Health and Social Care Committee- Maternity Services Expert Panel
Roundtable with clinicians (2)
Wednesday 26th May 2021

Jane Dacre: My name is Jane Dacre. I'm the Chair of the expert panel and there are some of the panel members on the call here, but also very kindly a mixture of midwives and obstetricians who've given up your time and we're very grateful to you for coming. Before we start I just need to let you know that for the purposes of transcription this meeting is being recorded. So if you don't want to join speak now or forever. The transcription will be sent to you and you can ask for anything to be removed after the event should you need to. As soon as the transcription has happened the recording will be destroyed. To start, if you could all introduces yourselves, and very briefly what you do and what your background is. So I'm going to go around my screen if that's ok. So Lesley, I've got you in my top left.

Lesley Regan: I'm an obstetrician and gynaecologist at St Mary's Imperial College. I'm one of the maternity advisers to the panel, and I'm actually working with Anita Charlesworth on the workforce section, but I thought I'd come and possibly get some more ammunition for the workforce section by joining today's roundtable.

Participant A: I'm [role] so I'll do my best to provide you with some ammunition Lesley. I'm also consultant obstetrician, down in [region] and [role at] our LMS [Local Maternity System] down here as well.

Alison Lacey: Hello everybody. I'm a member of staff working to support the expert panel on their assessment of the commitments.

Jane Dacre: So in fact Alison and her colleague Florence are the two most important people here because they're listening carefully to everything that we say and are making sense of it.

Alexander Heazell: Hi I'm Alex. Professor of obstetrics and a consultant at Saint Mary's Hospital in Manchester. I'm one of the expert panel members leading the work stream on safety.

Jane Dacre: Alex is one of our co-chairs for today.

Participant B: I'm the [regional role].

Participant C: I'm a consultant midwife at [hospital name].

Florence Young: Hello, same as Ali. I'm part of the Health and Social Care Select Committee team supporting the independent panel in it's inquiry into maternity services.

Jane Dacre: Sarah, our other co-Chair for the rest of the session.

Sarah Noble: I'm Director of Midwifery at South Warwickshire NHS Trust and one of the expert panel members and I've been looking at the commitment two, which is continuity of carer.

Participant D: 50% of the week I'm a consultant obstetrician at [hospital name] and the other 50% of the week I work as [role]. The other potential hat I bring is that I'm currently the [role].

Participant E: I work as a consultant midwife in [hospital name] in London. And for full disclosure I'm here in my NHS capacity but I'm also a [role].

Participant F: I'm a consultant at [hospital name] in London. I'm the lead for PMRT which is the perinatal mortality review tool. I'm also the lead for mental health and bereavement at our trust.

Participant G: I'm a senior registrar ST6 at [hospital name] in London. I'm also [role].

John Appleby: I'm the Director of Research and Chief Economist at the Nuffield Trust and one of the core members of the expert panel for the House of Commons Select Committee, and like Lesley I am going to be lurking.

Jane Dacre: Yes, so we've got a couple of lurkers, we've got some people who are keeping a note of what's going on and we have two chairs who are also in charge who are Alex and Sarah. So, can I hand over to Alex to introduce what you're up to with the commitment and to take it from there with the questions, unless I've left anyone out.

Participant H: Hello, I'm the [regional role] and it's nice to be here.

Jane Dacre: Thank you and sorry for missing you out. You all keep hopping around my screen slightly confusingly. So, Alex over to you.

Alexander Heazell: Great and thank you everybody. Just to reiterate Jane's point, thank you for giving up your time this afternoon. So, the first commitment is really focusing on the Government's halve it campaign; the commitment to reduce stillbirth, pre-term birth, neonatal death, maternal death and brain injury. Looking through the lens of your organisations, have you received clear guidance and training about what best practice is to be achieved to reduce these outcomes and has there been clarity about that?

Participant F: So, we've just started this initiative with the, as mentioned earlier, Perinatal Mortality Review Tool, which is part of MBRRACE, and it works across sites and we have a fortnightly meeting and it looks at all the stillbirths between 22 weeks to one month postnatal. So I think, given that we've been able to collect a vast amount of data, and we're looking at outcomes, and we're able to disseminate that within the trust, that's been quite helpful because there's a clear structure there and it gives us an idea of what we are looking at. And particularly to our trust, what specifically we need to be doing to try and reduce these rates. So I think that particularly has been very helpful. We were also part of the design study, looking at the gap grow chart, looking at customised growth charts, trying to reduce the stillbirth rate. I think the outcomes of that weren't particularly outstanding, the numbers were too small to make any difference, but certainly it's helped in terms of identifying small for gestational age babies.

Alexander Heazell: Ok, just to participate in the structure of the trial. Outside that, do you think there has been clear guidance about what's been implemented. Participant E your hand went up next.

Participant E: We have received guidance in terms of the core competencies framework, so we are in the process of implementing the core competency framework, which means our mandatory training is going up in terms of duration. So we had three days and it's going to go up to five days from June 2021. Of course that also has prompted teamwork kind of training to improve outcomes, however, you know, I think I also have to raise the issue of releasing staff to attend this training. There have been issues with the impact of COVID, but also the midwifery staffing and of course the support in terms of back filling or financial incentive to do that. I think for a period of time our practice development midwives team had to be redeployed to clinical areas so there was a temporary suspension of mandatory training. Some of the training has been moved to a virtual platform so it is happening on the virtual platform, but it is not the same, particularly with the simulations.

Alexander Heazell: So, that's been a decision in your unit to extend the mandatory training to that length?

Participant E: Yes, to implement the core competency framework.

Alexander Heazell. Thank you. Lots of hands now. Participant A, I think you were next.

Participant A: I've got so many different hats on here, but as myself from a clinical perspective and what's come down from the LMS, I would say all the stuff about saving babies lives, the actual guidance has been very clear. I don't think there is any doubt about this is what you should do and this is what we've been asked to do. The implementation has been the challenge and I probably don't need to tell you that, given that you've written a paper about it, but I can reiterate it for you in terms of if you implement this thing as it's been laid out, there are lots of unintended consequences around some of this for both women and for our service. The best example of that is foetal movements basically, in terms of the amount of extra work anxiety, the number of inductions and the whole knock on effect of that has been absolutely astronomical is what I would say. The number of people who have to intervene is so huge to actually prevent one adverse outcome. So I think the actual guidance is clear about what they recommend, but actually you know in truth and honestly… in my own organisation, for example, we have not implemented all the scan guidance because we simply have not got the capacity in terms of ultrasound capacity, to be able to scan every woman. Plus, the fact that actually there isn't the evidence that if you scan every single woman that's on that list of people, that that actually improves the outcome. And so this then becomes a balancing act within your own organisation as to what you think are the best things that you should be doing to get the best outcome for the women that you're looking after and with them. We've undertaken various forms of training- and I think we should come back to training but I want to give others the opportunity to answer the first bit-, but I have some significant reservations about the way we do training for some things and we need to think really carefully about that, although I would say that as the Director of Education. Sheep dipping people to do things is not the right way to bring about change in practice.

