Health and Social Care Committee- Maternity Services Expert Panel
Roundtable with NHSE/I
Tuesday 15th June 2021

Jane Dacre: First of all, thank you for giving up your time on such a hot lunchtime to talk to us. I think it might help if everybody on the call just quickly introduces themselves. I'll kick off and then I'll go around my screen, or my list of attendees, if that's OK? I'm Jane Dacre, I'm the chair of the Expert Panel. So going around my screen the first person is Previn.

Previn Desai: Hello everyone. I'm Previn Desai, Second Clerk on the Health Committee and the Head of Secretariat for this panel.

Robert Francis: Good afternoon. I'm Robert Francis and I'm a member of the Expert Panel.

Jacqueline Dunkley-Bent: Hello. My name is Jacqueline Dunkley-Bent and I'm the Chief Midwifery Officer in England. Jane- and colleagues- I apologise but I've just come back from leave today and I have to chair a meeting at 1, so I'll have to leave the meeting 15 minutes early I'm afraid.

Jane Dacre: Thank you. You pre-warned us, which is brilliant, so we're going to try and focus on you on you first, if that's alright Jacqueline. But thank you very much for coming, especially if you've just come back from leave.

Matthew Jolly: Hello everyone, I'm Matthew Jolly. I'm an obstetrician working down in Portsmouth, Chichester and Worthing and I'm also National Clinical Director of Maternity and Women's Health.

Stephen Peckham: I'm Stephen Peckham and I'm a member of the Committee.

Stephen Anderson: Hi, I'm Steve Anderson and I lead the Maternity Transformation Programme, working very closely with Jacqueline and Matthew.

John Appleby: Hello, I'm John Appleby, Director of Research and Chief Economist at the Nuffield Trust and I'm a member of the Expert Panel.

Soo Downe: I'm Soo Downe, Professor in Midwifery Studies and maternity adviser to the Expert Panel. Hi everybody.

Alison Lacey: Hello everybody, I'm a member of staff in the Health and Social Care Select Committee and I've been supporting the Expert Panel with their review.

Florence Young: I'm also part of the staff for the Health and Social Care Committee and, the same as Ali, I'm helping to support the Panel with this review.

Stephen Aldhouse: Hello. I'm a member of the Health and Social Care Committee team and I'll be working with Previn on the Expert Panel's work.

Jasmine Chingono: Hi. I'm one of the National Medical Director Clinical Fellows, based with the Health and Social Care Committee and I've been working on the maternity safety inquiry report.

Jane Dacre: Thank you very much. And as I said before, thank you very much for your time. We are recording this meeting and we'll make a transcript so that can remember what everybody has said. I hope that that is alright- does anybody have any objection to that? It's just to help us to capture the information. (no objections) The other things to say is that this is the last meeting of this group before we produce our report, so there is a bit of a speak now or forever moment about telling us what you want to tell us. Obviously after the report is published, you'll have the opportunity- as people have had before with these kinds of report- to make a formal response. I hope that that's

also ok. In relation to publication of the report, actually Previn you're probably the person who has got the most detailed dates, but the idea is that our report feeds into the Committee's report but is published separately. So, Previn, do you have any particular dates on that?

Previn Desai: Yes, that's right. So, the Committee has its own inquiry into the safety of maternity services in England, which covers some of the areas that we're looking at but is broader. We're hoping to publish both the Committee's report and the panel's own report at the start of July.

Jane Dacre: So, I hope also that people are comfortable with that. So, if we may just move on to the main body of the meeting, and I'm rushing through because I'm trying to stick strictly to time to give everybody a chance to speak, so apologies in advance. The first thing that we would like to ask you about is what we've called commitment two, which is the Continuity of Carer model. So just to remind you this that the majority of women will benefit from the Continuity of Carer model by 2021, starting at 20% of women by March 2019, and by 2024 75% of women from BAME communities, and a similar percentage of women from the most deprived groups, will receive Continuity of Carer from their midwives throughout pregnancy, labour and the post-natal period. Now, from our research so far this is a very aspirational target. One of the things that's come across to us as a Panel is that you guys have been set some really steep hills to climb, and I want to start by saying that we are on your side and our comments are intended to have a realistic review of the achievements that you've made, and those that actually we're probably going to be really difficult to achieve right at the outset. But this is a fantastic commitment and there is a huge body of evidence to support it. It's a completely appropriate ambition and it is likely, I think, to be central to improving the experience of women from Black, Asian and minority ethnic backgrounds and women from economically disadvantaged backgrounds. But we do have some questions about the implementation, if we may, so please feel free to just stick your hand up and answer, and to chip in.

