Written evidence submitted by British Maternal & Fetal Medicine Society (MSE0100)

On behalf of the British Maternal and Fetal Medicine Society, I would like to submit evidence to the Health and Social Care Committee on "Safety of maternity service in England." (https://committees.parliament.uk/call-for-evidence/210/safety-of-maternity-services-in-england/)

Summary:

Improving culture and professional relations between midwives and obstetricians lies at the heart of the problem when things go wrong. Addressing this issue should be the main priority of the Select Committee. Applying external pressure on maternity staff, fuelled by data from multiple sources, has certainly improved matters, but to progress further requires a new approach.

Instead, the BMFMS suggests that measures are taken to enable all maternity staff to do their best, rather than only relying on criticism for when they make mistakes. We suggest ways of improving staff culture and morale, and also to help ensure that midwives and obstetricians work closer together as key members of the multidisciplinary team. No professional barriers should deny mothers - high and low risk - appropriate care from obstetricians and midwives. Ultimately, the mother's wishes must prevail, informed by balanced advice and counselling. Restructuring of antenatal parentcraft classes is required to help mothers become better informed.

No measures will succeed unless the NHS invests heavily into maternity care to eradicate staff shortages. With litigation at an unacceptably high level, the NHS can ill afford not to.

Background: the BMFMS

1. The BMFMS is the biggest Obstetric society of its kind (https://www.bmfms.org.uk/). Its stated main aims are to improve the standard of pregnancy care by disseminating knowledge, promoting and funding research, contributing to the development and implementation of high-quality training and providing a forum where issues relevant to pregnancy care are discussed. In short, the BMFMS aims to promote excellence in all aspects of maternity care. The BMFMS was a stakeholder in the formation of Better Births, and also Saving Babies Lives Care Bundles v 1 & 2.

2. Your committee has invited submissions addressing any or all of 4 points. I will deal with all 4:

1) What the impact has been of the work which has already taken place aimed at improving maternity safety, and the extent to which the recommendations of past work on maternity safety by Trusts, Government and its arm's-length bodies, and reviews of previous maternity safety incidents, are being consistently and rigorously implemented across the country

3. In 2015 concerns about maternity safety were highlighted in the Report of the Morecombe Bay Investigation. Dr Bill Kirkup, its author, also presented evidence this year to your committee on 29 September. The BMFMS agrees with Dr Kirkup that lessons have not been learnt – hence the need for Dr Kirkup to be currently performing an independent investigation into East Kent Maternity Services – a unit I am personally familiar with, having been instructed by the Coroner as an expert witness for the coroners inquiry in 2019/2020, and more recently by the CQC, into the tragic death of baby due to substandard care by the obstetricians, midwives and neonatologists concerned.

4. However, despite evidence to the contrary from units such as East Kent, and others including Shrewsbury & Telford, safety has improved – but just not enough. Thus, in a review of Better Births 4 years on (https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf), it is commendable that there has been a 21% reduction in still-births between 2010- 2018 and a reduction of 15% perinatal mortality over the same period. This has been in part due to the initiatives prompted not only by Better Births, but also by Saving Babies Lives care bundles (v1 and 2), and increased investigation into maternity incidents by, for example, HSIB (https://www.hsib.org.uk/maternity/), MBBRACE (https://www.npeu.ox.ac.uk/mbrrace-uk) and Each Baby Counts (https://www.rcog.org.uk/eachbabycounts.

5. However, the incidence of brain injury, albeit measurements of this outcome are proving difficult, continues at an unacceptable level. In short, there are no grounds for complacency - particularly if we are to meet the target of reducing stillbirth by 50% by 2025. As Matthew Jolly, National Clinical Director for the Maternity Review and Women's Health, NHS England,

put it, we have another 25% to go. There remains a lot to be done and the BMFMS welcome the Select Committee's decision to investigate maternity safety.

6. The key problem that Dr Kirkup identified in Morcombe Bay, was **a breakdown in working relations between midwives and obstetricians**. I share Dr Kirkup's view that this issue lies at the heart of many of the problems in units found to be in need of improvement. The year after the Morecombe Bay report, in 2016, Better Births was published, (https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf). Its aims for maternity services included making them:
"…safer, more personalised, kinder, professional and more family friendly..." In addition, all staff were to be supported "to deliver care which is women centred, working in high performance teams, in ***organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries***".

7. We believe, therefore, that the Select Committee should prioritise the enhancement of professional relations between these two core professions. Dr Kirkup also gave verbal evidence to your committee that in almost all units he has visited, he can tell within just a few minutes where poor culture and inter-professional relations are apparent. Thus, although identification of a poor culture is easy, fixing it is not.

