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Submission to HoC inquiry call on the process of inquiries for maternity care
September 4th 2020

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(Our submission does not necessarily reflect the views of the organisations to which we are affiliated)

Summary

Inquiries such as this can make an important contribution to ensuring high quality care and promoting positive short, medium, and long-term outcomes. Assessing safety in maternity care must take the wide and the long view. Safety is integral to quality and promotes survival, optimal health and wellbeing, effective parenting and strong mother-baby and family relationships, in the short term, medium and long term, and into future generations. Examining quality from a narrow focus can be misleading and risks missing unintended adverse consequences of practices and policies.

In this submission, we make two key points:

1. We describe the critical importance of using evidence-based definitions and quality frameworks to assess quality.

2. A strong international and national evidence base demonstrates that midwifery continuity of care improves key safety outcomes. Implementing this model is supported by current government policy in all four countries of the UK. Yet it remains a struggle to provide this form of care for women in most of the UK. Why is this not a central concern for all those concerned with the quality of care for women and babies?

Introduction: safe care for women, babies, and families

3. We are Professors of Midwifery and related areas who have been active advisors on evidence-based care for RCM and RCOG guidance during COVID-19. Between us, we have led and/or collaborated in nationally and internationally funded research totalling tens of millions of pounds, relating to quality of care. We have published many hundreds of peer reviewed papers. Between us, we have practiced clinical midwifery for many years in many settings, in the UK and overseas; managed small and large maternity services; advised

national and local governmental bodies; taught hundreds of midwifery, obstetric, and health sciences students; and run academic departments. Our expertise also includes work on public health, improving safety, and involvement in legal processes concerned with clinical negligence. Many of us have had personal experience of pregnancy, childbirth, and childcare. Some of us have also had experience of bringing up children with severe disabilities.

4. Since everyone goes through the experience of being born, the provision of high quality, skilled, compassionate and knowledgeable care for women during pregnancy, birth, and the postnatal period, and for babies in the early weeks of life, is critical for the lives and wellbeing of everyone in the UK, and for social and economic prosperity. Whatever the outcome, pregnancy and birth are life events with lifelong physical and psycho-social consequences.

How can maternity inquiries promote safety and wellbeing?

5. Inquiries such as the current one can make an important contribution to ensuring high quality care and promoting positive short, medium, and long-term outcomes. However, to avoid unintended consequences, inquires with an interest in promoting the best care for all women and babies should explicitly guard against the creation of unintended adverse consequences for many, due to a narrow focus only on specific outcomes that are critical for a few. Safety in maternity care can only be ensured if services promote survival and optimal health, positive wellbeing, effective parenting, and strong mother-baby and family relationships, into future generations.

6. The current plethora of inquiries into the maternity services are very expensive for taxpayers. The fact that so many have taken place sequentially suggests that, as currently framed and performed, they are not targeting all the issues that matter, or that make the most difference to optimal care, experiences, and outcomes. For example, it does not appear that sites with the highest stillbirth rates (controlled for case mix) have come under scrutiny in any inquiry to date (MBRRACE-UK 2018), and there has been little attention to the very wide and unexplained variation in intervention rates, or to the evidence that the highest rates are not necessarily associated with the lowest mortality and morbidity, controlled for case mix (NMPA 2019). Continuing to undertake inquiries with a narrow focus on specific outcomes, in sites that are not outliers for those outcomes risks increasing fear and protective practices, reducing the potential for staff to act autonomously, increasing defensive practice and denying women and babies personalised, high quality, flexible care. This is the opposite of safe care, in the wider sense.

Evidence-based international definitions and standards for safe, high quality maternity care

7. Our observation is that, to date, maternity care inquiries have not always been based on evidence-based definitions of safety. Focusing only and strongly on specific serious adverse outcomes, and particular practices and interventions, as the cardinal indicators of 'safe care' can enforce standardisation, reduce the freedom of women who want to make different choices, and restrict the ability of staff to respond to non-standard needs and requests. At the extreme, a kind of normalising moral pressure is created, that results in a blame and shame response for any member of staff or service user who wants to make non-standard choices, and any member of staff that follows their professional code in supporting women who make such choices 'outside of guidelines'(Feeley C et al 2019). There are clear synergies between clinical, psychological, and social factors, all of which matter if women are to be and to feel safe (Renfrew et al 2014, Downe S et al 2016 and 2018). Setting up a dichotomy between 'safety' and 'women's experience', or 'mortality' and 'wellbeing', is inappropriate for any inquiry into maternity care provision, and investigations based on such a dichotomy are likely to obscure some of the key factors that influence safe or unsafe care provision.