Participant G: I want to echo a lot of what Participant A and E said. I think speaking from a trainee perspective, it was very clear from 2018 exactly what we had to do and what the four- and then the five- different points of the Saving Babies Lives Bundle were. I think because we move Trust every year, you can see the different ways Trusts try to implement the guidance and I think going from a DGH [District General Hospital] then to a teaching hospital you can really see the lack of resources that a lot of DGHs have to deal with, and what they're trying to do. Trying to make do with what they have in terms of lack of sonographers, trying to implement extra scans where they can or cannot, and then trying to do the best in terms of individualised care but staying within that guidance structure has been, I think, a real struggle sometimes for trainees moving up and deciding what is the best way to manage patients.

Alexander Heazell: It's been quite a long time since I was a trainee, but I think one of the things that changes a lot is how different hospitals interpret guidance, and how much of a problem is that do you think? And link that to the uncertainty around management that creates?

Participant G: I suppose thinking about the three different stages of training and I'm coming towards the end. When you're starting, you're trying to become more comfortable in the fray with the national guidance that the RCOG [The Royal College of Obstetricians and Gynaecologists] distribute. You go through your part 2, and then especially, I'd say again in teaching hospitals where they have a lot more power and clout and the confidence to say we don't necessarily need to treat the guidance

as more of a clinical law. It's trying to rationalise the two of how you've been trained to practice, which seems to be carried out in a lot of DGHs, but then I've noticed that difference going through a teaching hospital, and trying to rationalise the two I think that's something that's a struggle for some trainees. I can't speak for all trainees and that's something that's been very interesting to witness and be a part of.

Alexander Heazell: Yes, I think so.

Participant D: Lots of great comments already, one of the things I think is really important is about the balance between individualised risk, population risk and the trade-off of what happens if you make decisions clinically to induce one woman, the trade-off may be that another woman doesn't get that one to one care from a midwife because of the stretch of staff. And that constantly clinically for me is always a big balance that is playing out, and that's really difficult because individualising risk we don't have the tools to be able to do that. We know lots of stuff about population risk, but not necessarily about that one individual woman's risk. My last point was something that we talk about a lot at [organisation], coming back to those guidelines, about this concept of work as prescribed, so what we might put in a guideline, and work as imagined, what we all think as clinicians that we're doing but actually subtly what we actually do is different. And then the other bit of it is also what we think we're doing, and what we tell people we're doing, for the work as disclosed is different. So although we may have guidance, in some areas that doesn't necessarily follow through to actually the care that is delivered, and that may be for all sorts of complex reasons. But not only that it's very hard often to actually do what the work as prescribed.

Alexander Heazell: That's a nice way of looking at it. There are balances to be struck all the way through this system and that and that sort of level of nuance is very difficult to introduce a system wide level.

Participant C: I just really wanted to sort of reiterate, I suppose, what the speakers have said. Certainly I think, as Participant A said, the guidance is very clear and very descriptive. The problem is that it comes without any sort of resource behind it, so as Participant E was saying there are training requirements and the list for training requirement seems to grow and grow year on year, but there isn't any sort of additional resource to uplift your workforce, so your capacity to be able to fulfil that is limited. So you're then trying to do training to make you service safer, but in order to do that you're having to take away from clinical care too which is making your service less safe, so it's getting that that balancing act right. I think guidance is guidance but when it comes with requirements that you have to fulfil, say through the CNST scheme that have you achieved everything within this and you have to report on that… certainly within our LMS we have to report very regularly and report to the national team 'how are you achieving as a unit and as an LMS against these required standards' and it leaves little flexibility. I think that certainly working within an LMS you see the differences in the resources from the different hospitals and different units. So where one hospital may say yes, that's fine, we're not having any issues with that, say for scanning capacity, and another hospital down the road may be really struggling with it. How do you get that balance and that equity for the women? Because the women should be able to go to any unit and expect the same standard of care. I think there's a lot of work to be done, and I think that all the time you are trying to balance this safety trade off and think which bits are OK not to do and which bits do we definitely need to do, and how do you justify that reason. When actually if you had the correct resource behind it, you could implement everything from an evidence based perspective.

Alexander Heazell: I think that's a really good point and I want to come back to it, and perhaps touch on with everybody. Participant H, how does that work for you at a regional level?

Participant H: So, as you say it's sort of a helicopter view, overseeing the whole region. So I think our roles have been quite new as regional Chief midwives, but I think it's a really good opportunity to be able to put new structures to enable greater oversight of what's going on within each provider organisation and helping to support the LMSs is to pull it together. And as Participant C said, sometimes you can see differences with different organisations moving further forward than others, but it does give you that ability to identify that and put extra help and support in to help bring them up to the same level. I think that is the advantage with having the oversight. It's not so much about having scrutiny, it's more about being able to provide that help and support that they might need. So for example, one of our organisations has had trouble with providing the scanning element and we found out that that was because they didn't have enough sonographers. They're a split site, so on one side they have trouble recruiting, so we were able to support that by working with our nursing colleagues and the radiography lead within the region, and now they've got their sonographers to fill that gap and they're able to provide that requirement. So I suppose it's a different way of looking at it, but I think the structures that are being put in place with them, like the Perinatal Safety Quality Oversight groups in each region, are helping to us have that oversight to see where the gaps are to see where help and support required.

Alexander Heazell: Thank you that's really helpful. I said I just want to come back and just touch on one particular thing because several of you mentioned resource in different kind of ways. Participant E, you brought that as a human resource, but either way we look at it, whether it is PMRT or anything else, all of this has required work and input and hours. Do you think this is something that has been adequately resource or inadequately resourced?