Improving the culture on maternity units

8. One approach to rectify matters is to help increase staff motivation. Well motivated staff work better and most importantly in this context, work better in the teams they belong to. We support the use of tools such as the Maternity self-assessment tool designed to help units benchmark themselves against what "good" and "outstanding" services look like. Areas examined include leadership, team dynamics, governance, application of national standards, safety culture and business development (https://www.england.nhs.uk/mat-transformation/maternity-safety-champions/#maternity-self-assessment-tool)

Identification of Problems

9. To date the approach to motivating staff has been for various agencies to identify a problem and expect Trusts to sort things out – without necessarily providing the means to do so. **Table 1** lists some of the many agencies tasked with examining cases or units when problems arise. Identification of underlying issues is clearly important, and has undoubtedly led to improvements. However, this approach is insufficient.

Table 1 Some of the many agencies helping identify problems in maternity care. No more are required.

DATIX reports – triggered and reviewed internally
Local Maternity Dashboard
Strategic Clinic Networks
Each Baby Counts
NHSR
HSIB
CNST
Maternity Data Set
MBRRACE
CQC
Legal Department
SCORE survey
GIRFT
MDT meetings
Audit meetings

10. We believe that that we are now awash with monitoring agencies and data collection tools. If the Select Committee concludes that more are required, we believe this would be a mistake. There is no need for any more. It is what we do with all this data that is the issue.

11. In conclusion, we firmly believe that extending or increasing the number of agencies and measurement tools will not lead to the improvement required. After all, "You don't fatten a cow by weighing it."

Promoting change from within

12. Instead, we believe that other measures should be introduced to improve staff motivation and morale. We do not pretend to have the answer to this problem, but it is safe to say that *external* "carrot and stick approaches", or extrinsic motivation, are, by themselves insufficient, and in some areas of the NHS maternity care, have clearly failed. Encouraging improvements in *internal* motivation such as those suggested by the American author Daniel Pink, ie autonomy, mastery and purpose, (https://www.youtube.com/watch?v=u6XAPnuFjJc), have all but been ignored.

13. Worse still, any possible improvement in internal motivation is extinguished by the external enormous pressures that obstetricians and midwives find themselves under – particularly with staff shortages. Demoralised personnel in failing units, exposed as failures, without the means to change, become more demoralised, and one creates a perfect storm for further failure. It is unsurprising, therefore, that improvements, despite the example of Morecombe Bay and others, are, to say the least, minimal.

14. In short, what is required is to create a system or environment which enables and encourages staff to do their best, not just to punish them for their mistakes.

15. If staff morale and motivation is to be improved, the issue of poor staffing levels has to be addressed. In every service provided by different professionals, there are "fault lines". These are much more likely to be put under stress and become chasms when staffing levels are low or inadequate.

16. **Thus, the BMFMS strongly believes that the NHS should strive to increase the number of obstetricians and midwives to help minimise staff shortages.** This will not only improve morale, reduce sickness rates, and increase retention rates, but also remove the need for locum cover for obstetricians, and bank/agency staff for midwives – a perennial problem in some units, and the underlying cause of harm in the recent case in East Kent. In addition, increasing staffing would allow greater engagement with the likes of HSIB, PNNR, joint training and audit, contributing not only to creating a better culture, but also an investment in shared learning between midwives and obstetricians.

2) The contribution of clinical negligence and litigation processes to maternity safety, and what changes could be made to clinical negligence and litigation processes to improve the safety of maternity services;

17. The burden of litigation in the NHS is huge - particularly in obstetrics which accounts for > 50% of total compensation to Claimants. As a result there has been a move to consider a no-fault compensation scheme, based, for example on the Swedish model. We believe that this is a distraction and will make no difference to the safety of maternity care.

18. Sweden, whilst having many similarities remains nevertheless a very different country to the UK, socially, demographically, and politically. What works for the Swedes may not necessarily translate well into UK practice. Instead, the aim of any change should be to reduce the number of mistakes in the first place, hence reducing the need for compensation under any compensation system – adversarial or no-fault.

19. On this point, we believe that this is not the time to start blaming the blamers. More often than not it is those in the legal profession – on both sides of the litigation process, Defence and Claimant - who come under fire. In reality, whilst legal costs are high, they actually account for only a small and proportionate amount of the total compensation at stake. In addition, it remains the case that the current legal framework, far from being a cause of harm, can often be part of the remedy in that due process ensures a full and fair review of the case under discussion. Furthermore, the efforts of NHSLA and its predecessor, CNST, in striving to reduce litigation risk, have literally transformed the delivery of maternity care in the UK. Thus, for example, many units increased the numbers of consultant obstetricians in order to qualify for reduced CNST premiums. This financial lever has resulted in major improvements and should be continued.

