Health and Social Care Committee- Maternity Services Expert Panel

Roundtable with clinicians (1)
Friday 21st May 2021

Jane Dacre: Hello everyone. We'll start by introducing today's session. I've been commissioned by the Health and Social Care Committee to chair a group that is looking at evidence in relation to maternity safety, to see whether the Government has achieved its pledges, and you are a group of experts who know about it on the ground. This is a round table discussion which has some formality, in that we're going to be asking specific questions, and what I need before we start is for everybody to agree that the sessions should be recorded. So, can anybody who doesn't agree to be recorded put your hand up? Fortunately, I don't see any hands. The reason why we're recording is so that we can transcribe and pull out the themes that people are saying. I will start by asking everybody to introduce themselves. At the top of the screen I've actually got the Health and Social Care Committee staff, so do you want to start?

Florence Young: I'm Florence, I'm a POST (Parliamentary Office of Science and Technology) Fellow, but I've been seconded to the Health and Social Care Committee to help with this expert panel review of the maternity safety commitments.

Alison Lacey: Hello everybody, I'm Ali. I'm the same as Florence, working on the data from this Panel, and am interested in what you have to say this morning and working with that in the report.

Previn Desai: Thanks, I'm the Second Clerk on the Health and Social Care Committee, so in practice working as deputy head of the Committee secretariat and I'm also head of secretariat for the panel.

Jane Dacre: So that's our in-House staff who will be keeping us straight with points of order. I'll now if I may, jump down to our co-Chairs as it were, Soo and Lesley. Now our panel is made up of generic experts and subject specific experts, and Soo and Lesley are our subject specific experts. So Soo please?

Soo Downe: Hello, I'm Professor of Midwifery Studies at the University of Central Lancashire.

Lesley Regan: I'm Lesley Regan, Professor of Obstetrics and Gynaecology at Imperial College, based in Saint Mary's.

Jane Dacre: So, they're helping to co-facilitate today's roundtable. If I can move on to asking you to introduce yourselves, so Participant A can we start with you?

Participant A: Morning everyone. I'm one of the Obstetrics and Gynaecology consultants at [hospital name]. I've recently taken over the labour ward lead role for us.

Participant B: Morning everyone. I'm the Regional Chief Midwife [Trust name]

Participant C: Hi everyone. I'm a Clinical Team and Community Midwife at [Trust name].

Participant D: I'm one of the Consultant Obstetricians in [city] and I'm [specialist role] as well. Thank you.

Participant E: Hello good morning. I'm a consultant obstetrician at the [hospital name]. I'm the maternal medicine lead so dealing with complex pregnancies.

Participant F: I'm one of the consultant obstetricians here in [hospital name].

Participant G: I'm the Professor of Foetal Medicine at [hospital name] and [specialist role], based at the RCOG and RCM.

Jane Dacre: Just to remind you again that the session will be recorded, and we'll be taking a transcript. You'll be asked to approve it before it's published, and you can withdraw your consent if you don't wish for your anonymised contributions to be included in our analysis. I think that this information has been provided to you all in writing, so if people are happy, we will proceed along those lines. So, I'm going to kick off. I'm a physician and rheumatologist so my only knowledge, as I say to people, about obstetrics is as a consumer so the real understanding and work will come from you, but I will ask the first couple of questions to get everybody started and then I will hand onto my more knowledgeable colleagues. Just to say to everybody, please feel free to speak up. We want to hear from everybody because we want to have a rounded view. So, if you have something to say, please do say it and we want everybody we want everybody to feel able to speak. My first question, as a general opening question, is do maternity units currently have the right number of staff to deliver safe care? And is this consistent out of hours? So, who wants to start off in relation to that?

Participant B: Shall I start from the midwifery perspective? (*Facilitator agrees*) From a midwifery perspective, we do have a workforce planning tool that's been established for a number of years called Birthrate Plus, and we undertook a survey in January of all services in England to understand what their Birthrate Plus was recommending for them, and what their actual position was in terms of their funded establishment. That has shown a gap and over the last few weeks we've been working on a process to distribute £83 million worth of funding directly to maternity services to increase the number of midwives and obstetricians available for frontline care. I think Ockenden has really highlighted, and helped us to understand, that we needed to take a closer look at whether services were actually able to fulfil what their Birthrate Plus recommendations were saying. I wouldn't like to speak on behalf of my obstetric colleagues, but I'm sure they will be able to tell you that there isn't a workforce planning tool at the moment for obstetrics, but there is certainly one in development.

Jane Dacre: Can I then ask to bring in an obstetric colleague?

Participant D: So building on Participant A's work, I think there is not an obstetric equivalent of Birthrate Plus, however we have been able to use the underlying principles of Birthrate Plus to estimate that we are about 20% obstetrician's short currently. So, there are approximately 2500 obstetricians available now, 20% of that is approximately 500 and 80 have been committed, as Participant A said, in the most recent government promise, so we think we're about 420 down now. The way we justify that is because, I think, everyone accepts that complexity for pregnant women is definitely increasing and complexity needs more obstetric time. All maternity care is obstetricians and midwives together- however we divided out this- we all have to work together and for the sake of women, that's the best way forward. But if we just focus on the obstetricians, then we know that more pregnant women, for the first time ever, are pregnant over 30 than under 30, we know that less than 50% of pregnant women have a normal BMI, we know that caesarean rates have gone up 20% in the last decade, induction rates going up in the last decade, all of which kind of reflect complexity. So we think that we're about 20% short at the moment, I think that Participant A if you work out that the midwife estimates about 10% short so considering the increase complexity, we think 20% is probably in the right range. But a tool is being developed.

Jane Dacre: So, the direct answer to the question about having the right number of staff is no. Is that right?

Participant D: That's the shortest possible answer. No.

Jane Dacre: Can you expand on that in relation to out of hours care?

Participant D: So out of hours care in maternity is not just about staffing, it's about systems and structure. Consultants do not work out for hours in all units, in some units they do, in others they don't but clearly that is an inconsistency.

Participant G: I would like to build on what Participant A and D said. There are two specific things that you want to know about, one is out of hours care, and Participant D mentioned systems and efficiency, and that has much more of an impact in obstetrics than it does on midwifery. So, if I'm working in a town in Sussex as opposed to an inner city London hospital, the type and skill mix of obstetricians you need to deal with that complexity is different because Town X- nothing against Town X- but they would refer in the complexity into different hospitals so one has to bear in mind that there isn't a simple answer to the solution. But the answer no is absolutely categorical. We do not have enough staff to deal with the complexity now, and that is heightened and worsened out of hours, that's for sure.