8. For the current inquiry, the WHO framework for the quality of care for pregnant women and newborn infants (Tunçalp *et al.*, 2015) and the Quality Maternal and Newborn Care Framework from The Lancet Series on Midwifery (Renfrew *et al.*, 2014) are the most relevant (Appendix A). These evidence-based frameworks describe the full spectrum of quality care needed to optimise safety, positive experiences, and short- and longer-term wellbeing for women and babies, and to reduce unintended iatrogenic events. Applying them to an analysis of safety in any Trust or setting requires assessment of much more than mortality and severe morbidity. Based on the evidence, and these frameworks, safety requires consideration of all of the following:

> All childbearing women and their babies have access to services that are acceptable, appropriate, and adequately resourced. All receive respectful, relationship-based care that is tailored to individual values, beliefs, choices, and needs, and that promotes and strengthens the capabilities of childbearing women and their babies. All have care from the appropriate skill mix of staff who are well educated and supported to combine clinical knowledge and skills with interpersonal and cultural competence. Every woman and newborn who needs or wants interventions and practices to support and prevent complications, and to treat them when they occur, should have seamless, non-judgemental access to such services in a timely manner. No-one should have interventions or treatments that are unnecessary, unwanted, or unexplained.

9. Whether a broad or narrow definition of safety is used, members of inquiry panels should always check that they do not make the mistake that association is causation when they consider the evidence before them. For example, just because a certain type of care exists in a Trust, and the same Trust has particular issues of concern, does not mean that the cause of the issue of concern is the type of care that exists there. The notion that 'association is not causation' is a fundamental and basic scientific rule. Inquiries that do not pay attention to this scientific rule risk normalising assumptions about 'what works based merely on association, in the absence of actual evidence. These assumptions can end up being repeated from one inquiry to the next, taking on the power of 'fact' through frequent repetition. This minimises the potential for the inquiry to make a fundamental breakthrough for real and sustainable improvements in the quality and safety of care.

Operationalising authentic choice and optimal outcomes: Continuity of Carer (CoC) as a key evidence-based strategy

10. Choices, advice, and decision making, especially for the most marginalised women and babies, are best operationalised through properly implemented continuity of care (CoC) schemes. The evidence is absolutely clear. Good quality CoC provision, well integrated into the health system, and designed to enable positive staff-service user relationships, catalyses womens choice, and increases safety (Sandall *et al.*, 2016). Improved outcomes include reduction in prematurity and in overall baby loss, reduced need for treatments and interventions in childbirth, higher rates of physiological birth, lower requirement for epidurals in labour, greater levels of maternal choice and of positive mental health, and increased rates of breastfeeding.

11. Critically, properly set up continuity schemes are associated with improved choice, control, and outcomes for those with particular needs, as is evident in the very good outcomes for bereaved parents who have access to bereavement 'rainbow' teams and for BAME and marginalised women (Homer CS et al 2017). In the light of the current crisis around excess adverse maternal and neonatal outcomes for BAME women, this evidence is critical. CoC implementation is supported by current policy in all four UK countries. However, despite the striking evidence that properly resourced and implemented continuity of care schemes have a very significant impact on safety, yet despite government policy in all 4 countries, most UK women do not have access to effective and accessible CoC programmes. This is a system failure that directly impacts on

both choice and safety. This situation has been exacerbated during COVID-19, when some continuity of care schemes that did exist have been suspended.

12. Realising the benefits of CoC schemes will only happen if local Trusts are held to account for implementing them with fidelity to the models used in relevant trials. Inquiries that are interested in safety and choice should be alert for, and critique, 'work arounds' or 'bolt ons' to existing systems that avoid making the fundamental changes that are required. Good schemes will include education for change, a clear organisational expectation that staff will work in different ways, and protection of staff work/life balance. Features of successful CoC schemes include small teams of well trained midwives; reasonable caseloads; flexible working; effective and genuinely respectful interprofessional relationships; authentic midwifery autonomy and maternal choice; and fluid, non- judgmental, two way transfer arrangements (between professional cadres, and between birth setting (McInnes et al 2020 and Rayment Jones et al 2020). Maternity service inquiries should audit Trusts against provision of such a system of care as part of safety evaluations.

13. Relevant professional organisations should also be held to account for promoting continuity schemes are set up in every Trust and for the majority of women and their babies.

Conclusion: Ensuring inquiries catalyse safety and choice for all, in the short and longer term

14. Inquiries into safety in maternity care must take the wide and the long view. Safety is about optimal health, wellbeing, effective parenting and strong mother baby and family relationships, in the short term, the long term and into future generations, around pregnancy, birth and the early weeks of life. It includes genuine attention to the values, beliefs, needs and choices of individuals in their social and cultural context. It is not about universal application of population level standards to everyone without regard to their particular norms, values, and needs.