The first question is that the clinicians that we've spoken to, in relation to writing the report, have shared with us that the implementation of this has been more challenging than anticipated, and we were just wondering whether you had any comments about these challenges and whether you had any feedback on how you might address some of these challenges. Jacqueline, could you go first, is that alright?

Jacqueline Dunkley Bent: Absolutely, Jane and thank you to the Panel for recognising that the intention of Continuity of Carer, as supported by the evidence, will improve outcomes for mums and babies, and will be proportionate in terms of its reach for those who are socio-economically disadvantaged and women from a Black, Asian and minority ethnic backgrounds. We are five years into the implementation of a five-year policy, Better Births and so the Continuity of Carer started at the end of year two of this five-year process, because we recognised that it would be a challenge to implement, least of all because it's a different way of working. For those that are knowledgeable about how shift patterns work within a maternity service, there are midwives that have been working, for example, on the labour ward for 30 years and implementing continuity for them means that they would have to increase their knowledge and expertise in working in the antenatal area and indeed in the community. And equally midwives who have been working in the community for 25 years will be challenged and they will need to be upskilled, educated and trained to work in the intrapartum areas, and indeed in the antenatal area too. And I could go on and on with the permutations, but just to give the panel an example of some of the challenges that we are well aware of.

In year two I did a Continuity of Carer road trip and visited every LMS- local maternity system- of which there are 44 - and the majority of providers in England, meeting with a group of people to

support them with the implementation of the rollout of Continuity of Carer, bringing really pragmatic examples based on concerns that we'd heard across the country. Not all midwives want to work an on-call system, or indeed can because they have young families, so working through with them what that pragmatically could look like, for example, in terms of one night shift a week in a team of other midwives. The Royal College of Midwives has been absolutely phenomenal in supporting the system and their members with Continuity of Carer guidance. They published a guidance and a game of continuity and gave it to each of the Royal College of Midwives stewards and Trusts. So, we're well aware of some of the challenges that our colleagues face and that's why from 2018, to the current date in 2021, Health Education England have funded training of Continuity of Carer provision across England and that totals circa £1.3million investment over three years. And what that means is from a national perspective we recognise that the implementation of Continuity of Carer is a difficult, challenging thing to do, and you can't just launch a team without education and training about what it is, what you do, how you work with colleagues and how you really provide that care around the woman, and not around the building. So, we have informational continuity, management continuity, relational continuity so that we afford the privilege of having the outcomes mentioned by the Cochrane Review, and I'll just cite the 24% reduction in pre-term birth as an example. We've also had…

Jane Dacre: Sorry to interrupt, but I was just wondering, do you have any…it sounds as if we share the view about what an ambitious target this is, but I was just wondering, in addition to your roadshow whether you had any audit data or any evidence that shows how the trajectory is going with that?

Jacqueline Dunkley-Bent: Absolutely Jane. So just to finish off, we have also produced a really clever workforce modelling toolkit to help maternity providers, in a pragmatic way, understand how to understand their workforce numbers vis a vis how many models of continuity that they wanted to implement. And that was developed nationally as well. But in terms of some of the more pragmatic elements that you refer to, in terms of data, data capture and data monitoring we have the maternity services data set that will collect data from maternity providers for women that are engaged on a Continuity of Carer pathway and also monitor continuity at touchpoints through that journey. And then of course we'll have some end data that tells us how many women have actually completed the Continuity of Carer journey. I think you asked another question and I've missed that.

Jane Dacre: I was just wondering whether we had that data, that's what I was moving onto.

Jacqueline Dunkley-Bent: Yes, so we have some data. Matthew is obviously more well versed in terms of the data picture than I, but because of the maturity of our data capture systems, and systems being able to populate the maternity services data set, we haven't got the data that I've explained in as a robust way as we would like. We should have eventually everybody that enters a Continuity of Carer pathway at 29 weeks, we will have touchpoints to check that the Continuity of Carer journey is happening and then at the end of that journey we will know how many women completed that journey. At the moment we have survey data that tells us that we have 165 teams placed in areas where many black, Asian and mixed minority ethnicity and socio-economically disadvantaged women live. And in October 2020 we had 94,458 women booked into a Continuity of Carer pathway and received Continuity of Carer. And if I give you a comparative to that, in March 2019 we had circa 10,500. So, we have the pandemic in 2020 and yet we still achieved 94,458 women booked into a Continuity of Carer model. But I appreciate and acknowledge that it is a really challenging thing to implement this.

