusts to instigate a new process/structure/guidance, however in the longer term this additional 'task' has to be absorbed – there has been little assessment of the current resource requirements with all the additional activity expected of clinicians.

RECCOMENDATION:

Resource requirements to fulfil the current service, guidelines and patient mix must be assessed.

For the safety and wellbeing of women, babies and professionals it is essential that Trusts have sufficient funds to properly resource the service and that there are the trained people available to fill the posts.

One option to ensure this would be for midwife, obstetric and anaesthetist staffing levels to be legally enforced through Parliament.

Philosophy

This is from an NHS Trust patient information leaflet about birth:

"Choosing a natural childbirth, without the use of drugs or surgery, is choosing to trust your body and knowing that you already possess all the tools you need to give birth. Giving birth naturally is better for you and for your baby as you will feel more in control of your body and more aware of the experience."

We would state that the maternal and baby mortality rates of the past tell us that this is not the case – we know that appropriate interventions save lives. Women take in this sort of information and could refuse intervention that could be lifesaving. Women are also left feeling as though they have failed if they need intervention like a c-section. We also know that many women are left traumatised through lack of pain relief. Women are not being informed of all the facts.

Women are often 'opted into' midwifery lead care without the option being given of birth in an obstetric unit (OU) – even though it is only in an OU that specialist pain relief like epidurals are available. Women are also not informed of the NICE guidance that states that they can request a caesarean-section. Instead many units aim to increase homebirth rates and decrease c-sections.

The NHS Long Term plan states that *'About one in three women will experience urinary incontinence after childbirth, one in ten faecal incontinence and one in twelve pelvic organ prolapse'*. Are women ever told of this in the antenatal period? Are women told of this risks of this with different modes of childbirth?

At present women are sometimes having to make the choice between the 'homelike' environment of a midwifery lead unit (where partners can stay and there are birthing pools) versus the stark hospital environment if they feel they want the immediate presence of doctors, an epidural or a neonatal unit. Why can't women have both?

Whilst I know nationally the Royal College of Midwives (RCM) and RCOG are trying to combat this issue with their 'One Voice' campaign, two separate royal colleges and two very separate professions (i.e. midwifery and obstetrics) leave women often with very mixed messages.

We are also concerned about the pride of many midwives being 'autonomous practitioners' – surely everyone should be working as a team – not as individuals.

RECCOMENDATION:

For a single maternity service where women receive unbiased, evidenced based information based around their individual circumstances to get the right care for them.

Training – Pre-registration and ongoing training

Pre-Registration training: Multidisciplinary working has been proven to be essential for maximising safe outcomes in maternity. Why then are the maternity 'trainees' trained in silos? We have been informed that there is very little joint/mixed midwifery and obstetric training done in the pre-registration periods. We are also concerned that some midwifery courses appear to focus almost solely on 'normality' and physiological birth. We think it would be amazing for midwives and doctors to attend lectures together and for them to be buddied up during their training.

Ongoing training, development and skills & drills practice: It is essential for safe care that midwives, doctors and all other maternity staff are given time to refresh their knowledge, learn new procedures & techniques and practice their skills together. At present staffing and money pressures mean this often does not happen.

The Baby Lifeline report Mind the Gap showed the huge variation in training across the country.

A set of Core Competencies has been formulated by a multidisciplinary subset of the MTP Safety Workstream. What is now needed is the regular funding to allow this training to happen on a regular basis. **It is not acceptable for staff or patients that this training doesn't happen.**

The cost of a single incident resulting in litigation would pay for the annual training for all maternity staff. Annual, guaranteed ongoing funding is needed. We have no doubt that the litigation costs will reduce by far more that the cost of providing this training.

Leadership training/skills have also been demonstrated to being key to a 'safe maternity unit' – however the reality is that many midwives and obstetricians are promoted to Head of Midwifery and Clinical Director roles without the appropriate training and development.

RECCOMENDATION:

For recurring funding to be provided to ensure mandated safety training and simulation is provided to all staff

Training must also be available for all people moving into leadership roles within maternity

For maternity professions to learn & train together during their pre-registration training

Data

Publically available data on maternity sits in a variety of locations. This means it is almost impossible for a user to find all the information on their local maternity services and then to assimilate it to compare hospital Trusts. A user would have understand all the terminology and would then have to look online at MBRRACE Reports for each year, CQC Inspections for each Trust, NMPA Clinical data, the NHSE Maternity dashboard (currently under construction), NHS.UK for some limited information – and even if they did all of this much of the data is at Trust level not individual unit level. Investigations have shown that individual units within a Trust can have very different safety and outcomes.

In terms of making choices about where to have a baby (i.e. home vs midwifery led vs obstetric unit) women are making decisions on outcomes data that is 10 years old. Much has changed in these 10 years – including the network of OU's, the characteristics of the women giving birth and guidelines being followed. Up to date information is vital.