15. Recommendations, care bundles and their components, and other outputs, should be based on rigorous, good quality evidence, and not just expert opinion, or current norms, or current assumptions about best practice. All recommendations should be thoroughly assessed for potential unintended consequences in both the short and longer term. All should meet the standards for both safety and personalisation.

16. There should be clear terms of reference, every effort should be made to avoid bias, the inquiry process should be systematic, and the time period defined in advance. If a long time period is covered, differences in standards of care over time should be set out and taken into account. Those conducting the inquiry should not be connected to any legal processes concerned with negligence. Those presenting evidence should encompass all relevant points of view and stakeholder groups, including those with both positive and negative experiences, and those with different personal and professional values and beliefs about maternity care and the definition of safety.

17. As our submission above indicates, assessment of standards for safe, good quality maternity care should include examination of services that have the best outcomes in relation to their case mix; the highest scores on service user evaluations, and the most positive organisational climates from the point of view of staff. In this way service and policy colleagues can learn from excellence and turn the negative downward spiral of 'blame and shame' investigations into a positive upwards spiral of high morale and authentic desire for excellence. Improvements in services under investigation should be publicly acknowledged.

18. If practices are recommended, the inquiry should follow up to make sure they are implemented effectively, and that ineffective work arounds and bolt-ons are identified and addressed.
19. We would of course be happy to clarify any areas and add more information if needed. If we are called to give oral evidence, we will bring available research as requested.