Jane Dacre: Fantastic. So, I think Stephen's got his hand up, but just before I move onto Stephen to continue with the questioning one of the concerns- and I'm going to leave it out there and then hand over to Stephen- is that the people that we've talked to are slightly worried about the imperative that there is to document this is turning it into a bit of a tick-box exercise. So, I'm just going to leave that there with you if I may and move onto Stephen, who's got some other questions, and we can perhaps pick it up along the way.

Stephen Packham: Thanks, so I just want to pick up on a couple of things around implementation if possible, Jacqueline. I think what's been going on is great. I think most of these services though talk about this as being substantial organisational change. So, whilst training for midwives is useful a lot of the groups have talked to about the kind of difficulties of actual implementation through organisational change, and that's where they don't have the skills or support. And it does seem to vary between the LMSs as well, the kind of degree of support. So, one of the questions was, specifically how are NHSE&I now actually putting some of that implementation support into practice? And at the same time, there was also a question about whether continuity of obstetrician is going to be brought into those teams. So, I think those two together perhaps.

Jacqueline Dunkley-Bent: Thank you. It's a really valid question, let me start from the beginning. We have regional chief midwives that have been recruited during the pandemic, so there's a regional chief midwife in each region, and naturally part of the national ambition is integral to their ambition: to support their maternity providers to implement this model. Some of our national guidance that we have produced guides maternity providers how to start with Continuity and roll out at scale, and that's something to do with the core midwives being reduced and then the Continuity of Carer teams being built. Whilst you're double running with your current system and the new system, that's where the challenge has arisen. So, we recognise that. We've got national guidance to assist on that premise and we've also, as I said, recruitment of regional chief midwives and soon their deputies and project management will assist. In addition, LMS and policy support will ensure that they help providers to get this right. Because you're right, whilst education and training is important operationalising the model is important. So, we recommend a caseload of 36 for each midwife, but that's shared across the team, each will have their 36 so they'll operate a buddy system. We expect, and this was actually in Better Births, that every maternity continuity team, whether they're all-risk (which is what we recommend), whether they are high risk (some will have high risk only) or whether they are low risk they all will have a named obstetrician, and that named obstetrician will be able to support the team. And we've got some great examples of obstetricians sharing their experiences of supporting Continuity of Carer teams, where they have got to know the midwives and in doing so they've got to know the caseload of women and in doing so they've avoided some unscheduled appointments, because they've got that timely communication with the midwives and the women in their group meetings.

Stephen Packham: Thank you, that's brilliant.

Jane Dacre: Thank you. Stephen, I'm going to have to hurry you.

Stephen Packham: Just the one question on data: the 94,458 is that the full pathway? So, that's from antenatal to delivery to post-natal. And is there specific work around supporting people from deprived or ethnic minority groups as well?

Jacqueline Dunkley Bent: Yes, that data goes up to the post-natal period. We've only got the post-natal period in hospital; we haven't captured the community within that. And on your second question yes, absolutely. We've got that very ambitious ambition, the 75%, so what we are doing,

the equity strategy that we're developing and hopefully soon to be published- though not in time for your report- will support our local maternity systems and maternity providers to really focus in, proportionally, on the socio-economically disadvantaged and black, Asian and minority ethnic groups. The draft equity strategy at present is broken down into five elements that will help LMSs to understand the population, coproduce interventions, have action on maternal mobility and morbidity in experience. There's another element that looks at perinatal mortality and morbidity. There's another element that supports maternity and neonatal staff and the final element will create conditions to achieve equity. And they will be measured to ensure that that there's a measurement process that's built into the strategy.

Stephen Packham: Ok. Thank you.

Jane Dacre: Fantastic. Listen Jacqui, we need to let you go but thank you very much for your input. Do stay as long as you like, but I just wanted to make sure that your focus was at the beginning of the meeting. Stephen Anderson you've got your hand up, and then it I move on to Anita and Lesley to talk about staffing.

Stephen Anderson: I just wanted to add that NHS England and NHS Improvement, through the Long Term Plan, is committed to an enhanced model of Continuity of Carer for women from the most deprived areas and we're going to be starting the pilot for that this year, but that will be subject to a wider rollout later.