Jane Dacre: Participant C do you want to come in first and then I want to dig a bit more deeply into that.

Participant C: I just wanted to comment on the distribution of that staffing as well. So, from the shop floor perspective there's always one to one care in labour, it's prioritised, but perhaps on the postnatal ward, that number of midwives is perhaps not as great. So those midwives are overstretched. Also, in terms of community midwifery, so antenatal care, there might not be the complexity in terms of medical care that perhaps obstetricians are providing, but women require emotional labour, and therefore time, and there's a lot more that's being asked of the midwives at the same time as it being the same number of midwives. Whilst we may be able to, in terms of numbers, put midwives in place, it's about where those midwives are, if that makes sense.

Jane Dacre: That's really helpful and that was actually what I what I want to come onto next.

Participant F: Thank you Participant C for bringing that point. We always focus on the delivery suites almost like the fire service, when in fact of much of maternity care precedes that. I think the real strain that I've noticed in recent years has been the drain from the community in the sense that I perceive- I'm not a midwife, so I'm afraid I can't comment specifically- but my sense is that the community teams are stretched and stretched and stretched and the focus of everything is about the avoidable incidents that occur when these all go wrong in delivery suite and our maternity assessment centres. So, actually, we focus on what happens in secondary care to the detriment of what actually could be avoidable and could be pinched in the bud in in the community setting. And that's where our real lack is I believe.

Jane Dacre: So, the upstream stuff?

Participant F: Yes. And it's not just now, it's the ambitions of the future, and Soo will talk about this later I'm sure, but the whole issue about personalised care and continuity of carer all hinges on that upstream effort being adequately staffed, but our focus is always on the crisis points.

Participant A: So my point was sort of linked to Participant C's point about having the right people in the right place at the right time, and that extending beyond just obstetricians and midwives and all the other peripheral staff that play an important role. So, having ward clerks to help women get admitted to units so midwives aren't doing that role. Having the right numbers of middle grade staff,

some rotas, so that we haven't got a situation where we've got acting downs and we've got the right people in the right role to provide the right leadership in that situation and the deficiencies elsewhere that impact on staff in midwifery and obstetrics.

Participant E: I'm really building on the comments of the panel so far. I work in a District General Hospital with strong teaching hospital links, and we're seeing increasing complexity. In terms of the numbers of people working that complexity is not just dealt with by obstetricians, it is of course shared with midwives. There is obviously an assumption of individualised care for women and I can definitely discern some trepidation amongst midwives who have come to the job to look after women in labour, but not necessarily those with increasing complexity. What I notice is the increasing complexity, but not necessarily the support for managing that in a comfortable way, whether it is antenatally, peripartum or postpartum. We've seen all the stats - the women being older, heavier, with more comorbidities - and we have, as everyone has said, increased pressure due to numbers. So you have a committed workforce that is being stretched quite thin and being asked to do more complex work. I think this is an issue right across the board from booking to the postnatal visit.

Jane Dacre: So, the second bit of that question, which I think we've covered, is people's view of the right mix of staff and whether we currently have that in place. And, again, I think the very short answer is the same very short answer that we had before. Does anyone else what to add comments to what we have already?

Participant F: I just wanted to say, it's where we want to be in five years' time as opposed to where we are now, if we really want to deliver continuity of carer that is going to be a real challenge with the increasing complexity of the mothers who are coming through the system now. We've got to strike the right balance between a significant number of mums who will have complex health issues, and will require specialised care within a secondary care setting, and asking midwives to be that carer throughout that woman's progression may be simply too much for that midwife. I think we may be trying to make midwives general practitioners, a Jack of all trades if you like, which is great if everything is straightforward but actually you do need specialist midwives within a delivery suite setting, within a maternity assessment centre setting and within an antenatal day unit setting and I think continuity of carer just threatens that vision.

Jane Dacre: OK, so lots of people have got their hands up now and I'm being rather draconian about my timing here, so are anybody's points absolutely pertinent to this, or can we bring them up later because what I'm intending to do is to hand over to Lesley and move the conversation on a bit. So, does anybody still have a burning need to say something?

Participant D: We need to risk assess women better, and we will come onto that, but I think we also need to change the maternity structures so that one size doesn't fit all. [Regional hospital] is different to [London hospital], so we may need to restructure our maternity services as well as staffing.

Participant B: I just think we need to emphasise the importance of the multidisciplinary team, and continuity of care isn't about one midwife doing everything it's about being the person who holds the woman and navigates with her through the complexities, and with the team that she needs to work with. It's not about reducing it down to one midwife, one woman. It's her being an anchor for that woman.

Jane Dacre: Very helpful interpretation.

Participant C: For me it's that implementation of continuity of carer, making sure that it is implemented with what Participant B just said in mind, and that it is not interpreted in a way that expects that single midwife to do every aspect of care, when perhaps she's not as experienced in you know, magnesium sulphate administration or something similar. That we have core staff that are able to do that really complex care still.

Jane Dacre: I think we will come onto continuity of carer a little bit more at another stage, so I'm now going to hand over to Lesley, who's going to hold the ring for the next set of questions.

Lesley Regan: Thank you everyone for coming and giving up your time. I know it's at short notice and we really appreciate it. So, I think we've got a very cohesive multidisciplinary panel. Thank you. Can I be a bit naughty and start with what's scheduled as my second question first? So, what are the main factors influencing high staff turnover and attrition rates? And can I start by asking my midwifery colleagues to factor out what they think are the main turnover and attrition rate drivers.

Participant C: I think there's a few things. There's a primary concern amongst a certain group of midwives who are worried about the way in which continuity is implemented. I think a lot of that is fear, but those midwives have a lot of experience and are worried and are considering leaving the profession, which is a shame because they've got a lot of experience to teach the newer midwives how to engage and how to do the job. But also, I think the primary thing is the increasing workload, increasing workload with the same number of staff. So, for example, just taking quiet community teams being asked to do increasingly complex and numerous things within the same length of appointment. You've got a 20 minute appointment and you're expected to do another thing, another thing, another thing, and then if something gets missed, it's always going to be that midwife that's held to account for it despite the fact that the workload is unmanageable. so that's leading to stress and a lack of support, perhaps from leadership in some areas leads to kind of anxiety, stress, and burnout.