Participant A: Inadequate resource is the easy answer, of course. So the major problem with all of these initiatives is our workforce, so we have not got enough of anything. In order to do this really well- and we're going to come on to this with continuity of carer- you have to have a workforce, a midwifery, obstetric, ultrasonography and maternity workforce that enables you to not be stretched at every turn and to have people who have some oversight. And if I look with my LMS hat on, in terms of trying to provide opportunities for regional oversight for people to go and support other organisations when they're reviewing their outcomes, that is just extremely difficult because we actually are struggling to run our own service with the number of people that we have, and the fact that we've got locums in this system in terms of the medical workforce. And that applies just as much to the midwifery side as well where we have our senior midwives having to hit the floor when the proverbial hits the proverbial because it's so busy. We've got two consultant midwives, you know we are a big teaching hospital, but we still have significant problems in terms of our staffing. So that's the fundamental thing that if we could get that right, that would give us a huge amount of resource in order to be able to both have people in the right place to take on these extra workload and to release people in order to learn together, which is one of the big things that improve safety. If you look at the published literature on this, lots of different evidence, says if you get people to learn together, they will perform better together as a team and you'll get better safety. And until we get to that point, everything is going to be a struggle.

Participant B: I just wanted to second what Participant A has said there. From an LMS perspective when you're having this oversight and you have massive variation because of workforce capacity issues, and you're also limited with clinicians maybe not being able to provide appropriate time, and through a pandemic people being redeployed, it's extremely hard to be able to steer all of that while still kind of wading through the mud yourself.

Alexander Heazell: It all has a knock-on effect doesn't it. Everything that we've spoken about requires resource at some level, and it's unrealistic not to have that.

Participant F: The only thing to say is because of workforce capacity and resources, it means that some of us end up wearing multiple hats. And sometimes the overlap is quite straightforward, if you're doing PMRT and bereavement, but other times it would be helpful… certainly I've found particularly, when we're talking about ultrasound capacity and stuff, it means that the guidance isn't actually being followed because we have to modify criteria to suit our department. So for example, the guidance might say a woman with a BMI of over 35 needs to have a scan, but we can't accommodate it and we change that to make it BMI over 40. But in fact we're doing all the other women a disservice and so the reality is the guidance might be there, but when we have to try to enable that to happen on the floor is it's a bit more difficult.

Alexander Heazell: I think there is a debate, isn't there about whether national clinical guidance is pragmatic or whether it's aspirational. Because obviously if you always have national guidance that is always within what you can provide, we will never develop anything, maternity care will stay just the same as it was forever. And we won't down go down the route of continuity of carer because we'll say well, we can't possibly deliver this so we're not going to try, and we know that's not the right thing to do. So I think there's always a tussle between synthesizing what we should be doing and then interpreting that at a local level for what we can actually deliver, which isn't the same.

Participant F: Sorry, can I just add one thing and that is to actually look at what our targets are and what they actually mean now. So, traditionally people used to look at reducing caesarean section rates, but actually the reality is that maybe that's not necessarily, in certain contexts, the best thing. I noticed there was something about reducing the pre-term birth rate from 8 to 6%, but you know the distinction between, for example spontaneous and iatrogenic pre-term birth and is that something you really want to do, because perhaps you're actually improving care in the context of preeclampsia. So I think it is important to decipher and look into the rates that we're trying to achieve and ask if that is really realistic anymore?

Alexander Heazell: A valid point.

Participant E: I echo what everybody else has been saying, but I think the funding for back filling is very important and I know the Department of Health and Social Care used to have a budget for that to release staff to do the training. Because I think you know for us moving forward to the five days a week of mandatory training, if you are a part time midwife, that's two 1/2 weeks out of clinical practice so, how we're going to fill the rota and fill the gaps? think it's very important that this aspirational vision but I think you need to have resources attached to that for it to translate in practice. And I really think we need more midwives and we're always saying that, but any London trust may have 20 vacancies right now so the high rate of midwifery shortages is definitely going to have an impact on that.

Alexander Heazell: I think Lesley is probably rubbing her hands together with glee at these responses for her element. I just want to move on. Thinking specifically about women from black and minority ethnic groups, and also women who are economically disadvantaged, have you had any support to specifically improve outcomes in this group? Because we've been aware for quite some time that these groups have persistently worse outcomes and has there been any targeted support.

Participant B: I can only say from my LMS perspective at [region], but this is a work stream that has been quite high on our agenda. I think we have had some support but where it stopped is when it's come back to training, not only for a workforce capacity issue but just from a prioritising of the risk. So we had some opportunity to look at unconscious bias training specifically for maternity services and this was pursued to a point and then stopped due to resource. My argument here is that the risk

of death is still a risk of death, and so where we prioritize and make resources for saving babies lives and other agendas, It just still feels like….although we've been supported to do some work, we put a project together where we had a series of listening sessions for two months to gather the views of service users and we've set up a maternity network with some cultural competency seminars, it's only gotten so far and resource seems to be the limitation again. We've got a non-English speaking team at the one of our providers as part of the COC[Continuity of Care] model, and we're looking at how that can fit into the rest of the COC developments, but I think there's still more to be done.

Participant D: So, in my trust we have run our first pilot, and we're just about to do our second pilot of three, 2 hour cultural awareness session that's been a mixture of clinicians, of all different clinical backgrounds, and also with women from our MVP. Our plan is that over the next 12 months everybody across the department will attend that. It's being done virtually- as everything is at the moment- and it's a lot of small group discussion trying to explore some of the issues trying to have a safe space for discussing and asking questions and the feedback has been very positive, but that is something that we've developed internally, rather than it being something that has been given to us to do. But it is certainly a priority for my organisation.

Alexander Heazell: Just to be clear, that's a choice that your organisation has made, rather than that being fed downwards.

Participant D: Correct.

Participant E: Similar to what Participant D was saying, we are very lucky because one of our MVP chair is the co-founder of FIVEXMORE so we had some training for staff, starting with midwives and obstetricians, but I'm not aware of any operational support in terms of financial or resource systems to improve outcomes for BAME women, apart from the continuity targets but I think we're going to go into that afterwards.

Participant H: We know that continuity of carer models are important for all women, but within our region we're particularly prioritising women from black, Asian, minority, ethnic groups and those from economically disadvantaged backgrounds, as the most important groups to target with continuity.

