Written evidence submitted by HealthWatch England (MSE0069)

Brief introduction

In July 2020, the Health and Social Care Committee launched an inquiry into *Safety of Maternity Services in England*. The aim was to identify the recurrent failings in maternity services to help improve safety for both mothers and babies. In response to the call for evidence by the Committee, Healthwatch England analysed the data they hold nationally from local Healthwatch on maternity services to provide evidence to the inquiry.

We analysed three sources of data- data shared via the Civi CRM system between April 2019 - July 2020, via the reports library between April 2018 - July 2020 and via Healthwatch England's public feedback form (April – July 2020). For the purposes of this report, we looked at the terms of reference of this inquiry for which we could provide evidence:

- 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;

- 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";

- 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.

In total, we undertook detailed analysis of feedback from over 150 people (drawn from across 35 local Healthwatch) who had shared their experiences about NHS maternity services via the CRM and the public feedback form. We also drew on evidence from 19 reports, produced by 16 local Healthwatch, that had a specific focus on maternity services. This included reports by Healthwatch Shropshire and Healthwatch Telford and Wrekin, where communities have been previously affected by incidents in maternity care. Key findings from their work are included at the end of this report.

Below is the high-level summary with a few case study examples:

Impact of work which has already taken place aimed at improving maternity safety

The national maternity review – called 'Better Births'- was published in 2016 and laid out the vision for maternity services across England to become safer, more personalised, professional and more family friendly. Our evidence suggests that while many women receive care centred around their needs and circumstances, a significant minority still don't.

Women who have reported positive experiences had access to kind and professional support from midwives, doctors and nurses throughout their maternity period. They felt safe and better supported

around friendly and approachable staff, and when there was continuity of care which helped them build a better relationship with their care providers. Even where someone had had a traumatic childbirth experience previously, the opportunity to discuss their concerns with the midwife in detail and putting a plan in place from the beginning, greatly reassured them and their family.

My first midwife appointment was at least an hour long and the midwife went into great detail about my pregnancy and how to stay healthy throughout. Due to a traumatic experience with my first child, I did look to go elsewhere to have my second. I explained this to my midwife and had an in-depth discussion about the procedures they could put in place this time around. I then, as a result of this conversation, decided to stay with the same hospital. I have absolutely nothing but praise for the elective section team, they were amazing. Myself and my husband were looked after. I especially liked the fact that I had the same midwife supporting me during my time at the hospital.

Patient story shared with Healthwatch Warrington (2019)

I was admitted with my daughter as her jaundice hadn't cleared. I was also struggling to breastfeed, putting a lot of pressure on myself. The healthcare team were brilliant for the 72 hours we were admitted- they were very attentive and supported me to move to bottles and formula without feeling guilty. The service they provide is invaluable to first time mums like myself.

Patient story shared with Healthwatch Sunderland (2019)

On the contrary, women who had negative experiences during childbirth said that they felt staff were often dismissive about their concerns. For example, when a patient raised concern about reduced foetal movements, they were made to feel like they were wasting staff time. However, during delivery, they found that the baby had his cords wrapped around his neck. On another occasion, a patient felt ignored when they reported experiencing severe pain following delivery- after three hours of requesting for help, the doctors eventually checked and found some remaining pieces of placenta inside her.

We have heard about staff being patronising, abrupt and on occasions, rude. In one instance, staff did not consider the patient's preferences of who and how many staff see their body, making them feel uncomfortable during labour.

I had my first baby at [Name] Hospital. During my labour, the midwives were passing smiles to each other whilst I was screaming in pain. One of the senior midwives said to me 'you're not going to die' in front of my husband. There was no privacy at all- staff were coming to see me while I was delivering my baby. There were more than 10 doctors, nurses and midwives present, we don't know why? It was a horrible experience for us.

Patient story shared with Healthwatch Hillingdon (2019)

We have also heard mixed views about support with breastfeeding- while many have said that they received the right amount of information at the right time, other have reported that they did not receive

sufficient information about feeding their baby until during or after the birth of their child. This was particularly challenging when the baby was born tongue-tied.