Lesley Regan: Thank you, and I think that comes back to Participant A's earlier point about task shifting, and that we need support staff as well, so midwives and obstetricians can focus on what they need to do with the complexities.

Participant B: I think what Participant C has described, we've had evidence around why midwives leave, and they've talked about workload and control being issues, which is why it's helpful to have this injection of funding. Although, as my obstetric colleagues have outlined, it's not necessarily the funding that will cover all elements, and certainly from the amount of bidding that we've seen from services, it would suggest that there is greater need. I think the other thing is around control, and I think the issue of continuity is a really important one. I think some people, as Participant C said, are fearful of what it means, but if it is introduced properly in a co-produced way with staff, actually it can increase control and agency of midwife so that they become the autonomous practitioners that they expected to be. But it does require implementation to be very much focused on working with teams, not just imposing a model on them. And also, I think this point about culture that Participant C just touched on is a really important one. If it feels like there's a blame culture rather than a learning culture, I think that is very discouraging for staff and very destructive on the working environment. And I think that's why there's a lot of work being done around the culture of kindness, looking at how systems influence how individuals behave, and thinking about how we can support midwives better with our professional midwifery advocates. And that kind of work is increasingly coming to the fore, so much so that our professional midwifery advocate role has been adopted by nursing as they've recognized its value.

Lesley Regan: So we'll come back to culture later and I know it's linked in, but we've got to somehow divvy up the questions so Participant E, I'd like you to give me some thoughts about in your experience or in your patch what's really contributing to the attrition and high staff turnover?

Participant E: In my unit the main issue is staff being stretched. This pandemic has really shown that as soon as we are in an emergency situation all the training elements for medical staff are the first things to go because we have to pare down to the basic service. So there is a feeling of dissatisfaction, a feeling of literally just covering the bases. There is no real chance for development. Everybody in O&G is a committed professional wanting to make progress and to do more. The rota gaps are very demoralising. I think they are a major source of disillusion and make it much more likely that someone will not wish to continue on the medical side. I think what's been said about continuity of care is very important. It needs to be a joint multidisciplinary venture. But in the same breath we've been talking about significant shortages so for these teams to be properly effective we need the bodies on the ground. So I think the problem is rota gaps; just covering service without a feeling of advancement. When you are lacking staff, senior practitioners want to do more than simply hold the hand of people who are less experienced. They want to get on and deal with the complex cases. We are compromised on every level if staffing and resources are short.

Lesley Regan: Thank you. So, attrition is a major issue, both at trainee level and also at consultant level. I'm going to come back to Participant A in a minute, but Participant D, do you want to make a comment about the older consultants and attrition and perhaps pensions and things like that? Other factors that are really crucial.

Participant D: Thanks very much. I think I think you're absolutely right, I think there are three main things if you look at the RCOG data, the RCOG data says that we need to recruit to numbers not posts at the beginning of careers because more than 50% of our trainees and consultants will take more than a year off. The second thing is I think we need a personalised care plan for whilst you're training, and whilst you're a consultant. Let's have a focus on what do we need to develop to bring the joy back into what we're doing. And finally, Lesley, exactly as you say one of the big issues at the moment is there's almost a financial reward, or there's certainly a penalty for working past 60 as far as many people perceive it. There is an Association of Royal Medical Colleges group exactly working on trying to understand how we can stop attrition at the elderly end, let me call it that because clearly that's what it has been described as. How do we stop people dropping off too early, as well as dropping off during their training? It seems to be people at ST2 level people drop out, and over 60 when people drop out, and I think those two need to be addressed in very different ways, but the Association of Royal Medical Colleges is trying to have a think about pensions etc.

Participant A: So, I had some of the similar points that people have mentioned. I had career progression in terms of looking at expanding roles and being able to do things other than just clinical, so for example university leadership roles and management roles, and not leaving Trusts to take those up elsewhere. From a midwifery staff point of view, I had things about minimum hours contracts, you know we're losing staff because we're putting minimum hour contracts in which in some ways help staff but in other ways we lose really good staff who might be willing to work fewer hours. Then just things generically around support with stress and adverse outcomes and making sure that we've got those things in place so that people feel supported when those things happen and don't leave for other careers.

Jane Dacre: So, I'm conscious time is moving on. The other thing we wanted to talk about was do you all have access to training and professional development and have there been changes in

workplace culture since 2015? Participant G and F, do you want to contribute? I know I've rather glossed over you, and if you pull in both questions, we won't be objecting.

Participant G: I'm going to have to pull in both questions I'm afraid. From a personal perspective, we're meant to have 16 SPRs [specialist registrars] and junior doctors here and we have 5 rota gaps at the moment. That's almost a third of our workforce that isn't present. The impact of that is that we have to cover, so consultants are covering various roles, and what that means is that their SPRs [specialist registrars] are left virtually unsupervised to deliver service. The consequence of that is that they are unsupported, and they also miss out on their training opportunities because they're having to provide service cover. And that has two ramifications: on the training aspect they're missing out on training, and on the support aspect where there are medical, legal, concerning or adverse outcomes, they're often left to blame. So, the lack of learning opportunities with an increasing the blame culture, as Participant B spoke about, is a bad, bad combination. It's a terrible combination, so we're having an exodus at the junior level. My fear is that if we don't put in the return that we need now, no matter how much you plan for increasing consultant posts in the year to come, you're just not going to have the staff to fill it because they've left, they've gone. So I'm afraid that we may be doing too much too late and there is a sense of urgency about this that needs to be addressed right now, because there is this exodus, there is a blame culture, there's a lack of training that they come specifically for. By the time we get round to sorting this out we're just not going to have the staff there to fill the posts that we've managed to get together. So that's my major concern. On training and professional development, it would be great if I had the time to do so. I'm in a different position because I've got a huge academic role so I do have access to training opportunities, but I cannot say that for my colleagues. I'm not certain that they do have that optimal access.

Lesley Regan: I think what everyone is saying is that when we're firefighting, then the training and professional development are the first thing to go out of the window, and in some ways it's the thing that we need to focus on, because that's what's going to retain our midwifery and our obstetric team. Participant F do you have anything to contribute?

