Written evidence submitted by Baroness Cumberlege and Sir Cyril Chantler GBE (EPE0001)

Dear Mr Desai,

In your email of April 12 you asked Baroness Cumberlege and I to respond to the Health and Social Care committee Expert Panel's request for our view of the progress the Government has made against its commitments in the area of maternity services in England. Specifically we were asked to comment on the following

1)By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.

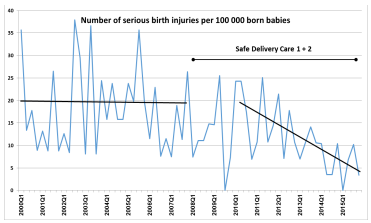
2)The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.

3) Safe staffing – "Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm."

4) All women to have a personalised care and support plan by 2021.

It is important to recognise the background to this work. In 2014 the chief executive of NHS England commissioned Baroness Cumberlege to carry out a review of maternity services in England. The report entitled "Better Births" was published in 2015 with 28 recommendations. Overall the report was intended to facilitate a more personal and safer service for women in England. Whilst it was recognised that significant improvement in outcomes for both mother and child had occurred over the previous years it was also clear that other countries such as Sweden had better outcomes. Over the years the cost of compensation to support babies damaged in child birth has risen. In 2019/2020 according to the latest report from NHS Resolution, maternity cases accounted for about half of the total £2,157m paid out and total claims in the year for maternity cases amounted to £2,389m. The number of settled claims each year is around 130 where clinical negligence is accepted or proved but there are around another 70 damaged babies where the test of negligence is not met. In Sweden the requirement for compensation is whether the damage would have been avoided given best practice not whether it was negligent. The emphasis is on learning not blame and since this new system was introduced by the Swedish insurance system, LOF, the number of birth injuries has fallen (see figure).

BIRTH INJURIES 2000 - 2015



LōF

Ambition 1)

Progress towards the ambition of halving the neonatal mortality and number of still births from 2010 by 2025 is shown in the table below taken from the most recent ONS data published in February 2021.

	Neonatal deaths per 1,000 live births		Stillbirths per 1,000 births,	
	England Neonatal		England Stillbirth	England Neonatal (24 weeks and over)
2010	2.9		5.1	2.0
2011		2.9	5.2	2.0
2012		2.8	4.8	1.8
2013		2.7	4.6	1.7
2014		2.5	4.6	1.6
2015		2.6	4.4	1.6
2016		2.8	4.3	1.6
2017		2.8	4.1	1.6
2018		2.8	4.0	1.5
2019		2.7	3.8	1.4
(2025	*1.5*		*2.6*	*1.0)*

This table shows that the decline in Stillbirths is very encouraging having fallen from 5.1 in 2010 to 3.8 and is on track for the ambition of 2.6 in 2025. The comparable figure for Sweden in 2019 is 3.19 per 1000 births.

The fall in neonatal deaths is less encouraging having fallen from 2.9 to 2.7 against the ambition of 1.5 in 2025. In 2019 the rate in Sweden was 1.4. However there is a particular problem here because the figures now include babies born at 22 or more weeks of gestation not 24 weeks or more. The table shows that when these extremely premature babies are excluded the progess is also good and on line to achieve the ambition of 1.0 per 1000 births by 2025.

The Maternity Transformation Board of NHS England with its associated Stakeholder Council (with which we are associated) has just completed 5 years of work to improve services and the clinical and administrative leadership has been impressive. There have been a variety of initiatives to implement the recommendations of Better Births not least the Saving Babies Lives Care Bundle mark I and mark 2. The importance of Continuity of Carer and better digital information systems has been recognised. There are many other current actions including a focus on reducing premature births, and using the new Local Maternity Systems to make sure that all trusts, units and services meet acceptable standards and that the serious discrepancies in outcomes for Black and some Asian women and those socially disadvantaged are eliminated.