Jane Dacre: Brilliant, thank you. So, the next thing is a really tricky one, and I think this is holding you guys back in terms of delivery from what we've seen so far, and whilst we absolutely applaud the commitment to achieve safe staffing within maternity services, we realise increasingly what a knotty problem this is. So, we've got some questions for you, if we may, from Lesley and Anita around what we've found so far in this area.

Anita Charlesworth: I'm going to ask two questions that build on the conversation that we just had. We've had quite a lot of evidence that has said that while a lot of people support the principles of Continuity of Carer, and understand the evidence base for it, while we haven't got enough staff there is a real problem with introducing that, so the two questions are related to that. The first is the extent to which Continuity of Carer is factored into the calculations of the workforce we need, and in particular the 1:24 ratio, which at the moment I think your numbers are to get to 1:25, and if it doesn't reflect into Continuity of Carer how does that work? We don't know what it means in terms of the extra needs for obstetricians, we don't have a standard for that. And then the second question related to that, which came up a lot in the evidence we've received, is while we have such shortages of staff in particular, this is compounding a lot of issues around culture. And the culture is a real issue. And to pick up on what Jacqui has talked about in particular, it is the most vulnerable and those from black and minority ethnic groups who appear to have some of the worst experiences, and so we're interested as well, while at the moment you're not projected to get to safe staffing numbers through this Parliament, and you're trying to do things that require even more staff, how do you manage the fact that culture, in the evidence we've received, appears to be suffering because of that?

Jacqueline Dunkley-Bent: Thank you Anita, and again really valid questions and I know the history and the context within which those questions have been asked. Can I just say that we rely on the Birthrate Plus workforce planning tool to work out safe staffing levels, and what Birthrate Plus has told us is that you don't need additional staff above and beyond what your workforce assessment has shown that you need. And so, every organisation, because it's a part of the CNST [Clinical

Negligence Scheme for Trusts] incentive scheme must go through their workforce planning and assure their boards that they have the appropriate number of midwives. So firstly, Birthrate Plus say that you don't need any more midwives to do Continuity above and beyond the number of midwives stated in the Birthrate plus assessment. That's the first thing. The second thing I would say is that not all services have met the staffing level that Birthrate Plus has set, and that's where I think the challenge is and that's where I think nationally we have to be mindful that our ambition for meeting Continuity for most women in England will be somewhat laboured or delayed because we will be catching up with the numbers of staff we need. What I will say is that the £95 million that we've just secured from NHS England Improvement means that we will be able to recruit to the midwifery staffing deficit defined by Birthrate plus. So, we wrote out to every maternity unit and their Director of Midwifery, and their Trust told us how many midwives they were short based on the Birthrate Plus assessment. That helped us to know the deficit for England.

Anita Charlesworth: Could we offline pursue that because the figures we've had from yourselves and we've gone through suggests that at the moment we won't be consistently meeting Birthrate Plus standard across the country over this Parliament, so I think that's quite an important factual point if you're understanding is that we will. So, we ought to just follow up and clarify that.

Jane Dacre: Yes, I think so, but can I just leave that there for the moment with a view to us following up offline because we've got a huge amount to get through. Can I move onto Lesley because we've got some further questions about staffing? I do apologise for this steeple chase, but we have an hour and a lot to get through.

Lesley Regan: I will talk fast. So, Matthew, Jacqueline, Steve nice to see you again and thanks for coming. Lots of the focus group discussions that we've had amongst midwifery and obstetrics colleagues have all flagged up issues and concerns not just about rota gaps, you won't be surprised to hear me say that because as you all know we don't have an equivalent of Birthrate Plus, although hopefully one of the recommendations will be that we work on that. But so many colleagues have said that what they're really worried about is addition to the workplace rota gaps, and the attrition rates which are being exaggerated for both midwifery and obstetrics staff because of the rota gaps. So it's like a vicious cycle, and we wondered if you had any comments about that. What measures are in place to try and reduce attrition rates and as several of our colleagues have said bring back the joy into maternity.