Participant F: No, I think that's entirely true. I think we know how to do training better and there are bodies out there who offer good training opportunities within a multidisciplinary setting and in context which is vital. Training provides that glue for a team to learn and work together and to plan for the future, but that part of the job is pared first, and I think we ignore that, or we let that drift at our peril because it distances people, disconnects people and there is no sort of common feeling or progression, or individual sense of you know of focus in your in your professional life.

Lesley Regan: Participant B, can I come back to you from the midwifery perspective and ask about training and professional development? I'm sure that there will be similar issues, but do you want to make any comment about restricted access? Because I think it will be restricted for most won't it?

Participant B: Yes, I think one of the things that has become apparent over recent years is the number of training hours that have been made year on year and an increasing number of things are being squeezed into what's called the mandatory training sessions, with some trusts saying that they would need up to two weeks per year, per midwife if they were going to properly implement all the training recommendations that have been made. So clearly there is an issue there about what is being expected, which perhaps reflects Participant F's comment about turning midwives into GPs where they're expected to be experts on such a wide range of areas that it becomes almost impossible. I think there was partial acknowledgement of this in the workforce bidding in that Trusts were encouraged to bid for monies to support the multidisciplinary training, but I think that the

point that is being made is that when the chips are down, the first thing to go is training. I think COVID is probably the most obvious example of that, because when COVID struck, and we were facing sometimes staggering staff shortages, training courses were simply withdrawn by Trusts on a wholescale basis. But the importance of it has been outlined by my colleagues in producing coherent, friendly, respectful teams that will be kind to each other when the situations are difficult and that's what we need to be investing in, and I hope that half a million pounds that was announced for the safety training that has been focused at Trust boards will help Trusts realise that actually the training is not an optional extra. It's not a nice to have. It's absolutely essential for the safety of services. The other thing I would say is that I think increasingly for development opportunities staff are finding that they're being asked to do training in their own time, because Trusts are again not valuing the training or recognising that the continual training of staff is as integral to safety as having the right numbers of staff present. So, I think that a focus on Trust boards and senior leadership to really drive this point home is going to be really helpful.

Lesley Regan: Thank you, that's really helpful and a very pertinent point about if you're being asked to train in your own time that surely must up the attrition rate and the dissatisfaction rate. Participant's D and E any comments about training and professional development and access, or lack of access? I'm afraid the stories are consistent throughout all of the participants.

Participant E: Well, as we said before, training is nominally available, but if there is a rota gap a junior trainee is not going to be encouraged to go, in fact they will be discouraged. So that junior is less well-trained and cannot really take on the roles that they should within a multidisciplinary team. It is the consultant who will take up the slack as they are ultimately responsible for performance. The consultant also has less opportunity for advancement. By the time you reach the senior ranks, you are looking at service development, at innovation and keeping yourself interested enough to stay on past 60. It's a general rule that service becomes everything whilst training and development opportunities are reduced. I think this is about priorities as well. If your non-clinical managers have to balance the books, they're focused on throughput and cases completed. It's a short-term vision because if you invest in the development of your staff the whole team is more interested, more functional and able to deal with problems. We've mentioned increasing complexity and everybody including consultants needs to step up with their abilities. Midwives may show an aptitude and wish to extend their specialist skills. Not everybody in the team has to deal with a complex pregnancy. In a smaller hospital that may not be the caseload, but in a large centre there must be training opportunities for midwives who want to take on more complexity, juniors who are thinking of sub-specialising and for consultants to maintain and extend their skills. All that suffers if the realisation isn't there at management level and without the human resources of enough staff.

Participant D: So, I think it's four things. I could not agree more that training at unit level, just as Participant F said, provides the glue for a department. It brings everyone together, everyone can work together, so I 100% agree with that. I think one of the successes over the last five years- let's not just be too miserable- I think the Maternity Incentivisation Scheme by NHS Resolution, has changed the discussion at trust level from what's the cost of training to what's the value of training. I think the maternity incentivisation scheme has helped managers understand the value to training, all be it at the financial level- they don't really get the glue discussions- so I think that's been a real success. But look at COVID. Suddenly no one's allowed in the department, you're not allowed to train together, you're watching screens all day, and I think we all have seen that glue in a department reduce. Everyone's a bit fractious, everyone's a bit grumpy. You know it's just difficult times at the moment. The last things I want to say, and this builds on Participant B's point, there are too many recommendations and too many reports. There is a recommendations soup at the

moment, and the standard trope is: have a recommendation and ask for training, whether or not that's going to work, or not work, or whether there's any evidence for it. We need less recommendations. We need to consolidate and focus and allow some kind of unit prioritisation. Not all units have the same problem, so let's look in the mirror, see what our problems are, and try and sort them out. So, less recommendations. And my last ask is that we have some central training that can be localized at unit level. Why are we all producing training at local level all the time and reinventing the wheel? So, I think glue, maternity incentivisation needs to continue, the recommendations soup needs to stop, and we need some central provision of training to help units reduce the burden of providing training.

Lesley Regan: Thank you, that's helpful. Participant A do you have any further comments?

Participant A: So, from my perspective, we'd actually had really positive change in terms of team training and learning running up to COVID from 2015. But COVID put us in a big backward step- as it has for everybody- and I worry about recovery going forward, particularly with the competing interests of Obs and Gynae, for those that work in smaller units being a dual specialty and the pressures that are coming from management in terms of meeting waiting list times. Extra gynae clinics, extra theatre lists, and the competition for our time with that divides what we're able to provide between the two specialties, and I think that's going to be a huge problem going forward because the ask on us is more and more.

Florence Young: I just wanted to let everyone know that Participant H has been able to join us.

Lesley Regan: Welcome Participant H, my name is Lesley Regan. We've been asking about the main factors influencing high staff turnover and attrition rates, and if you don't feel too sort of pounced upon, we'd love to hear your views about that. Or alternatively, if you'd like to give us your views about what access do you have to training and professional development?

Connection issues

Lesley Regan: Florence, could you look into that for us. And then for the purpose of the recording, I think that all of my expert colleagues here understand this inherently, that one of the problems that we've had in staffing, both for midwifery and for obstetricians, has been that the gaps are all predicated by what the establishment is, which is predicated by the budget of that unit. So, the gaps in the rota don't even address what is going to produce the safe staffing. I feel, although everyone knows that, for the purpose of the recording, I think I need to just state it again. So it's not a question of how many rota gaps we can sort out, it's actually about asking the question of what do we need- which I think was what Jane posed to us- what do we need to deliver the safe staffing and achieve the four commitments that we're actually criticising.