There is also little/no data tracking longer term outcomes for mothers and babies - particularly on maternal injury/issues like incontinence to assess how this is affected by the type of birth and on longer term outcomes for babies who are suspected of suffering injury during birth.

RECCOMENDATION:

Assessable, easy to understand user information should be available at unit level to allow women to make informed decisions about their care provider, place of birth and other choices

National data on outcomes by type of care at the start of labour must be updated

There should be tracking of longer term outcomes for women and babies

Regulation/Accountability

Many bereaved parents ask the same question – 'Who is ultimately accountable?'

Who is being held accountable for recurring errors within a Trust and who is responsible for monitoring trusts to ensure poor care is identified and urgent improvements made?

The landscape is complex with different organisations involved - Trust boards, CCG responsibilities, LMS's, NHSE, NHS Resolution, HSIB, Royal Colleges and the CQC. Which organisation is ultimately responsible for identifying Trusts with poor outcomes and taking action? This issue was identified in the Morecambe Bay investigation and we believe is still an issue today.

There seems little consequence on a Trust Board/management when there are avoidable deaths or major failings are uncovered. Instead individual nurses and doctors are taken to NMC and GMC hearings when they make mistakes – mistakes that possibly would not have been made if they weren't tired, without training, without adequate resource around them

RECCOMENDATION:

Sadly we believe that only once a Trust Board is prosecuted for systemic failings in maternity will others sit up and ensure the units they are responsible for are safe.

Recommendations in the Report of the Morecambe Bay investigation relating to professional responsibilities/accountability must be implemented.

Guidelines and recommendations

Our 'lay' perception is that guidelines to be followed in maternity care are in many disparate places – NICE, clinical guidance from the Royal Colleges, Care Bundles produced by NHSE, guidance from other professional organisations (like BAPM, BFMS), best practice guidance produced by charities (like Sands, Bliss), information from organisations like MBRRACE and latest research publications.

Clinicians in Trusts around the country are duplicating laborious, complex and time consuming work pulling together all this guidance and research to produce guidelines for staff in their hospital Trust or Clinical Network area. This means that guidelines across the country are often inconsistent and there is huge duplication of work. These guidelines are often paper based or not in very user friendly format. We have raised the question many times as to why there isn't a central site/app produced and updated by maternity experts to allow clinicians to quickly access the information needed at the relevant moment. When we have asked the question all have agreed that it should be done and would be invaluable.

Also numerous reports published each year – hundreds of pages long with many recommendations. However there is little coordination, resource, finance to implement the recommendations. The MTP Safety workstream Insights group is starting to look at this but more resource needed to ensure all recommendations are implemented in a timely manner to improve care and save lives.

RECCOMENDATION:

For central production of up to date maternity guidelines easily accessible online/app in 'human factors' friendly format to follow in all situations.

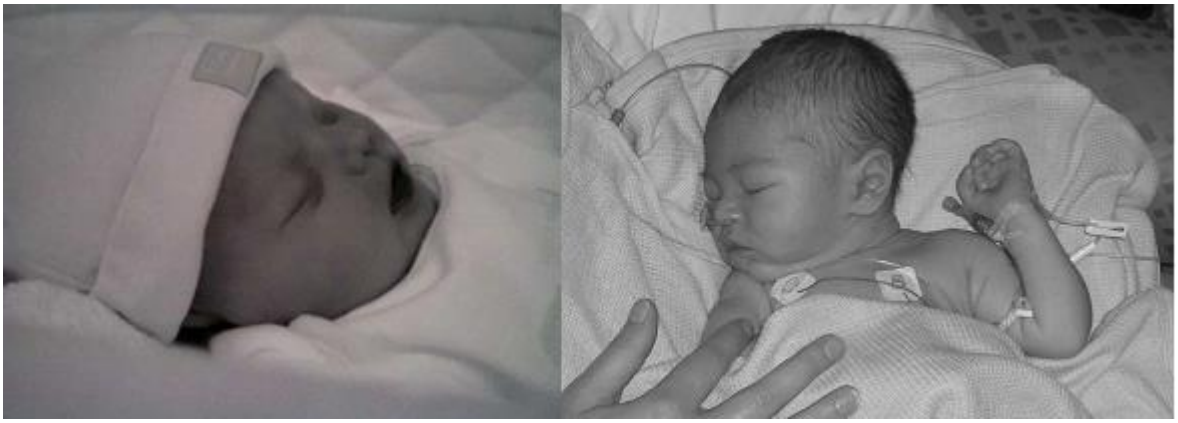
For appropriate time and resource to allow all recommendations to be implemented nationally and in units

As bereaved parents our only wish is for other parents not to suffer the devastation that we suffered. We have no doubt that actioning these recommendations would result in far fewer deaths and injuries and a huge reduction in the litigation costs to the NHS.

Nicky Lyon & Michelle Hemmington

Co-founders Campaign for Safer Births

campaignforsaferbirths@gmail.com



In memory of Louie Buckley and Harry Lyon