Matthew Jolly: Shall I do the obstetric bit and then Jacqueline can come back on the midwifery point? First of all Leslie, the great news is that the Department of Health have given the college the money to develop and obstetric version of Birthrate Plus, so that work in now underway. We have struggled over the years about not really agreeing what the correct obstetric staffing should be so that will make a big difference. As you know the RCOG [Royal College of Obstetricians and Gynaecologists] and the Health Education England work very closely together and so they are already looking at the implications in terms of training places, looking at the projected shortfall in obstetricians, largely based on the Ockenden Immediate and Essential Actions about what we need to do in terms of obstetric presence on the labour ward, and prolonging that and the two ward rounds per day etc.

I think the points Anita made about staffing and culture, and the points you made about staffing and attrition are all part of a bigger picture. I'm sure when you have units where the staffing is stretched that will make it a less enjoyable place to work and that will feed into culture problems and attrition problems. That's why we're so please that the additional funding has come into maternity services to start to address those gaps. I know you've got further questions coming up later about culture,

but there is a lot of work on that wider picture. There's a lot of work going on, particularly with the fantastic RCOG [Royal College of Obstetricians and Gynaecologists] team and in Health Education England, and attrition is a part of the work they're doing on this. As further learning comes out about what we can do, then obviously we will try and incorporate that, but I think the key thing is getting the numbers right and I think there are big steps to address that.

Lesley Regan: I just really hope that HEE [Health Education England] now are going to base this on what's needed, as opposed to what that Trust has budgeted for in their establishment because I think that is always the concern, always trying to play catch up, so if they can think about what is needed for staffing, as opposed to what's in the budget I think that would really make a big difference. And I think a big difference to morale as well.

Matthew Jolly: Yes, and I think the RCOG [Royal College of Obstetricians and Gynaecologists] tool provides that structure, it provides a mechanism but which you can then hang those other steps on. Once we've described what it should look like we can start building to that.

Lesley Regan: And the other question- I'll be very quick because Jane's instructed me to speak quickly- colleagues have really flagged that they are worried that budgets for existing staff training and CPD [Continuing Professional Development] have been negatively impacted by the commitment to recruit and train new midwives and new consultant obstetric staff. So some thoughts about how we square that round hole.

Matthew Jolly: I don't think that's the case to be honest. I mean, the additional funding is to provide the extra staff, plus the funding is there for backfill to attend the training- which is where the major cost pressure has been. So I think that actually the additional funding is addressing a lot of that. Lots of the training itself is multidisciplinary training, which is led in-house.

Lesley Regan: And almost every person we spoke to was concerned that that (training) was the first thing that went during the pandemic and has been very difficult to reinstate.

Matthew Jolly: So if you look at the plans for that £95 million that's been announced you will see in that the answers to your question.

Jane Dacre: So that came later didn't it? The chronology of that might explain the confusion. OK, so Lesley thank you. I'm sorry I'm going to move onto Soo and Robert and this bit is about personalised care. We absolutely welcome the commitment in this area, which is really important, and I think we're worried that the group of people that we've been talking to want it to stay but realise that currently it's a study. It's a big challenge to make it work. Soo, can I hand over to you and Robert for the next section?

Soo Downe: Yeah I'm just thinking Robert, I've got four questions listed here for me but I'd like to take the last one if possible, and then maybe Robert might take one of the others, because I think it speaks to some of the other things that we've been discussing. So, if there is conflict between what's recommended as best practice in guidelines and informed decisions made by women, how will this be managed? And this is a real problem for staff, both I think in obstetrics and maternity, when women make choices that are either not available because for example, the Trust doesn't have all four places of birth, or when they're seen as out of guidelines. And staff get caught in a space where they are professionally mandated obviously to provide what the woman needs and wants, but the Trust might not support them in making that provision. So this touches on culture and staffing and tick-box exercises, and a whole range of things. So I'm interested in your views about this.

Matthew Jolly: Shall I start on that Jacqueline? So the Montgomery v Lanarkshire ruling makes it clear that women's autonomy trumps everything else. That doesn't mean that we don't do everything we can to communicate really clearly with the woman and make sure that she gets the material facts. And we should clearly document those conversations and make sure that we've clearly explained and given the information in the most understandable way possible. But ultimately, if the woman chooses not to follow the recommended guidance or what the clinicians have suggested might be the safest way of doing things, then we have to respect the woman's view on that. We can't overrule somebody's autonomy. Well, I'm conscious that Robert Francis is here who could tell me more about the law than I ever could, but that's my understanding of the Montgomery v Lanarkshire ruling.

Robert Francis: You're right so far.