Participant D: I was just going to add emphasis to that and say that of course the RCM and the RCOG figures for estimated shortfalls and staff assume that we're currently at the right level. Because it's building on that basement thing. So, I think we need to have a better understanding of are we at the right level to give the right care for women?

Participant B: Yes, we have attempted to do that with the Birthrate Plus survey to say exactly that question. What are you being recommended by Birthrate Plus and what is your actual establishment and we're trying to plug that gap. I do think it would be welcome though, to understand what good care looks like in a bit more detail to say have we fundamentally got this right in some of the assumptions that we make. I hear a number of services described 10 minute antenatal appointments, and when you think of the business of welcoming someone into a room, palpating

the abdomen, taking their blood pressure, testing their urine and actually asking them how they are and how their baby is- plus the slew of information that there is to share with them and for them to share with you- 10 minutes is ludicrous, really as a proposition. So, I think there is some work to be done on a time and motion study to understand the reality of what time is needed to deliver the right standard of care. And I think asking women is an excellent place to start as well.

Lesley Regan: Are there any other quick questions before I hand back?

Participant E: I just wanted to add that in workforce planning the ideal is a young consultant working 10 PA's. Many workforces contain very different working patterns. In my unit we have consultants working a range from 5 to 8 PA's. The number working a full 10 PA's, which is what the workload is predicated on, is quite few. So in terms of bare numbers, you must look at the job plans involved.

Lesley Regan: Thank you, that's another point just to emphasise for recording, Participant D's point about how we need to recruit to numbers, not posts, and also what you're emphasising Participant E, is that there may be many individuals who are working in maternity services, both midwifery and obstetric, who don't want to work full time and we're going to lose that expertise if we don't provide for them. I'll always remember arguing with HEE [Health Education England] on many occasions that it was assumed that every individual was contributing 10 sessions when we know that that just isn't the case. Also, in the Obs and Gynae field, that there will be a lot of obstetricians who are also undertaking gynaecology sessions, both operating and clinics, so you can't assume that a consultant or even a senior trainee is devoted to firefighting on Participant F's labour ward. So, Jane, it's 10:52, so I've caught up a little bit, but back to you unless I've missed somebody. Participant C, you've got your hand up.

Participant C: Just to add in about that continuity of carer, because the implementation in the teams is being driven by the number of midwives rather than looking at how many hours those midwives can work. So they're putting very strict limits on minimum hours that you need to have to be part of those teams, and that unfortunately means that it's kind of trying to put a bit of a square peg in a round hole at times. When actually there are really compassionate, really amazing, really supportive midwives that just can't quite fit that box but really want to deliver that continuity of care.

Lesley Regan: That's a very good point. So, we're losing talent because we're not flexible enough.

Participant C: Absolutely.

Jane Dacre: Thank you very much everybody. It's interesting to see how many of the issues that you are throwing up here actually resonate across the whole of the NHS, so it's going to be interesting trying to sort it out. And, also, Participant D, I think you'll be pleased to know that we're evaluating not making more recommendations in in a report. We're evaluating where we are and making judgements on that.

Participants D: There are too many reports that would never pass muster at journal level.

Jane Dacre: I should have pointed out at the beginning that the first half of the meeting was all about staffing, but I think you probably all got that. So, what I'm going to do now is to introduce the second half of the meeting, which is going to be led by Soo Downe, and this is about looking at the commitment for personal care and support plans. Soo, can I hand over to you now?

Soo Downe: Absolutely, and I think it segues from what we've discussed before and there's a couple of questions that come up for me about culture that maybe we can pick up again in the discussion later, that kind of goes underneath a lot of what people have been saying. I've got a couple of things

I want to highlight a bit later too, but I think this this is a kind of bridge now, this personalised care and support plan to possibly that discussion. Is now a good point just to say that there will be an opportunity to send anything written in if you don't have time to talk about it, and Previn will get back to you? So, if you feel, as we get towards the end, panicked because you think there's critical points that you want to make, we still want to hear from you about them. So, if Jane brings down the hammer at 11:30, then you could still contribute afterwards. So, the question I've got here is, how well do you think personal care and support plans meet the needs of pregnant women, and of course we also mean pregnant, intrapartum, post-natal women-and possibly also their families. So, has anybody for anything they want to say about personalised care and support plans.

Participant B: I absolutely welcome the focus on personalised care. I think one of the things that we've heard from women for too long is that they've been told they can't do this, they can't do that, and the universal application of something that is supposed to be a guide as a policy. So, I think that's excellent. My hope is that in implementing this approach to care what we are doing is focusing again on the culture of units and how implementation is facilitated and held back. Because I think if we don't, it risks becoming a tick box exercise bureaucratic thing, where we just have a bit of paper that we tick a few boxes and write a few stock phrases, rather than really getting under the skin of what matters to practitioners. What is it that leads a midwife to say to a woman I'm afraid you can't give birth in the birth centre because your BMI is whatever it is and that's outside of our guidelines? We really need to be unpicking the culture that leads practitioners to be feeling, perhaps what is described anecdotally, as fearful of offering choice to women. And ensuring that we are facilitating the care that women want, that women understand fully what options are available to them, what the consequences are, what the potential chances and risks are, and I think part of that is moving away from this erroneous assumption that the concepts of risk and chance, and what makes safe care, is universal and objective and somehow stands alone. They are individual to both women and practitioners and I think in the implementation of personalised care and support plans, we absolutely have to focus on that element.