3) Advice, guidance and practice on the choices available to pregnant women about natural births, home births and interventions such as C-sections, and the extent to which medical advice and decision-making is affected by a fear of the "blame culture";

20. Neither obstetricians nor midwives should hold the predominant view on the value of normal delivery, on the one hand, or caesarean section on the other. In failing units, in particular, personnel resume to stereotype. Thus, obstetricians are described as doing too much too soon – over-interventionists - whilst midwives too little too late, or under-interventionists. Over emphasis on the value of natural birth, or caesarean section is simply

misplaced. **The goal should be to give mothers a balanced view of the risks and benefits of aiming for vaginal delivery, and also, of planned caesarean section.** Mothers should be encouraged to have a realistic expectation of what is likely to happen in their pregnancy and delivery. Particularly important is the need to highlight what may be required if things do not go to plan, and, for example, an assisted vaginal delivery (forceps or ventouse), or emergency caesarean section is required. By preparing the mother properly, and without giving the impression that one mode of delivery is inherently better than the other, means that we are not setting many mothers up to fail. Mothers should not feel they have failed simply because they have not had a normal vaginal delivery without analgesia.

21. To alter the balance to a more measured portrayal of mode of delivery will require a review of antenatal parentcraft. This has largely been dominated by advocates of natural birth, to the detriment of mothers who do not achieve one. Instead, the NHS should ensure that mothers receive a full and balanced preparation of childbirth led by advocates of neither normal nor assisted birth.

22. In the UK, it is a fact that 1 in 6 women will require an assisted vaginal birth (forceps or vacuum) and at least 1 in 4 will require delivery by planned or emergency caesarean section. In 2020, it seems entirely inappropriate that the need for intervention is rarely discussed in the antenatal period. Surely this should be integrated into advice given by both obstetricians and midwives, allowing women and their partners to be better informed and prepared? Antenatal classes should include more detail about obstetric interventions, explaining how commonly they are required and why they are needed. Concentrating almost exclusively on providing information about 'normality' in antenatal classes, no longer seems appropriate.

23. This process, may, in the end, require a change in mind-set. Perhaps the nomenclature needs to be changed. After all, when nearly half of mothers do not have a normal vaginal delivery without assistance, surely this means that our concept of “normality” needs modification. Thus it may be better to avoid the words normal or abnormal altogether, using terms such as vaginal or assisted-vaginal birth or caesarean section.

24. Along with any change in emphasis on the nomenclature, whenever a mother chooses a caesarean section for “maternal request” ie for no particular medical or obstetric reason, she should not attract criticism for exercising informed choice. If, after a proper appraisal of the benefits and risks of having a planned caesarean section, a mother chooses an abdominal delivery, she should be supported, and not regarded negatively as being “too posh to push”. Such paternalism is misguided and misplaced.

25. Institutional paternalism should also be avoided. The NHS, guided by NICE, have repeatedly discouraged a mother’s choice for planned caesarean section on the grounds of cost. However, NICE has consistently failed to provide an accurate assessment of the true cost of planned caesarean section by not taking into account the avoidance of litigation. When risks of planning for vaginal delivery are acknowledged and insurance costs distributed accordingly, it becomes clear that, unsurprisingly, planned caesarean section is actually no more expensive than planned vaginal delivery - which attracts vastly more litigation costs

(https://f1000research.com/posters/8-518). Of note, insurance for potential litigation mainly for those planning vaginal delivery, now accounts for around 50% of the maternity tariff.

4) How effective the training and support offered to maternity staff is, and what improvements could be made to them to improve the safety of maternity services.

26. In Better Births, it was suggested that as they work together, they should train together. We fully support this aspiration - and support team training such as PROMPT (https://www.promptmaternity.org/) which emphasises the value of staff working together with a common goal.

27. Maternity care has traditionally been split into midwifery and obstetric-led care.
28. However, this concept of midwifery-led care – for low risk women, and obstetric-led care - for high risk women is, at least some respects, flawed. In reality, *all* mothers receive and require care by both professions, directly or indirectly, irrespective of risk.

29. For some women fortunate enough to experience a low risk pregnancy and uncomplicated normal vaginal delivery, it is tempting to describe such service with midwives at the centre of care. In contrast, for women with high-risk pregnancies, it is equally tempting to describe obstetricians as being central. The reality is, however, that midwives and obstetricians are all "in it together". That is to say, even the least complicated pregnancy has, behind the scenes, an obstetric team poised to intervene, if needs be within minutes.

30. Thus the mother having her third home-birth at term having had two successful home births previously may, incorrectly, be perceived to be of little interest to the average obstetrician. However, obstetricians are always required in case the unexpected occurs – for example the undiagnosed breech presentation or life-threatening post-partum haemorrhage.