Postnatal issues with breastfeeding were missed. As my baby was gaining weight, I feel that issues with pain during breastfeeding were overlooked. I sought support from helpline numbers and eventually at 8 weeks went to the breastfeeding support group where a tongue-tie was identified.

Patient story shared with Healthwatch Stoke-on-Trent (2020)

A minority of our evidence also suggests that staff on occasions have been negligent with the care provided which has left people anxious, frustrated and even traumatised. For example, a patient who was promised an epidural, did not receive one, which left her traumatised and suffering from depression. On another occasion, a new born with feeding issues had not been placed on the infant feeding pathway. It's family was not provided with a breastfeeding assessment tool either- as a result, the baby became dehydrated and hypoglycaemic. New born babies have been discharged soon after birth without properly examining them for serious health issues, as described below:

My son was discharged after 6 hours of being born. After a few days, I felt something was wrong because he wasn't warming up and was always cold. At the six week check up with a GP, she checked his heart and found that there was something wrong- basically he had holes in his heart. My GP was very surprised that my son wasn't properly examined and was discharged so early.

Patient story shared with Healthwatch Buckinghamshire (2020)

Advice, guidance and practice on the choices available to pregnant women

According to the vision outlined in the Better Births review, women should be able to choose their maternity plan including the place and the type of birth. Our data largely suggests that most women are offered a choice so that they are able to make an informed decision about their childbirth and aftercare. Where women had a choice, they felt that it gave them control and helped them to feel relaxed.

My elective caesarean was supported by a specialist elective midwife who advocated for my choices, respected and promoted normal physiology in a medical environment and cared for me holistically considering my visual impairment.

Patient story shared with Healthwatch Stoke-on-Trent (2020)

However, a significant minority has reported that they were either not offered a choice or it wasn't clear to them what this meant. For example, some thought it was simply a choice between hospital or home birth or they were unaware that their local hospitals could provide home birth services as well. In 2018, a report by Healthwatch Cheshire East found that expectant mothers often did not get the opportunity to speak to a GP first. When they rang the practice, the reception staff gave them a number for the community midwife. As a result, they were not always aware of all the options on offer. The same report also found that some

practice staff would only offer the local community midwife to new mothers because they thought it was for the best- this removed the choice for expectant mums.

A recurrent theme from our data suggests that where women were not given a choice, they were not consulted about their care during the initial months of pregnancy. For example, they were unable to have a choice as to where the service will be accessed, even if the service was available in another location. They felt that their opinion wasn't considered, and a service was allocated without their involvement.

> On the online notes system there was inaccurate information from my initial community midwife appointment. Some questions I hadn't even been asked and the reponses were assumed, such as choice of location for birth. My notes stated [Name] Hospital throughout but I never intended to go there.
>
> Patient story shared with Healthwatch Stoke-on-Trent (2020)

A report by Healthwatch Rochdale in 2018, found that while most women were offered a choice of hospital, midwife led unit, or home birth across all the local hospitals, within the BAME communities, there was a notably higher incidence of not being offered any choices. Healthwatch Tower Hamlets reported in 2019 that women of Bangladeshi origin were not familiar with the concept of homebirth and associated it poor safety- they felt that they had not received much information during their antenatal care about it.

We have also heard that some women were offered less choice and support during their second or subsequent pregnancies.

> With my first child I was offered a choice between the [Name] and [Name] Hospitals. With my second child, I was not given the option but allocated to [Name] Hospital. I was told I would have to self-refer if I wanted to attend the other one.
>
> Patient story shared with Healthwatch Stoke-on-Trent (2020)

Training and support offered to maternity staff

Our data suggests that most maternity staff are provided with training that is relevant to their role- for example, Healthwatch Richmond upon Thames found that all maternity and neonatal staff at a local hospital receive infant feeding training. Another local hospital had commissioned training looking at human factors to enable staff to look at their responses to stressful situations (Care during Pregnancy- Antenatal Care; report by Healthwatch Richmond upon Thames, 2018).

In 2018, Healthwatch Havering undertook an Enter and View visit to the maternity ward at their local hospital and reported that staff had all mandatory training up-to-date, covering all essential elements. In the same year, Healthwatch East Sussex also reported similar findings from their local midwifery unit - they found that staff at the unit were skilled in providing breastfeeding and nutrition support and received annual training updates. Some were trained to provide specialist services, for example at the tongue-tie division.