Participant G: I think there's a much more fundamental problem with the personalised care plans, which is that central to personalised care plans is informed decision making and informed decision making is about risks- we're legally obliged by the Montgomery ruling to be frank and produce objective risk assessments. The problem with personalised care plans is that we're using a risk assessment tool in the first booking visit which is 60 years old, it's a paper or digital checklist and this paper or digital checklist does not look into the interactions between risks. What do I mean by that? It's like when we had COVID, we said everyone over the age of 70 is high risk and that's blatantly wrong. I'd rather be a healthy 71-year-old than an obese, smoking 40-year-old with heart disease that likely would have died, and those interactions were not taken into accounts. What that means is that we stigmatise about ¼ of our women and call them high risk, and the 75% we call low risk and we send off to have informed decision making about the care they want. That population contains 80% of the stillbirths and 85% of the pre-term births in the population so our basis for risk assessment doesn't work. And the real nail in the coffin is we do a risk assessment, we call someone high risk, and then if the woman was to say to me "doctor, what is my risk?" I'm unable to give her a numerical value for that risk because the checklist-based system is 60 years old. There are things right now (and my particular bugbear right now) and this is initiative that the Tommy Centre is trying to promote, is to introduce objective risk assessment in the first trimester, both for placental dysfunction and for pre term birth so that women can make truly informed choices. So I think, personalised care planning will, of course, for the majority women meet their needs because the majority of women will have healthy pregnancies, but it doesn't take into account the fact that we stigmatize 25% of women and call them high risk, and the introduction of accurate assessment can

deescalate risk in over half of those women and let them have access to proper midwifery care and not be forced into medicalisation. And the second thing is if we introduce proper risk assessment in the first trimester of pregnancy we can double our prediction for pre-term birth and still birth, and we will then actually have the opportunity to potentially reduce still birth and pre-term birth by the date set by the Government. But if we carry on with the 60-year-old checklist system, we're never going to get there. That's the definition of madness, isn't it? Doing the same thing over and over again and expecting the results to change.

Soo Downe: So, Einstein said apparently. Just before I move on, I want to probe a little bit into what you said there because I think that's fascinating and very helpful. Do you think personalisation is only about risk, or do you think it's also about benefit? Is our focus on risk obscuring the fact that there is also benefit?

Participant G: Absolutely. I think we can absolutely talk about the chicken and the egg etc. and I think you're absolutely right, but if we don't get risk assessment right, we can't talk about the potential benefits of interventions. There is no point telling a truly low risk woman we've stigmatised as high risk about the benefits of intervention when she didn't need it in the first place. So, if we don't get risk assessment right, how are we going to possible talk about beneficial interventions when we haven't assessed her risk appropriately. So fundamental to this is assessment of chance, explaining that chance, and then basing our personalised campaigns. But Soo, don't get me wrong, I'm not talking about the 95% of women who will have a good pregnancy outcome whatever we do, I'm talking about the 5% of women who have stillbirths and pre-term births. We're doing them a disservice and we've been doing that for the last 50 years. We've got to change that. And if we carry on and have a great system for personalised care planning, but we still have the same number of stillbirths I would argue that we're not delivering good healthcare.

Soo Downe: Great, thank you. Participant C.

Participant C: It's really interesting what Participant G said because I feel that in good midwifery care, good multidisciplinary care that allow midwives and obstetricians the time to spend with women, you are constantly risk assessing at every opportunity then, so that it's not wholly reliant on that initial risk assessment that you do at booking. We don't use the national notes at our Trust, we use our own bespoke ones that change regularly according to changing guidelines, and it does include placental dysfunction and risk of still birth, so it is quite holistic in that respect. But I feel if we can actually get the midwife support right, and allow women time to send with the midwives who are not feeling rushed, not running through a tick list or who don't have time to safeguarding… for example our specialist enhancement team, who support women with social care and safeguarding issues has been reduced, they're not taking on women in the numbers that they used to, so the team of midwives are now caring for those woman as well. So, you've got this thing- I'm sorry I don't know who said it- but about midwives becoming general practitioners but also becoming social workers at the same time, and so that risk assessment gets blurred all the time. With personalised care plans are we talking about the book that is printed and put in the booking notes, or are we talking about personalised care plans where there is individual planning that goes on with the midwife, the obstetrician and the multidisciplinary team? Because I perhaps there is a little bit of a focus on the booklet and we should be refocusing that energy and that investment within the time that the midwife has with the woman. I know that's the idea behind continuity of carer, but I think if we're distracted by something like the booklet that the woman may never look at again then we might just be missing a trick by muddying the waters.

Soo Downe: Thank you very much. Participant D?

Participant D: I could not agree more about better, let me say, benefit assessment at the beginning. I think we have to anchor it, but that has to change and adapt all the way through the pregnancy journey. So, this is not just about booking. We do one assessment and then it's ossified, never to change again all the way through. I think that that is wrong too, but I think there's more to it. We have to think of it as a continuum. In labour, for example, at the moment we ask the question 'Is the CTG ok' when we should be asking 'is the baby ok' and it's bananas that we just forget everything else apart from this little tiny heart rate trace. I think that's part of this more sophisticated system, but we also need to say what matters most, what's important for you. So Participant G and I both cycle across London every now and again, now most people say he's a lot quicker than me, he's got a nicer bike, but a lot of people say 'God that's so dangerous, you shouldn't do that', but you're allowed to take risks and you're allowed you're allowed to do what's right for you. But you're also allowed to say what you're terrified of and what you don't want. And I think we have to capture that and use it in a really sensible way. And my last point is, and we talk about it all the time in the training stuff, let's make the right way the easy way. Let's make it easy for people to do this personalised care planning. Let's integrate the Tommy's app that we've been working on, let's integrate other systems into standard practise, so it's actually easier. On Participant C's point, if you look at the information you have to provide at booking these days, it's about a two day appointment as far as I can work out in the community, so let's make it easy by integrating some of these aids and tools into our standard care, so that's is easy for women and it's easy for professionals to get this personalised care planning. Let's make it easy to do.

Soo Downe: That's great, and actually I think we're answering all three of the questions in this segment in the conversation, so I think we'll just let this run so that we do cover those three things. Before I go to back to Participants B and C is there anyone else wo want's to come in.

Participant E: It's been touched on already by other speakers, but we use an old system. It's like using a very old net; it's not a very fine mesh and too many people are caught in it who do not need to be there and there's not enough time to focus on the people who do. It needs to be much more responsive; risk changes and it's fluid. I think the advent of the Tommy's app is going to be really important. We're missing some major risk factors like ethnicity and the concept of multiple disadvantage. It was used in the pandemic for risk, but is not among the reams and reams of things that are ticked off in a personalised care book. There is focus on the fact that many women have this information available on their phones. That doesn't suddenly make it more worthwhile and exacting information - it's just on your phone. It's not sensitive enough. Personalised care may be changing with each visit, depending on how high risk that woman is. I very much agree with the idea that the woman uses that information. It does not mean that there is no way a high risk woman can go to the birth centre because there can be a discussion about it. It is her risk and her right to do as she wishes with that information. But the type of conversation you have with a woman who has a proper personalised care plan is a totally different therapeutic conversation to what we're doing at the moment. We are catching too many people in the net and medicalising them unnecessarily.