Alexander Heazell: Sorry, but again this is the same thing with Participant D, this is your region taking initiative rather than being…

Participant H: Yes. There are also some Black, Asian and Minority Ethnic groups for actions as well that are from NHSE and the LMS, these are all targeted with achieving those actions. Within our region with all of our LMS have achieved those actions, but I'm aware that not all regions of achieve them. So there are some targets around it.

Participant G: I would say it doesn't feel like there's any clear guidance or impetus from governing bodies down towards Trust and filtering down to trainees. It's either if you have your own personal interests or it's organically homegrown. I do recognise and appreciate that the RCOG has a task force that was created last September, but unlike, say, looking at Saving Babies Lives where there's a really clear bundle and objectives descriptive ways and methodologies applied to that, the same hasn't been done, I would say, for disadvantaged women at all. It still seems to be something that's pending, that's what it feels, at least anecdotally, when I speak amongst peers.

Participant A: So, Participant G is right, we have got a taskforce from the College's perspective with three work streams, one of which is absolutely focused on addressing some of the inequalities associated with race for women. But other work streams around professional progression, and also

what's going on within the college, has been happening since the end of last year and is starting to produce some outputs. But it is still fairly early days in terms of that and some national and international initiatives or recommendations are coming out. But that work within the college has people very committed to that work and working with other organisations across the board such as RCM [Royal College of Midwives], 5X etc. to try and really come up with some positive outputs that will start to address this space. Because there hasn't been anything directive from the centre, aside from the things that Participant H talked about, for the LMSs in terms of delivering those four- and I can't remember all four- but they were for delivering specific things, one of which was an SOP [standard operating procedure] around COVID for women from black and minority groups. So there were some specifics that we were asked to do as an LMS, and I've got my LMS hat on, which we achieved. Like the others who've already spoken on this issue, locally we've done quite a lot of work. We've had continuity of carer teams for 20 odd years, but those are in the most socially deprived areas and we've extended that to black and minority ethnic groups as well, although there was a considerable degree of overlap between those two groups anyway previously. But the work that we've done as an LMS is because we've chosen to do that work rather than being asked. It's not been one of the projects or priorities that's been asked as part of that maternity transformation up to this point. But I think there's no doubt that certainly as a College we're really committed to working across the board with stakeholders to try and start having some impact in this area, because it's clearly a bit of a national disgrace, quite honestly, that it was still in the situation we're at.

Sarah Noble: Shall we pick some of this up because I think it's going to overlap with some of the commitment 2 questions.

Alexander Heazell: I was just going to ask one final question which hopefully might link in a bit. It is what has been the trigger for those initiatives that all of you have highlighted for those groups. Has there been a local champion? Obviously, some of you serve more diverse populations than others. I work in central Manchester and although our single biggest population is white British, it's outnumbered by everybody else, and the impression I get is it's really from feedback to our service or an internal desire to address that rather than external stimulus. With what Participant A said, what made you choose those groups for continuity of carer first, what spurred those initiatives on?

Jane Dacre: Can I jump in there and suggest that maybe we hand over to Sarah and let's run on for another 5 minutes at the end to pick up all of this stuff? It's fantastic to hear. Is that alright?

Alexander Heazell: Yeah, that's fine. I think it will probably come out in Sarah's conversation anyway.

Sarah Noble: Thank you. So just carrying on and I think we talked about some of these issues anyway, the part I've been asked to look at his commitment two, which is around continuity of carer, and there are three questions that we want to sort of put to you today to have some discussion around. I think you've got them on the agenda, but I'm just going to read through all three and then we're going to sort of go one by one, but I know there will be overlap. So the first one is, have you received clear guidance on the meaning of continuity of carer and how to implement the model? So two questions in the one there. Has continuity of carer achieved a positive impact for service users? And the last one is what challenges or barriers have you faced while implementing continuity of carer and have you experienced any unintended consequences? So there will be a lot of overlap, but if we just if we could just focus on the first one, so the first one is, have you received clear guidance on the meaning of continuity of care are and how to implement the model?

Participant C: Right, I feel like I've lived and breathed continuity of care. So I would say yes when initially the guidance came out about what was meant by continuity of care we had, obviously the guidance through came Better Births and there quite a lot of guidance from the Royal College and initially that that very clearly laid out, what the expectation was. I think my experience and our experience- the Trust- we were very keen to get it implemented and to move forward with it. We could clearly see the evidence and the benefits that could be achieved by implementing continuity. I think then there seemed to be a little bit of a lull, and there was some confusing messages coming out and when we started looking at what all the places are doing, how it had been implemented, and there seemed to be a lot of differences. Some places doing it one way or the other doing it another, some places were doing it at a higher ratio. And so it got a little confused. I think recently the clarity has come back and there seems to have been more steer from the national team. We've had the ability to meet with our regional leads, and also national leads, about what exactly is meant by continuity, and what those ratios should look like. With regards to how to implement it, no, it seems like nobody really has a defined answer to that. Again, I think that there's more clarity now about what we need to do but it has been a bit of a challenge. It feels like we've been on this road, along on this journey, for quite a long time and so things have changed, but now we seem to be clearer.

Sarah Noble: Thank you. So, clear guidance, a bit of ambiguity but clear guidance on what continuity of carer is, but not so much clear guidance on how to implement.

Participant B: just to really say the same thing. The implementation guidance has been less clear, and some mixed messages being shared between providers. It's been a bit difficult to get any kind of standard route for implementation.

Sarah Noble: What would have been helpful?

Participant B: it's difficult because priorities have obviously been, as we've said, for the black and ethnic minority groups and socially deprived but not everybody's had the same population numbers to take that up as a priority. So I think differing population priorities across the providers, and I think if we could have had some unanimous decision on what we target first might have helped.

Sarah Noble: So broader implementation but very population specific. You know it's so different, isn't it, across the country?

Participant B: Yes.

Participant H: I agree that initially there wasn't that much guidance around implementation. I think that's got a lot stronger, and I think the appointment national lead has really helped, especially in our region. I've also made a commitment to employ a regional lead, because I think that's really important as well, so she works with the national lead and we've been doing continuity carer assurance type visits or places where they've got low percentage rates. But for me, those visits have been really important in relation to targeting the executive teams within the organisation so that they understand continuity of carer, and how to implement it. And that's really made a difference.