In our view there are still matters of concern in ensuring improved learning when things go wrong and how best practice can be spread. Induction and Caesarian Section rates in Sweden are just over half those in England and whilst recognising that strict comparisons between England and Sweden are not possible given the many differences between the two countries the cost of support for families when babies are damaged during birth is far less there than here. One recommendation in Better Births which has not been implemented was for a Rapid Resolution and Redress System modelled on the Swedish insurance system and based on the test of avoidable

harm not negligence. By removing the notion of blame and emphasising the need to learn we believe many fewer babies would be damaged and large sums of money could be saved. There will always be risks in clinical practice but they can be reduced when clinicians who work together in multi profesional teams also are encouraged to learn together.

In Summary, we believe that the work by NHS England and the support from the DHSC and the government, including extra financial resources has enabled good progress to achieving the 2025 ambitions but more is still needed to ensure success.

Ambition 2)

Progress with continuity of carer has been slower than we would have wished. This is partly because of Covid 19 and also because of staff shortages particularly of midwives but also of obstetricians because a designated obstetrician is an essential member of the continuity of carer team. However there have been other problems with its introduction because to do it successfully, requires a change in the way midwifery teams work both within the community and in hospital. That is why some areas have been more successful than others. The recent increase in funding to increase staff numbers is likely to be very helpful in achieving the ambition as will be the new ways of working which are becoming more popular as they are seen to be successful. Continuity of carer is at the heart of achieving the "Better Births" ambition of a more personal and safer maternity service. The Cochrane reviews of 2016, 2018 and 2020 have shown that it improves both clinical outcomes and women's experience of care.

It is also important to make sure information is available to the mother and the midwife and to other members of the team across the local maternity system. One of the recommendations of "Better Births" was to create a digital care plan and record to replace paper records. Progress on achieving this has been slow but recently, stimulated by leadership from the chief executive of NHS England, it has been accepted that this will be achieved over the next 18 months. The care plan and record will be developed jointly by the mother and the midwife and then be accessible and interoperative with all the services that are necessary to achieve a successful birth experience. This includes laboratory investigations, ultrasound scans, general practice support and of course interaction with the associated maternity unit. This progress is also relevant to achieving ambition 4. As with continuity of carer the need to support women from the Black and Asian communites and those socially disadvantaged is particularly urgent.

Ambition 3

Ensuring safe staffing levels is work in progress. This has been the case for many years and various initiatives have been tried. (see for example the report by the Kings Fund on the Dept of Health plans for a Centre of Workforce Excellence from 2008; https://www.kingsfund.org.uk/sites/files/kf/proposals for a centre of excellence.pdf).

This is not the place to review this topic; it is a wicked problem because there are so many factors that influence whether staffing levels are adequate and certainly Covid has had a major influence on this. However the recent increase in funding of £100m a year to improve staffing levels is very welcome and demonstrates the government's commitment to dealing with the undoubted shortages in some areas at some times.

Ambition 4

Assessment of progress in achieving this ambition is difficult because it depends in part on what is meant by a personalised care and support plan. It is also difficult to know in what proportion of the around 670,000 births each year in England this has been achieved in whole or in part. It also begs the question of what is to be regarded as an adequate plan. Certainly as it was conceived by "Better Births' it was intended that every mother should have the opportunity to discuss with her midwife how she wanted the birth of her child to be organised. Having developed this plan the task was to wrap the care around the mother so that this could be safely achieved wherever possible. We are not at that point yet and again the pandemic has undoubtedly slowed progress. However there has been progress and as **continuity of carer improves and the digital care plan and record** is introduced, along with the better organisation of services within the Local Maternity Systems, we believe that by April 2023 it should be available to the vast majority pregnant women in England.

With the cohort of birthing mothers who are usually comfortable with the use of personal technology increasing there is an opportunity to strengthen continuity and thereby improve safety. Since the woman and her family are at the centre of care we foresee with mobile phones and other personal technological devices she can be a full participant in her treatment and care. She should be able to communicate and gain access to her midwife, obstetrician and other health professionals when she requires information, assurance or advice especially if she has concerns. It places her in joint control of the process and enables her with confidence, to exercise choices and to 'own' her pregnancy, labour and aftercare. Having jointly created her digital plan and having access to her records she has the knowledge required to make informed decisions and ensure they are upheld.

Sincerely,

Baroness Cumberlege, Sir Cyril Chantler GBE.

April 2021