Participant F: So, the clue for me is in the name. It's personalised and how do you get to know a person? You spend time with them, you listen, there's trust and respect each way. The current system isn't affording that, and therefore that's where disillusionment sets in, because it's not personalised, it's a tick box exercise, so we need time to do this.

Soo Downe: Thank you.

Participant A: So, I think Participant F's actually just beat me to the post about this as that is exactly what I was going to say. To be able to have detailed discussions with women, and to change plans

and respond to changing factors, during antenatal care you need that time to sit down and talk to the woman. A 15-20 minutes antenatal of obstetric appointment might be adequate for some women, but for lots of women more time that is required. And you need to be seeing the same woman back again repeatedly, which when you've got half a clinic that's a registrar that changes each week or it's a locum if short staffed- going back to our staffing levels- and you've got the consultant, that's doing half that then you don't necessarily see that same woman again. I think that's even more of a challenge than the continuity of carer from the midwifery point of view is how you provide that for the higher risk women that are coming to the antenatal clinic to be seen.

Participant B: Thank you, I would just build on that point about continuity that everyone is making, and this is where midwifery continuity can make a huge contribution, because you don't have to have these repetitive conversations that drain women, having to tell their story over and again and actually you do build a complex relationship where there is understanding of what that family actually wants. And the second point I'd like to make is just on the concept of risk. I think we need to let go of this idea that somehow there is a perfect way of doing things, that if we just put this in and that in it would somehow create a perfect outcome for every woman. Sadly, that is not the case. We want to understand what is the right outcome in the right circumstances but there is no such thing as a perfect risk way of entering into this situation.

Participant G: Very briefly, I couldn't agree with Participant B more. That's the concept of risk, it's not perfect. If I say that's the risk of the horse winning it doesn't mean it's going to win or that it's going to lose. So, absolutely by explaining risk properly, women can understand that there's a chance and it's not a certainty. The second thing is Participant E made a very sensitive point about ethnicity and it's important to point out that the current checklist, worsens the health divide, and the introduction of an algorithm integrates ethnicity into that risk assessment. The only way we are going to lessen the health divide in ethnicity is by introducing such algorithms that take in and integrate risk assessments and include ethnicity.

Participant C: The point I just quickly wanted to make was that we've talked a lot about risk, about outcomes, measurable outcomes, stillbirths, pre-term births, etc. but really at the heart of the personalised care plan is that positive birth experience, so that positive pregnancy, birth, and postnatal experience, and so much of the care just drops off after the baby is born. We need to remember that it's the journey and a lot of what midwives do is not just about the skills, it's emotional labour and supporting women to have a positive birth experience and that's such a big part of the personalised care planning. I think it's just worth remembering that it's not just about measurable outcomes.

Soo Downe: Thank you, that's really helpful. We've got about seven minutes left for this section, and I think what I'd like to do is have a bit of free ranging conversation about the final question which is: to what extent are staff able to enact personalised care plans? And that's kind of tied up, perhaps with training and education which we've already touched on to an extent, so we don't need to go to that too much, but I think the interesting thing here is what if a woman makes a choice that is countercultural for the organisation that she is booked with? What happens when the choices she makes on her personalised care plan are not choices that are necessarily offered or supported by the organisation she's with? How do staff manage? How do you think staff can be able to manage that potential clash?

Participant G: Can you give an example Soo?

Participant D: That happens every day. We had someone with four previous sections who wanted to have a baby at home

Participant G: Why is that countercultural?

Participant D: That was her choice and that's just an extreme example. We have this all day, every day. In fact, we have a whole team just for this. There's a midwife in charge of a group who just discuss these kind of elements. The bottom line is all women deserve support and all women deserve to be listened to. You're allowed to drive a motorbike across London, I wouldn't say that was a great choice, but it's a perfectly rational, reasonable choice by today's societal standards. So, we just have to make sure that people are not making uninformed choices, but if that's the choice it makes it more difficult. I think it is more difficult supporting the staff who have to care for them in difficult situations. I think that's a real tough one. You expect two community midwives to go and look after this woman with four previous sections who are terrified of this, at least partly because people like me go 'oh four sections at home!' So, I think there are issues. Of course women should be supported in every single decision they make, but we also have to support teams and staff because these are tough times for people and staff are very vulnerable too and staff are worried that they're going to be sued.

Soo Downe: Precisely, that's my point. You've talked exactly into the space that I think is interesting for conversation here, because the question really is do you think that most Trusts would respond in the way that you've set out.

Participant D: Unfortunately, I've already been ascribed as elderly and I'm nearly 60, which is the same age as Participant G's checklist, I've been in the hospital so long now that you don't know quite what happens outside it and that's real issue. I don't know, is the simple answer and maybe ask other people if they know. Do they have similar systems in their hospitals or someone like Participant B, who's in charge of a whole series of services, may have a much better handle on it than me? But, certainly, that is it's a well-established thing for us: there's a consultant, there's a consultant midwife and there's a whole way of doing it.

Participant C: I think in the Trust that I work in we're pretty good at this and supporting women to have whatever birth choice they want. I don't think that that's necessarily representative of the wider picture because I've been a lecturer and I have seen the different practices across the Trusts that our students go to. Some Trusts, for example, don't even use pools for women who have no complexities, so water birth isn't a thing for them, it's just not an option. So, women don't have the same choices across the wider network. Unfortunately, they just don't. So, if they don't have the traces at the basic level, then when it gets to be more complex it very much depends on the leadership and is the leadership on board with you. Is the consultant team on board with you as the midwife? We've had particularly complex cases where women have been really complex and actually our consultants have gone out to the home because they won't come to the hospital. There was an occasion where they up staffed the whole unit over the weekend that this really complex lady was due to have a complex birth, to facilitate three midwives going and a doctor if necessary. These things were facilitated and put into place, so I think it's really careful planning and really good culture and really strong leadership that trusts its staff to make sensible and safe decisions as well.