Participant E: I think there's been a clear steer in terms of series of publications from NHS England on implementation guidance, the targets, the policy, I think that's been there throughout. I think there was also some HEE funding in 2019 and all trusts could access it to get some continuity training, so that was great because it was some real resource attached to that for training and project management. I have to say we were probably slightly different than a lot of other trusts, in the sense that when the policy was published in 2016, we already had the 35% on continuity in

place. However, when the target came through for women from ethnic minorities and women in the highest index of deprivation, that then became a problem for the Trust in the sense that 45-50% of women in our catchment area fall into that definition and we also have 50% of women that are actually out of area because we are big tertiary referral unit. So that meant that the lack of an incremental target, if you are 35 then you have to increment by 20, then that would have put us on a different part to reach, maybe more than 35 by now. What that has meant is a reorganisation of the team to direct to those deprivation pockets and those target groups, which in a way has diluted continuity, because it's not geographical anymore, it's only targeting certain groups independent of other factors. So I think the blanket approach from the policy might not have been as helpful as an incremental target would have been for us.

Sarah Noble: That's a really good point. Something around the target, because actually we shouldn't be changing clinical practice to fit around meeting a metric, it should just be able to grow organically.

Participant D: I think that the role of the obstetrician in continuity, for me, feels unclear and at my Trust we have two sites that tackle it quite differently. So, I think that when we talk about continuity of carer, I think the guidance for the midwifery part of the team has been much clearer and I think for the obstetrics part of the team there's been very little, if any and therefore it's very complex to provide obstetrics continuity, especially with most units having obstetricians in training as part of the team. It's all very well a women being booked under my name and coming to the clinic that I go to every week, but actually she may then over the course of her pregnancy, never actually see me and may see a different trainee every time. I think that on the whole obstetrics continuity has not really been addressed, I don't think anywhere, successfully. I certainly see this [in role], that there may be a named obstetrician given for umbrella continuity, but that's not in any way the same model as the midwifery continuity of actually the same person.

Sarah Noble: Thank you. And of course there's no metrics on that because we're only measuring, the majority of appointments which are with midwives, rather than looking at the continuity across the MDT (multi-disciplinary team).

Participant A: I entirely support what Participant D said. I think there are some ways around this in terms of we have all midwifery teams are associated with particular obstetricians, but they may not be just one obstetrician, there may be more than one obstetrician to provide some continuity when we're on leave for example. So there are ways of doing it, but there's been absolutely no guidance about it. And also there is considerable variation across the country and especially specialist things like twins and epilepsy and diabetes, and actually we could definitely have some more quality gains by being a bit more insistent potentially- as much as I hate dictating. Sometimes the encouragement that people like the Twins Trust, who have been really trying to improve the outcomes for twins, has not had the traction it should have had. Again this partly also then comes back down to staffing because we just can't provide the infrastructure to enable someone to take on a specialist clinic as well as a general clinic. The other thing I would say with my LMS hat on, I think continuity of carer has been a real challenge for us, quite honestly. I think there has been clear guidance and some of it, I think, is utterly ridiculous. So, for example, we have a fantastic team in one of our trusts and getting really positive feedback, but that wasn't continuity of care because they just happen to have one more midwife than you were allowed in that team and therefore it didn't count. And I think that sort of thing is utterly ridiculous, quite honestly. That's the sort of thing that we can get to when we start everything about the metric and not actually about the outcome. So I know we're going to come to some challenges, but one thing I would say is that I've been working with my own midwifery team now since I was a consultant (and that's quite a long time) and that's works extremely well for

both the staff involved, but also for the women, but they still have intermittently not been able to provide intrapartum care because of the staffing issues.

Sarah Noble: Yes, we'll come back to some of those barriers, but if we move onto the second bit, about has continuity of care in your experience had a positive impact for all service users.

Participant A: As I say, I've worked with the continuity of care team for many many many years and I can absolutely see the positives for those women who get that care, in terms of them being supported. Actually we published many years ago about the positive outcomes within our continuity teams when they were Sure Start teams before that all got chopped because of cuts. So you know there are some real benefits. We know there are some benefits, both in terms of the outcome for women, and also in term of the relationships that you build up over the years. I know some of my midwifery colleagues extremely well. We email each other, they ring me up, I'll ring them up. It works really well in terms of the teamwork. I think it can be a really great model, but I don't think it's a model that you can roll out for the whole service. That's what I would say, but I'll come back to that.

Participant C: We've got four continuity teams now and absolutely the feedback that we get from the mums, the families and the staff that are working in those teams is very positive. We have women asking for that type of care when they're not in one of those teams, saying 'can I have that because my friend has that?' So clearly the demand is there for it. I think it's difficult to say how it's had a positive impact for all service users because not all service users are accessing that, until we're at a place where it's the default care provision we're not going to see that. But from the data that we're collecting, and the feedback that we're getting it's absolutely positive.

Sarah Noble: Thank you. The unintended consequences when you're in that transition two tier system.

Participant H: Yeah, we're definitely seeing positive experiences Sarah and also outcomes as well. As part of looking at SIs [serious incidents] we're also looking at whether those women have been in continuity of carer models, to see if it's made any difference to outcomes which will be really interesting. And that came from one of our providers having reported that they had five stillbirths, and I happened to ask her if there on continuity of carer models and none of them were so we've started to look at that across the whole region now.

Sarah Noble: That will be really interesting, and actually I'm thinking for HSIB as well, with all the HSIB data we'd be able to look at that.

Participant H: Absolutely, we've talked to HSIB in our region about that already. And also ensuring that we're promoting mixed-risk teams across the region, because that's what we found seems to work best, especially in terms of having like two tiers, so women are all included within the continuity models and I think that's really important as well.

Sarah Noble: Thank you, from a system perspective pulling into what Participant A was saying where you concentrate on a certain team of it, but then it leaves somebody else out. So it's more inclusive from a system wide approach.

Participant H: Absolutely. Including the consultant within those teams as well is absolutely crucial. And so many benefits for the obstetrician as well, I think, moving forwards if that's working properly.