Matthew Jolly: Thank you. But it's clear that we should document it really clearly and the art of this is really good escalation within your organisation to the most experienced clinicians. They're often very good at diffusing those situations and explaining things, and certainly in my clinical experience there are several ways of finding a middle ground in most cases. It is relatively unusual to end up with a very polarised position. And if that's the case it's probably telling you a lot about what else is going on, either in your organisation or in that person's life. So I think it's respect, good communication and appropriate escalation to the most skilled and knowledgeable people within your organisation that will take you a long way down that line. In terms of actually building the skill sets to do that, I think things like using the IDECIDE tool which guides people through the consent process and giving material facts and clarification will all help with that process. Sorry, that's an abridged response as well, but hopefully it covers some of what you wanted to know.

Soo Downe: Thank you. Robert did you want to ask the other three questions?

Robert Francis: Because of the time, I'm going to combine two questions. One is about monitoring. It seems to us that the personalised care plan is meaningless unless it is implemented once it's prepared, and we wondered what, if any, steps are being taken either now or in the future, to monitor whether that in fact happens. And the subsidiary question, comes out of what we've already said which is whether when women make these choices whether they are in reality in the sense that the resource is there to meet those choices.

Matthew Jolly: Perhaps I'll start off with those again. So, in terms of monitoring what care is delivered as a result of the personalised care support plan some of those areas are easier than others. So if we look at things like the Saving Babies Lives Care Bundle, where we'll identify additional scans or additional pathways that are required for people at risk, we are developing metrics to monitor whether those are delivered or now usually using the more routinely collected data we have particularly as we move to electronic records. So as we become more digital it will be easier to monitor what care people actually deliver at the moment. The problem is that if you wanted to start to try and audit everyone's care pathway all the time, the burden will become impossible. So it's about using our routinely collected data to understand whether people receive the care or not. But in addition to that we have other mechanisms for identifying when care is not being delivered appropriately. That's usually when things haven't gone to plan, so things like the perinatal mortality review tool, the basis of that tool is to compare the care that was actually delivered with the care that the guidelines advise that people should receive. So the PMRT [perinatal mortality review tool] is a very good mechanism for doing that check to see whether people got the personalised care that was described in the care plan when it was produced, or what the national

guidelines recommend. So there are mechanisms to pick things up at the moment and as routinely collected data gets better, there will be ways of automating quite a lot of that.

Soo Downe: We did have one other very quick question Jane, if that's possible, which was a risk assessment tool. So in looking at the current risk assessment tools that are used to decide what might be offered to women at various points- might be relevant material to them in terms of Montgomery- we think they might not be fit for purpose as they were designed many years ago. So the question is, are there any plans to update the risk assessment tools used as part of the booking appointment?

Matthew Jolly: They are being updated. So things like the Saving Babies Live Care bundle again, we've moved from asking people if they smoke or not to doing carbon monoxide testing, so you have objective mechanisms for seeing what's going on. There are score cards for whether people need aspirin or not, whether there are additional risks for growth restrictions. Jacqueline, I'm sure can describe some of this in terms of the social risk. We do Whooley questions for mental health. And what's really existing is the research that's going on with the Tommy's Group that's hosted at the RGOC [Royal College of Obstetricians and Gynaecologists] - that some of you are very familiar with - where they are starting to develop mechanisms of using data and logistic regression analysis, and eventually AI, to use that data to reduce risk assessments. So we've got some things better now and some even better things planned for the future.

Soo Downe: Great, thank you.

Jane Dacre: Sounds great, because I think the comments from one of our obstetricians was that the tool was older than he was, and he did not look like a spring chicken.

Matthew Jolly: Well there are more modern tools out there. Just look at the care bundle for evidence.

Jane Dacre: Lovely, that's great. That's just what we wanted to confirm. So the last thing actually is all about maternity safety; the rate of still birth, neonatal deaths, maternity death and brain injuries, where some fantastic progress has been made in the statistics. Some really impressive work. I'm going to hand over to John, who has been having a look at the numbers, and he's got some questions for you as well.

John Appleby: Yes, I'll speed my way through. We've got just four questions. The first one is about how you set targets and we wondered whether you are, or are planning to, gather data from the number of avoidable stillbirths, neonatal deaths and so on, or whether in a sense the target already takes that into account- obviously the targets aren't set at zero neonatal death and zero still births. And if they were priced in, where has that been stated?