Participant A: So, I just wanted to echo some of those points as well. When Participant D asked does the same thing happen in other Trusts, we again have a process to manage situations where women are asking for things that don't necessarily tick the boxes. And I think we're fairly good at supporting women in those situations, but I've certainly worked in other Trusts previously where that hasn't

happened, and I do think within each individual Trust there's variation in terms of what they feel comfortable with. Within Trusts people tend to know which obstetricians to go to, to have that discussion, if we want to do things that you know slightly more off the wall, than maybe other people are comfortable with. I think it is, as Participant C rightly said, it's having a culture within a unit where we're supporting women to make those choices and to have the information to make that informed choice.

Soo Downe: Thank you, and of course as Participant D rightly said which is supporting the staff who may be nervous about their choices.

Participant A: Absolutely, yes.

Participant B: Certainly, the Ockenden Review suggested that most Trusts do have a process in place in [city] around supporting choice. I think the fact that it becomes a special thing that one has to do because a woman has stepped outside of guidelines- which is the common phrase that is used- suggests that fundamentally we might be thinking about this in the slightly strange way that we've already predetermined who can do this, that, and the other, and then it's women having to actively step outside of something pre-determined guideline rather than starting with what the woman wants and then building the care around that. I would absolutely reiterate the support of staff in situations which can feel challenging and fearful is fundamental, and that requires good leadership that says that women centred care is not punishable by the loss of your PIN.

Participant F: I think it's all been wonderfully captured, and I really couldn't add much more to it than that. I think the key thing is to support the woman but support the staff who are caring for her as well. And the tendency is not to do either because it's inconvenient. So, I think I'm in agreement with all I've heard.

Soo Downe: Thank you, and now back to Jane.

Jane Dacre: So, a universal agreement is a pretty good place from which to move on, isn't it? So, I just wanted to say that from my perspective, it's been a fascinating conversation I think and hope that my colleagues from the Committee will have captured a lot of nuggets from it. I want to remind you all that the conversation has been recorded. We will get a transcript and the transcript will be sent to you in case there's something on there that you would wish to be removed and things will be anonymised. So, the next steps from our perspective is that what we've been doing is we've selected Government pledges to look at, and today we've been looking at personal care and support plans and staffing. The information that you've provided will go back into a kitty with written documentation that we've received. We've also had conversations with the Department of Health, and we are hoping to get a one to one with the Health minister responsible. This will all go into a report where we'll try and distil the findings into a CQC [Care Quality Commission] style rating on the four pledges which will be published in its own right, but will also be fed into the Health and Social Care Committee who are doing their own maternity review. So, it will be published independently but will also inform their review. This is the first time that we have used this process and the idea is to bring some objectivity into the evaluation of pledges that are made, because our view is that pledges tumble out in difficult areas, but how do we know whether they've actually been carried out. So that's the process that we're doing and our and our aim is to have our document around the end of June, which feeds into the Committee processes. And as we've been going through the conversation we will not be making specific recommendations, but where we find that a pledge has not been met, or that it has a poor CQC rating, we're hoping that the narrative around that- which will include the contributions that you've made- will make it quite obvious what needs to be done.

We then reserve the right to come back and look again in the future to see whether any improvement has been made in in that regard. So that's just to ensure that you understand the context and to ask anybody if they would like to have the last word or words, or to ask any questions about the process.

Soo Downe: Can I just say something? The one thing I want to do is I want to reflect what Participant D said about bringing the joy back. I thought that was really pertinent comment, bringing the joy back into obstetrics and midwifery practice and I kind of wonder if that might be a kind of uniting metaphor for a lot of what's been said. That was all.

Jane Dacre: Fantastic, and Lesley do you have comments on the conversation today?

Lesley Regan: Just to say again, thank you to everybody and it really is very nice to go to a meeting where everybody is trying to push the same way forward and everyone is being very generous to each other. I think that what this is demonstrated is that we can't improve things in maternity safety unless we are working as a team, and how the obvious mutual respect between everybody here today on this platform needs to be sort of captured, put in a bottle and then distributed widely. I think that coming back to one of Participant D and B's very apt points about how we have to continue to promote training that isn't just training tick box, but training that is really meaningful and does put the joy back into everything. I did one of these conversations live a couple of weeks ago and I remember talking about being a junior obstetrician and the joy of being present at a delivery and the joy of delivering a baby and the joy of getting that wonderful note on scribble paper from someone saying 'thank you for helping me get what I wanted' and so much of that has been lost. I was on the labour ward just the other day and everybody there was really, really agitated because there was someone who is losing blood in theatre and everyone was stressed, just the misery that was there because they didn't have enough staff to provide the care that they knew each of those would want. So, I hope that the outcomes of your, if you like your critiques of the pledges, will make it so obvious what's needed. An injection of staff, I think, underpins everything in maternity safety.

Jane Dacre: Thank you, so can I just go to the to the committee team? Is there anything that we missed? Is there anything else that you need or that I should have said?

Previn Desai: No, not from my perspective. We will follow up with participants in writing and if you'd like to submit anything further to our inquiry to our work please get in touch. Thank you for your time particularly joining at short notice. It really is appreciated and from my perspective, we've got some really good quality information to drive this work forward.

Jane Dacre: Well it just remains for me to say thank you very much for a really rich conversation and I think it will be a really important part of the evaluation of the pledges that we do going forward. This is the first time we've done this so thank you for being nice about it. It's been really great to talk to you all and I will look forward to receiving the transcripts.

Thanks from all participants.

Additional comments included in the chat box

Thank you, Participant B - it's helpful to understand the bigger picture within CoC

[10:37] Participant C (Guest)

Human Factors training would be very valuable too

(1 liked)

[10:39] Participant F (Guest)

...or woven into our conventional training opportunities ie seen as integral to all practice

[10:39] Participant C (Guest)

We are allocated 7 hours per year to complete 2 weeks worth of online training - then midwives are pressured to complete in own time

[10:40] Participant A (Guest)

we had really good MDT training prior to COVID that integrated human factors - COVID has severely adversely affected that currently

[10:40] Participant F (Guest)

As are the docs - online training can be pernicious!

(1 liked)

[10:42] Participant F (Guest)

...and they understand how each other work too!

[10:43] Participant F (Guest)

'The team that play together stay together'

[10:47] Participant C Maternity Services (Guest)

Can I just make a point about newly qualified midwives also, and their lack of support - often thrown in the deep end

[10:51] Participant A (Guest)

And those of us working more than 10PAs to pick up roles

[10:53] Participant A (Guest)

I think that contributes to burnout and attrition too. There is the pressure to take more work on (clinical and non clinical) when staff would ideally prefer to work slightly lesser hours