Participant E: Yes, I mean absolutely in terms of positive impact on outcomes and experience of women and families in our care, and I think the system has been, because it's very well established,

has been going on for 20 years or so. The link obstetrician model works very well. It might mean as Participant D and A were mentioning, that you might not see the same consultant obstetrician, because there are trainees and all of that, but the case loading teams are working very closely with the link consultant. So it might not be the face to face consultation or whether the care planning and the personalised care planning is constantly checked between the midwife navigating the care of the woman getting the input of the specialist, an obstetrician as needed. The majority of the outcomes will be on our population mix-risk basis and we are now in the process of looking at the outcomes from our women in those areas of deprivation. So we are seeing small scale data from [hospital name] and those outcomes in terms of referral to social services, capitalising on all these social support and we're about to pilot some social prescribing, linking it with the continuity and so that has worked very well. So in terms of unintended consequences, I think again, those targets have changed the geography of the teams and there has been a lot of implication of the caseload midwives, because given that they're not based on a post code basis- they're trying to target all the women from ethnic minorities- so the caseload has changed, they're travelling much more, they're stuck in traffic for an hour going between visits. So I think you know we really need to rethink how this target influences the implementation because all the evidence on continuity is about self-governing and autonomous teams. I think the Trust, the services and the teams themselves should be given the opportunity to look at their own population, their own demographic and what works best in that area. Because otherwise translating the evidence in a very basic way is not going to achieve the same outcomes, I believe.

Sarah Noble: It's interesting. In terms of the target, and changes that have been made to fit the target, where has the driver come from? Whereabouts in the organisation or LMS or regional/national, where do those decisions to make changes to fit the target come from?

Participant E: I think full scale implementation is clearly going to take a while, so the NHS long term plan and the national drive to target ethnic minority groups has been the main reasoning to target the women that are actually experiencing the worst outcomes first and then we think about the others. Of course in a in a Trust where you had the case loading teams operating for 20 years we are experiencing what Participant C said, with women coming saying "I had that last year" but now you are low risk and not planning a homebirth so you are not eligible for caseload care anymore. So this is also something that is increasingly happening. I think there are also some consequences on midwives in terms of when they signed up for the job, they knew they were going to work in a close knit team based in a certain area looking at a mix-risk caseload, and the moment you change this case load to give them just very high risk in terms of social complexities and vulnerabilities that's honestly changing the job description, because then is a lot of safeguarding. It's absolutely fine that we prioritise women that need it the most, but I think we need to achieve a balance otherwise you have burnout, and very high turnover within the teams because they cannot cope with the increase workload because of the caseload.

Participant D: I just want to respond to one of the earlier comments on the work of [organisation] and we just need to remember that [organisation], have lots of qualitative information, but reporting to [organisation] isn't mandatory and [organisation] don't have the denominators, and [organisation] is not ever certain that it's got full numbers, so [organisation] have to be cautious when thinking about the actual numbers around it. But for the qualitative stuff behind what [organisation] is seeing and learning from continuity, [organisation] have much information.

Sarah Noble: Can you share anything? What is that saying?

Participant D: With some of the potential unintended consequences, I've just jotted a few things down. I think one of the things that we potentially see is if there is continuity and something is not picked up on during the antenatal pathway- an element of the mothers history or a blood test or an investigation- then there's this sort of potential of a lack of fresh eyes, whereas if another was to meet the women it may be that that investigation would be picked up. So we do see that from time to time. And then thinking about some of the learning that we've seen from intrapartum areas, I think sometimes because the woman and the midwife have developed such a close relationship over the course of the pregnancy, there can be what may be described as a loss of situation awareness. So, the midwife doesn't necessarily see the whole helicopter view of everything that's going on with regards to that woman's labour and that there can be some normalcy bias, so an expectation bias or a desire bias that over the course pregnancy they have got to know a woman well and understand very clearly what her sort of personalised approach to labour and birth is, and that in their human desire to support that to happen sometimes some of the signs that things might be moving away from that might not be as clear. Because the clinician is so within that that that relationship and that that lack of fresh eyes is, I guess what we're seeing might impact sometimes on decisions and escalations etc. within the intrapartum period.

Sarah Noble: It's really interesting to actually study that, to see whether there is any evidence of that, because we know that situation, or the lack of situational awareness happens, irrespective of the model.

Participant D: Yeah, exactly. And I can't tell you what the denominator of that is, and that's where it becomes difficult to understand whether that's continuity of carer directly impacting on that, or whether that is just human behaviour, and in any of us-continuity or no continuity- could be in exactly the same situation

Sarah Noble: So moving on then to the last question which is around the barriers of implementing continuity of carer and unintended consequences.

Participant B: We've had some barriers with a different outcome measures being collected at different providers, so it's just meant that the evidence base hasn't been as strong as what it could be. And on staff challenges, like it's been mentioned before, in terms of burning out and people maybe not signing up to work in this way and feeling like it might just go away if they ignore it for a little while, and it's obviously not. At the moment, as an LMS we've got five providers that are going through the change management process all at the same time, having exhausted all the willing members of staff to get COC off the ground and to be the default model, so it's just a challenging time at the moment.

Participant C: I wrote down a little list as I knew the question was coming up. So staffing, and by that I mean the willingness and ability of staff to work in a continuity model. So obviously different ways of working suit different people at different times of their lives, and for some people if they've got a lot of family commitments, a lot of restrictions around flexibility, we have a lot of part time staff in our organisation, so that makes it a challenge getting the numbers right in the team it to the amount of women that can be cared for. That's a consideration that we always have. Changing work patterns, I think when people have worked this way for the past 20 years and this is how they've always worked there, there is some reluctance, I think, to try a different way of working. We certainly found that with the teams, our experiences has been that we give them a lot of flexibility over how they work and some of them have really struggled with that because they're so used to having a prescriptive way of working and they're trying to get their heads around this. They're asking, 'what do you mean I can do it like this'. So they end up accruing a lot of hours, or not working

enough hours, or just really struggling with that diary management side of things. I suppose an unintended consequence of that is that they need a lot of support to get going and get familiar with that way or working.

Sarah Noble: And when they do, is there a benefit of that when you get through that transition?

Participant C: Yeah, so the staff really like it. We are still having to tweak things a little bit in in some of the teams, but the staff really like it. I think one of the problems that we've got is that if one of the team has sickness, or somebody leaves that team, because they work in that way, who then picks up their caseload. Again, because we're not a full-service model there's nobody that you can pass on and say you'll get continuity from this person. Those women are either picked up, and so the other members of the team's caseload get too big, or they get transferred to a traditional model of care, which is not what they've been used to or have been expecting, so that that caused us some problems. I think that introducing the continuity teams again, another unexpected consequence is that because they've been drawn from our existing staffing workforce that we've got that then is putting additional pressure on the traditional model. So for some of those midwives working in a traditional model, they found that their caseload has increased significantly because we've been sort of pulling people from different areas to try and create case continuity teams. So whilst they take a proportion of the work, because that's ratio based, it doesn't balance out. And I think that leads me to my next point, which is the workforce modelling. So, we've used Birthrate Plus historically to do our workforce assessments, but that is not based on continuity and provision of continuity worked out on a midwife to woman ratio. Before we started, we did a Birthrate plus assessment that said that you need this amount of midwives which is absolutely nowhere near enough to what we need to do a continuity model. So trying to then have that discussion with the trust board about "well, yes, this assessment that we paid for told us that you needed this amount, but we don't, actually we need this amount." I know that there has been quite a bit of work done on modelling for continuity and there is a tool out there now for that, but that's only been fairly recent, which we found very, very helpful. But that has been a significant challenge and if we could get a really robust tool that you can then say "well, we've done this assessment, here you are exec, this is what we need" that would be really really beneficial.