Matthew Jolly: Because Jacqueline has to go in about 30 seconds, so I'm going to ask if there is anything you want to say before I deal with the rest of this question.

Jacqueline Dunkley-Bent: I've got somebody starting the meeting for me, so I've got 5 minutes. I was going to pick up the surveillance, the improvement side with the maternity safety support programme.

Matthew Jolly: Should I do the avoidable deaths bit then quickly? So MBRRACE [Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK] reports talk about where different care might have resulted in a different outcome, rather than using the term avoidable. Some of the Lancet papers on stillbirth talked about avoidable, but that was very much

based on the sort of death, rather than actually looking at the care. The only way you can really look at avoidability is to do a case review. Now of course we are doing case reviews at PMRT [perinatal mortality review tool] and that's giving us the learning and also our confidential enquiries do case review, and HSIB [Healthcare Safety Investigation Branch] reports do case reviews. So those give us the learning, but they wouldn't give you a score about the number of avoidable deaths. I think that's sensible because I think if you start to score Trusts on the number of avoidable deaths, and start to dig into that, you start to drift into a blame culture and there are a lot of unforeseen consequences to that. There would be a risk of people women shaming, with comments like 'you smoked' or 'you're obese' or because they made lifestyle choices. I think we really don't want to go down that line, so I think that principle of getting as much learning as possible, either from best practice or when things go wrong, and feed that in an iterative process to inform quality improvement is the way we want to go. In terms of the actual numbers, I think there's two sides to that question. One, yes, the MBRRACE reports do give you a clue about how many stillbirths and perinatal deaths are avoidable and you can extend that to pre-term births, brain injury and maternal deaths. They give you an indication about where care could have been better, so they think that's informed the aspirations, but actually if you look at the science of leadership and setting ambitions, setting a really big ambition is more likely to be achieved by galvanising everybody than a small ambition. I think there is something about how you galvanise people by setting a really big ambition. And there are papers written on that, and I think that helped.

John Appleby: Jane, I'm conscious of time, can I at least get the questions out?

Jane Dacre: No, you carry on. I think we've got 15 minutes.

John Appleby: Ok. Well the other aspect of these national targets is that they are national targets and of course there is a distribution of events, as in where, across the NHS [National Health Service], and one of the things we wanted to know was what strategies or developments are in place to detect and support, what we should call perhaps, underperforming Trusts or units. And I do recognise that some of the numbers are very small, so you can be looking at chance events and so on in some of these measures. But yes these are national targets so what about the distribution, is what I'm asking.

Jacqueline Dunkley-Bent: Should I make a start with this Matthew? So thank you, and a really pertinent question. What we're trying to do is to ensure that we have a good surveillance across England, across our 125 maternity services. And to do that we've developed and implemented and operationalised a new quality surveillance model. And that's really designed to proactively support Trusts that require support before a serious issue arises. I call it upstream work. And this model provides, should provide, a consistent and methodological oversight of all services, specifically concerning safe maternity of course, and so the model helps with gathering, learning, insight to inform improvements. That is implemented now across all the local maternity systems, and is very new, very embryonic. At present it's shown to be working effectively. It's highlighting some of the soft intelligence that we wouldn't get through just data alone. And as Matthew frequently talks about, if Morecambe Bay has taught us anything it's taught us that we cannot rely on data in itself, we have to have that intelligence. We also then, in relation to the quality surveillance across all maternity providers, we also have the Maternity Safety Support Programme and that's a programme that we provide for any maternity provider that has been recognised by the CQC [Care Quality Commission] as for example, required improvement or inadequate, or indeed of concern to HSIB [Healthcare Safety Investigation Branch] or CQC [Care Quality Commission], or any form of warning notice applied to them or any form of inquiry. And what we've done in recent times, so that we can focus upstream with capturing services before they end up with a CQC [Care Quality Commission]

inadequate rating, we've changed our criteria by which a Trust would enter onto the programme too. So our criteria is broader, and we are focusing on services through that soft intelligence and other metrics show us that they need support before they have a CQC [Care Quality Commission] inadequate. So that's the Maternity Safety Support Programme in a nutshell. It's supported by heads of midwifery and obstetricians who will go into an organisation and help them on their improvement journey.