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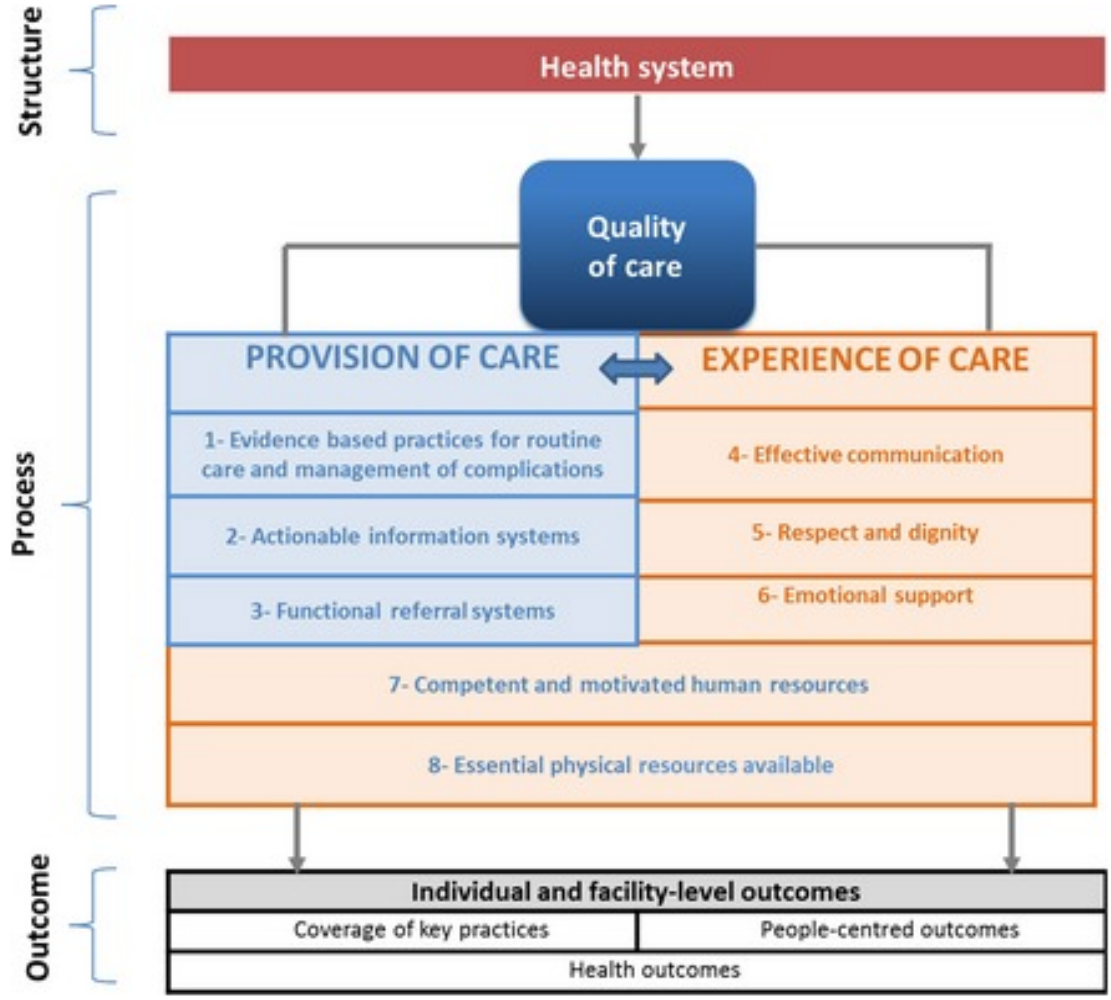
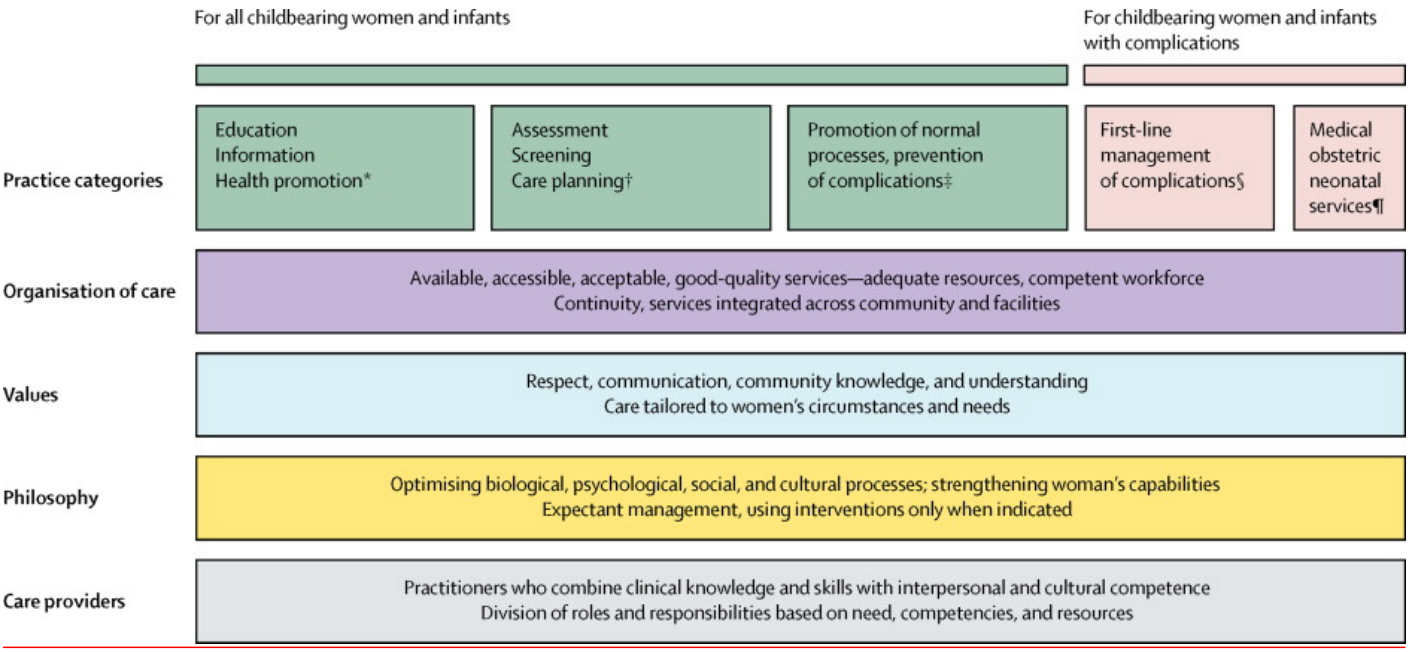
Appendix A

The WHO Quality of Care Framework for Maternal and Newborn Health 2015



The Lancet Series on Midwifery Framework for Quality Maternal and Newborn Care 2014: components of a health system needed by childbearing women and newborn infants



*Examples of education, information, and health promotion include maternal nutrition, family planning, and breastfeeding promotion. †Examples of assessment, screening, and care planning include planning for transfer to other services as needed, screening for sexually transmitted diseases, diabetes, HIV, pre-eclampsia, mental health problems, and assessment of labour progress. ‡Examples of promoting normal processes and preventing complications include prevention of mother-to-child transmission of HIV, encouraging mobility in labour, clinical, emotional, and psychosocial care during uncomplicated labour and birth, immediate care of the newborn baby, skin-to-skin contact, and support for breastfeeding. §Examples of first-line management of complications include treatment of infections in pregnancy, anti-D administration in pregnancy for rhesus-negative women, external cephalic version for breech presentation, and basic and emergency obstetric and newborn baby care (WHO 2009 monitoring emergency care), such as management of pre-eclampsia, post-partum iron deficiency anaemia, and post-partum haemorrhage. ¶Examples of management of serious complications include elective and emergency caesarean section, blood transfusion, care for women with multiple births and medical complications such as HIV and diabetes, and services for preterm, small for gestational age, and sick neonates.

15 September 2020