Sarah Noble: I'm just going to come back round. We've got about 5 minutes left and three hands up so if we could go back round, with a minute and a half each, and try to tie it all together.

Participant H: Many of the same points as Participant C from a provider level. From a system level I think one of the biggest things, which I mentioned earlier, is that the engagement of the executive team and actually getting in them in a room together to discuss it on a face to face basis has really helped us. I think a lot of the LMS have said they've made significant progress since we've done that, so I think it's wider than the maternity team, obviously and being able to myth bust a lot of the time during those visits, and target the blockers, helps them move forward. So I think a lot of it is wider, like targeting the financial Director and things like that, rather than just leaving it at the Chief Nurse.

Participant A: I agree with much of what's been said. I think unless you get the right number of midwives in the system-and we are chronically short at the moment- this is going to be really, really challenging to achieve, and there will be unintended consequences. And if you want to look at those, just look at the clinical director in Worcester resigning because of the unintended consequences have been forced out of path because of the metrics. This stuff is really challenging. I don't think that all midwives want to work in a continuity team. They will not. I don't think they ever will all want to work in the continuity team. I've seen some really damaged and burnt out midwives who have been trying to work in a continuity team and should have left before. I think it was Participant E who

raised that some of the women you are looking after are really challenging to look after, and if you're constantly looking after women all the time who are really challenging or have social issues, mental health issues, et cetera, that burns you out and it's not doable for the whole of your career. So we need to think really carefully before we say the whole of maternity has to work on a continuity model. The other but from the obstetrics perspective, you need some expertise when things don't go according to plan, and the midwives who can run your HDUs [high dependency units] and have that sort of experience, you absolutely need them there as well to support the women who are looking after those women in labour. Because with the best will in the world, you cannot be the expert at absolutely everything. And some of the uncoupling around intrapartum and antenatal and postnatal care needs to be carefully thought through. I think there are some real benefits doing continuity antenatal and postnatal care, and actually if you uncouple some of the teams, in terms of not having to provide intrapartum care as well, actually you would probably get to a model that many women would find would be very positive and would be deliverable in terms of the numbers as we as we roll it through.

Sarah Noble: Thank you. So obviously the evidence say that it's all the way through the pathway, but actually maybe what you're saying is that achieving antenatal and postnatal continuity may be better than where we are currently.

Participant E: So I'm not I'm not going to go through all the barriers other people have said, I think just thinking about the issue with the large Central London trust is also that's a lot of the staff doesn't live locally, so commute is an issue in terms of having continuity when you live an hour and a half away from the area that you're covering. I think one of the challenges is also the large proportion of women that are out of area for us, so they are referred to us as a tertiary referral centre so we could provide antenatal and intrapartum but it's impossible to provide postnatal care because they might go off to Kent. So I think it's important also to think about, when we say all women, yes absolutely, but then there are issues with the catchment areas and where your staff actually lives.

Sarah Noble: Or eligible women perhaps? Thinking about intelligent targets isn't it? I'm going to try and really surmise in about 30 seconds. Jane what we've heard going through all three questions, but the good thing is we've got 10 minutes for you to say anything that might have been missed. So, I think what I'm hearing is there it has been clear what continuity of carer is, but there have been mixed messages, and there's been changeable targets along the way when people have started, then have to change and pull back. There hasn't been clear guidance around how obstetricians, and the wider MDT [multi-disciplinary team], fit around continuity of carer. There are issues around staffing, both in the traditional model and in rolling out continuity of care, and we need to address that fundamentally to get staffing levels right to have any success in any model. There have been challenges around the operationalisation and there are so many things to consider. There's something around getting the whole system working by getting buy in from the board. In terms of the staffing, actually, what do we need? Do we need more staff for continuity of care? We don't have a validated tool. I think that I've hopefully captured some of the main points. I probably didn't write the last couple of comments down, but hopefully that reflects the main points. Is there anything that anybody wants to add?

Participant E: Just something that maybe I forgot to say, but how COVID has disrupted the whole system. Because of course we now have midwives that are still shielding, working from home, [suffering from] mild long COVID, people have been off sick for a year with long term COVID so the staffing is worse than it has ever been.

Sarah Noble: Yeah, fantastic. I think we can pick up the comments. Keep your hands up. I'm going to hand back over to Jane and then hopefully if there's other things that people wanted to add around, or around commitment one as well.

Jane Dacre: Thank you. I wondered actually, because we slightly cut you off in your prime Alex, whether there was anything that you wanted to come back on as well?

Alexander Heazell: I guess this came out in the continuity of carer target, what struck me a bit was a lot of discussion on human resource which touches on Participant E's last point about how COVID has hit that. I guess, it was really to see whether because there wasn't enough central guidance, particularly in the case of black and minority or disadvantaged women, do you think that has impacted on the resource that you were able to direct? Because you've all made individual decisions about what to do. How have you resourced those individual projects? Is that LMS money or is that individual stuff within units?

Participant H: LMS led I would say Alex. Using the transformation funding to help resource it.

Participant A: I think it's mainly come down to the fact that as I sit as the Chair of the LMS I could suggest that maybe we could use that money to do this, because everybody needs to do some work around it and using people who've got other projects within the transformation program that they couldn't move forward perhaps in the same way, that they could do some work around some of the black, Asian and minority ethnic priorities, because obviously with COVID that became even more imperative. I think one of the things that might help us if we had a national commitment to reducing the mortality rate of black and minority ethnic women. We can't get anybody to sign up to that. The beauty of having a target in terms of overall reduction is that it gives something for people to really focus on, and a four times higher maternal mortality rate for black women is, as I said, a national disgrace and I think we need to be absolutely focused on reducing that. I know that we are getting data published soon about the how that interacts with deprivation as well, and it's even worse when you take that into account. Some of these things are beyond the scope of maternity in terms of, the wider determinants of health, and that's for government to think really seriously about, but this is an opportunity for you to get government to think really seriously about it. So I would just urge you to have some of those prompts in there when you feedback around this about lost opportunities possibly to do more than we currently are doing.