A well-trained workforce was able to provide better care, as reported by Healthwatch Tower Hamlets below:

I'm going to give birth at the [Name] Hospital, I have a complicated pregnancy and I suffer from lupus. I think the hospital has improved a lot. They're the same midwives I knew from my past pregnancies, but you can tell they're nicer and less stressed. I think they have received a lot of good training.

Patient story shared with Healthwatch Tower Hamlets (2019)

We have heard some concerns about how staff did not deal well with patients which they believed was due to lack of adequate training. In 2019, a combined report by Healthwatch Buckinghamshire, Oxfordshire and Berkshire West found that there was a lack of sensitivity training for midwives regarding racial stereotyping, which was very exhausting for pregnant women. In another report, an individual felt that their concern around breastfeeding wasn't taken seriously by staff because they were not trained well to address her issues.

Midwives and health visitors should enquire further about issues with breastfeeding and not accept pain as normal. Perhaps this is down to training.

Patient story shared with Healthwatch Stoke-on-Trent (2020)

Whilst undertaking their work, some local Healthwatch felt that occasionally staff lacked specialist training which became a barrier to providing good care. They recommended staff to get additional training such as gestational diabetes training and training to support expecting mothers and their partners around mental health issues.

Person was 41 weeks pregnant and has been taking medicines for depression and anxiety- she also has had one miscarriage. After several cancelled appointments, the midwife made a home visit. However, during the appointment, the issue of mental health was skimmed over. Both she and her partner felt it was more of a tick-box exercise than a conversation which made them feel uneasy. They feel that there is a deep-rooted problem with midwifery provision and needs to be addressed possibly by training.

Patient story shared with Healthwatch Bedford Borough (2020)

Key findings from Healthwatch Shropshire report [Maternity and Mental Health Engagement - June 2019]

- Number of people engaged- 348
- Majority had been given no information or advice about maternity and mental health.
- The lack of opportunity for parents to raise their mental health concerns came through as a main theme in the feedback.

- Experiences of speaking to their GP about antidepressant medication was varied- some felt informed and supported while others were advised to reduce their use or refused it all together.
- Evidence suggested that some GPs may not prescribe antidepressant medication due to concerns over litigation.
- People valued the mental health support they received from health visitors but felt it should be available more frequently and for longer.
- Around 7 in 10 women reported having a mental health condition during the perinatal period and said they had not received any mental health support.
- Concerns were raised by staff about the reduction in visits and work pressures they face which impact women particularly during the antenatal period.
- People's experience of waiting to receive mental health support ranged from receiving support on the same day to waiting more than three months.
- People found it difficult to self-refer for mental health support.
- Nearly half of the people who had previous experience of a mental health condition felt that the support they had received during their maternity period was the same or worse.

Key findings from Healthwatch Telford and Wrekin report [Maternity Mental Health - September 2019]

- Number of people engaged- 215
- There is a stigma around mental health, including a lack of support for parents dealing with maternity mental health issues.
- There were breakdowns in communication between expectant-parents/new-parents and professionals which had a significant impact on mothers who had already experienced mental health challenges.
- Many felt that they had sufficient information about how pregnancy and childbirth may affect their mental health, however, there was insufficient advice and guidance around medication and mental health during and after pregnancy.
- Many were unaware that they had a care plan in place that considered both their maternity and mental health/wellbeing needs.
- There was a lack of support groups for mothers and partners that were experiencing mental health challenges.
- Nearly 2 in 5 partners felt that there was a lack of support for their mental health challenges and their feelings were not being considered. Some had to wait for two months to receive any support.

About us

We are the independent national champion for people who use health and social care services. We're here to find out what matters to people and help make sure their views shape the support they need.

There is a local Healthwatch in every area of England. We support local Healthwatch to find out what people like about services, and what could be improved, and we share these views with those with the power to make change happen. Healthwatch also help people find the information they need about services in their area. Nationally and locally, we have the power to make sure that those in charge of health and social care services hear people's voices. As well as seeking the public's views ourselves, we also encourage health and social care services to involve people in decisions that affect them.

healthwatch

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