John Appleby: Thank Jacqueline. Two more, and then that's it from me. We know that there is an improvement in stillbirth rates nationally and so on, and again it's a distribution question in a sense. Who is benefiting and who is not, particularly by socioeconomic deprivation backgrounds and ethnic minorities. We've got data now from the Department of Health and Social Care on these distributions over time and it's clear that some inequalities are getting wider, maybe some are slightly narrowing, mostly overall there's not much change in the differences between groups. Are there specific strategies that you're pursuing? I know these are not, in a sense, part of these particular targets. And just quickly was there a health impact assessment of this which would have had to address the sort of equity issues around this policy?

Jacqueline Dunkley-Bent: Absolutely. Each LMS would have done their impact assessment so that they can be proportionate with their care provision, but also in the equity strategy this is one of the elements that services will have to act on and this will be monitored. It will help them to understand their demography so that they can be purposeful with their interventions. We have universal offers, but actually for the Black, Asian, minority women, socio-economically disadvantaged women for example in the Saving Babies Lives care bundle 2, the pre-term birth element will specifically support Black mums and South Asian mums who are more likely to have very pre-term births. We also have an initiative for the consanguinity- close relative marriage- knowing that that does influence morbidity amongst those families that choose to have close relative marriage and that's predominately the South Asian population. So we have specific initiatives that are targeted towards those communities too and that's in relation to genetic counselling, so culturally sensitive genetic services. We're just planning that, and we've got the funding for that, and we're planning how that will be deployed for families so that they can make reproductive choices. And also the Health and Wellbeing Fund, the Starting Well programme that some £7.6million will be deployed over three years to help reduce inequalities amongst new parents. And we know that COVID has shone a light on maternity inequalities and that's why last year Matthew and I wrote to maternity providers, asking them to implement four key interventions that cost nothing, but are integral to how a midwife and a doctor would work.

John Appleby: So we should read across and not treat the targets in a box. And last, and this is quite a specific issue that has cropped up in our work, certain migrant women are currently required to pay NHS overseas visitors charges for maternity services and the Patients Experience Library reports instances where confusions over this policy leads to women that do qualify being incorrectly informed that they will be charged, and as a result some of these women avoid accessing maternity care. What more can be done to ensure greater clarity in who is exempt from charges and remove this barrier to safe care?

Matthew Jolly: So in some ways this is more of a question for the Department of Health because it's part of their policy, but actually there is quite clear guidance about this. And certainly the principles were that if a woman presents in need, she should always get care when pregnant. The guidelines clearly say no woman should ever be denied access to maternity care, whether they can pay or not. I did try and go to the Patient Experience Library, to see if I could see the specific examples of what had happened, and I think trying to share those examples with the NHS so that we can identify when

things are going wrong and take that learning and improve things. But the written guidance, and I'm sure the clerks can link you through to that, are very clear about never denying women access to maternity care. There's a whole series of exemptions, for instance refugees are exempt from those charges anyway. So I suspect that there might be individual cases where individual people aren't aware of the guidance, and I think in an organisation this big there will always be those glitches. And we need to learn how to minimise those as much as possible, but without the specific examples it's really hard to say. But the guidance gives the clear intention.

John Appleby: Thanks Matthew, that's great.

Jane Dacre: I think that probably gets us through all of our questions. So, is there anything else that anybody would like to add by way of clarification or further questioning? I think it's been fantastic. A really, really helpful meeting and lots of clarification for us over areas that we were a bit perplexed about. So thank you very much for your positive responses to a meeting which could have made people feel uncomfortable, but your honesty in the way that you went about the discussions has been really helpful. Also, it's reassuring to hear about the inequality strategy. That sounds like a fantastic innovation that will really improve the situation for some groups of women that we've seen coming through who may be disadvantaged by the way we're currently working. So it really comes back to me to thank everybody, Matthew, Jacqueline, Stephen, for your honesty and the answers to the questions. Thank you to the Panel for allowing me to beat you into asking things far more quickly than you might normally have liked too. And thank you also to NHSE/I [National Health Service England and Improvement] colleagues in keeping your answers so succinct and clear so that we got the answers that we needed. And thank you also to the committee staff for supporting us, and I think this is it in terms of our formal discussions with you. But I want to finish on a positive note to say that the pledges that have been set are incredibly ambitious. It's very impressive, the amount of effort and work in good faith that has been done towards achieving those pledges. I have to say that some areas where there are gaps certainly isn't to do with the competence and the passion of the people that are in this room. So thank you very much for you time and support of this process. Thank you everybody.

All: Thanks.