Participant B: I agree, I think that we definitely need an injection of more resource into this area, and I think what the message that's being put out is it's not been a priority for so long. We know these statistics have been around for a while and it's been a little bit of lip service while the BLM [Black Lives Matter] movement is going on. The reality is that the problem isn't going to go away unless we start tackling it with effective resource. To say we prioritise agendas because the risk is death, like again Saving Babies Lives, but we won't prioritize the agenda of racial health inequalities even though we know that the risk is death, not just for black women, but for Asian women and mixed race women as well. I think that we need to do more. It's just seconding what Participant A was saying not only setting a target for black women, but we know that our neonates who are black and brown skinned are also more disadvantaged. Can we see some changes in targets there on how we reduce their neonatal deaths rates?

Alexander Heazell: The message is well heard within this group and I'm quite sure that it is something that we will carry forward to reassure people here. There is clearly a great deal of passion about this in the room and we will make sure that happens.

Lesley Regan: I think the contributions have been so interesting and I'm particularly interested in Participant E's comments about how if you actually enforce a national solution about continuity of care, we are likely to lose some of our key midwifery colleagues. Once again, I think came out in the other round table that we can't impose a national solution, we have to have local solutions, and empower those local groups or regions to have the right numbers of staff and then implement what's right for their case mix and their geography and all of those things too. So I think that the local solutions and empowering maternity units and LMSs to do what's best for their communities is really, really important message for us to get across.

Jane Dacre: I'm going to have to intervene there I think. So we've got just three seconds for Participants G and H to have your last words and then I'm going to wrap up.

Participant G: I think a lot of it has been said, but I think the focus again should be on the most deprived, whether that's black Asian, minority, ethnic or most economically disadvantage, because if you raise up the lowest within society it will impact everyone else positively, and that's what you can see during examples throughout history. Even recently as well. But I think everyone in this room is very motivated, so that will naturally happen within your own arena. So you have to have that national impetus to move it through, and I can understand it's difficult having broad national sweeping policies, but if there is some way of implying that it should have a local veneer to it, I think that might be the most helpful. We do need those champions to think outside the box.

Participant H: Just a quick point on resources. As we know providers have had to bid for funding for workforce money at the moment, but that's only for band five and six midwives and for some consultant time for the foetal monitoring lead per Ockenden recommendations. But that's just a drop in the ocean, you know. We need much more investment in midwifery leadership and obstetric leadership as well. And those things are really important to make the differences that we need.

Jane Dacre: So that's come across loud and clear. We've got one minute left, so I want to finish off by thanking everybody. You've given us some show stopping quotes, so have a good look at the transcript. The conversations been really interesting and will be really, really helpful. You know, our aim is to help make all of this better by evaluating the government pledges. We've just chosen four areas, but certainly the issue of workforce and resource has come through very loud and clear in this conversation. So our aim is to put all of this into the melting pot and come out with CQC style ratings against the pledges that we've selected, that are in your pack. So we should be doing that in about a month's time, after which I think we all will need to run for the hills because it's going to put us in trouble listening to all of the things that you've been saying. But I just wanted to say thank you so much for your time and your contribution and thank you also to Sarah and Alex for getting your colleagues to make such a fantastic contribution. So brilliant. Well done everybody. Thank you so much for coming.

Alexander Heazell: I'd just like to reiterate that. Thank you very much. Jane, as an outsider of maternity care has been told by lots of people that obstetricians and midwives don't get on with each other and that to fix maternity cave to make us get on and I think you've been a fabulous advert for the fact that actually we do get on really well and we've got the same things. So thank you very much.

Jane Dacre: Thank you very much for your contribution and watch this space.

Additional comments included in the chat box

[14:24] Participant D

The trade off is very difficult to teach as well, much comes from clinical experience

[14:24] Alexander Heazell

This is true and I think reflected in what Participant G was saying about stages of training.

[14:26] Participant A

Our trainees (senior) struggle with the decision making especially regarding induction as they worry that if there is an adverse outcome they will be held to account

[14:27] Participant G

Sometimes it feels as though our training is becoming more defensive rather than clinical in obstetrics. On occasion the two approaches serve the same purpose and overlap and other times they do not. If it is the way you are trained e.g. reduced FMs you cannot always distinguish between the two.

[14:28] Participant A

Agree

[14:34] Participant A

But MIS requires you to implement it (unless you can convince your commissioners that what you are doing is reasonable) and if you don't you lose significant money.

[14:41] Participant B

I agree

[14:45] Participant D

Passion from clinicians and the local MVP

[14:46] Participant A

Same with us -agree Participant D

[14:49] Participant B

As an LMS, yes we have. The guidance on the meaning has been forthcoming both within Better Births and in the Implementation guidance and whilst some elements needed clarification, this has been well supported by the national MTP. Implementation guidance has been less clear with occasional mixed messages being shared between providers. Adding the percentages has often felt like providers were trying hard to hit the target and missed the point of improving outcomes. More guidance about the role of the Obstetric team would have been helpful?

[14:49] Participant F

We have clear guidance; our women are booked into teams. Definitely positive for both the women and the midwives. Covid has been a challenge

[14:58] Participant B

Whilst providers are implementing it can feel like a two tier service until everyone is on the same pathway.

The women in receipt of CoC have reported very positive feedback and staff who are left to develop their own team, self managed and self rostered also report favourably.

[14:59] Participant A

Agree it is a two tier system at present

[15:04] John Appleby

Many apologies but have to go to another meeting. Thanks for the roundtable, very useful.

[15:04] John Appleby no longer has access to the chat.

[15:11] Participant B

Staff feeling unsure about the model, not involved from the beginning of the changes in the Trust, feeling "done to" , working out of comfort zone, lack of support from management, trying to fit a hospital model roster into a model which staffs the women's needs, not a building.

[15:18] Participant B

we have had midwives leave midwifery all together from the burnout of CoC

[15:28] Participant A

Agree Lesley very important

[15:29] Participant A

We need more staff

[15:29] Participant A

Agree Participant H