31. Similarly, the mother with pre-eclampsia at 32 weeks carrying triplets, requiring an emergency caesarean section could be regarded as of little interest to the average midwife. On the contrary, in this example, the mother will need significant midwifery input to help her meet the challenges of carrying, delivering and looking after her triplets. Thus, even the most complicated of pregnancies also requires valuable input from midwives in both antenatal and postnatal settings. To complicate matters, in reality most pregnancies oscillate between episodes of low and high-risk. In fact, any pregnancy can only be reliably categorised as low/high risk in retrospect – a luxury not available in prospect.

32. This false dichotomy between low and high risk – and hence who is charged with looking after such mothers is often at the source of problems. To make matters worse, the nomenclature – as mentioned above - surrounding this issue is also unhelpful. Thus, an assisted vaginal delivery is called "normal", whilst the 25-30% of women having a caesarean section, "abnormal" with midwives' attention mainly being on the former and obstetricians the latter.

33. What is important is to play the maternity team to its full potential. There should be no professional barriers so that midwives can easily refer to an obstetrician, and obstetricians can likewise give midwives support. Mutual respect and a positive workplace culture are critical for safe maternity care.

34. The midwifery/obstetric led care split is not only a myth in reality, but it also serves women badly in a number of ways. For example, labelling a pregnancy as high-risk, can increase maternal anxiety and restrict reasonable choices for that mother when it comes to mode and place of delivery. Conversely labelling a pregnancy as low-risk, can, if circumstances change, result in a reluctance to reassign the pregnancy to more intensive care for fear of disappointing the mother concerned or disturbing the status quo. Finally, a “silo mentality” discourages working relations between midwives and obstetricians, and mothers can lose out.

35. We therefore propose that we review the outmoded concept of obstetric/midwifery led care, opting instead for a more fluid model of care which recognises the vagaries of pregnancy, puts at its core the needs of the mother, and helps avoids any turf war similar to that observed at Morecombe Bay with midwives unable to work with their obstetric colleagues. Only then can maternity care be truly regarded as woman-centred. To achieve this, midwives and obstetricians should be much more mindful of the work each other does.

36. We suggest that there are areas in day-to-day practice where midwives and obstetricians can and should work more effectively together. Thus, for example, there should be more shared ward rounds. This already occurs on delivery suite, but to a much lesser extent on the antenatal or postnatal ward. Combined antenatal clinics, and input from both midwives and obstetricians at debriefing meetings may also help. Such an approach will inevitably lead to more shared decision making and serve to improve maternity care.

37. Good leadership is essential to keeping morale levels high. So often, however, senior obstetricians, and more so, senior midwives, find it challenging to maintain hands-on skills due to the demands of committees and administration. To ensure that we have good clinical role models, senior staff must be allowed and encouraged, by means of proper job-planning, to work clinically, on the wards and on delivery suite. More consultants are almost certainly required in an increasingly consultant-delivered service.

38. Staff are so engrossed in supporting clinical maternity services that effective multidisciplinary team training remains the 'Cinderella'. Training is oft ignored, despite being the core of any effective strategy which aims to improve decision-making, communication & team working, thus ensuring better maternal and neonatal outcomes. Adequate time and resource to support multidisciplinary team training for *all* staff in *all* units is a pressing need, too long ignored.

39. Furthermore, one issue highlighted by a former chair of a NICE guideline, was that existing guidance is not followed in practice as often as it should be. This situation can only improve with more staff and therefore more multidisciplinary working.

40. Maternity care during the Covid pandemic has proven how quickly services can be reorganised to maintain safety when clinical leadership prevails – and also how quickly it reverts to the old ways when senior midwives and obstetricians have to spend more time on reporting to the various agencies than working on the shop-floor. This illustrates the value of implementation being clinician rather than management driven.

Input from all members of the MDT is import

41. It should be emphasised that the multidisciplinary team involves other clinicians besides obstetricians and midwives whose members includes sonographers, anaesthetists, physicians, psychiatrists and physiotherapists, depending on the mother's needs.

42. The commonest cause of maternal mortality in the UK is maternal medical and mental health disorders. A third are associated with serious substandard care where different management could have resulted in a better outcome. MBRRACE reports consistently highlight failures in communication between all staff caring for pregnant women (obstetricians, midwives and medical specialists) that can result in substandard care with potentially devastating consequences for these complex cases. The challenges to good communication between obstetricians and midwives also impact relationships with other professionals responsible for the care of women at increased risk of death in pregnancy or the puerperium, and improved morale and motivation will help to address this.

4) The role and work of the Healthcare Safety Investigation Branch in improving the safety of maternity services, and the adequacy and appropriateness of the collection and analysis of data on maternity safety.

43. HSIB has a worthy aim – to undertake independent external reviews in a timely fashion when things went wrong. Unfortunately, the process has significant drawbacks. The investigative process is gruelling for staff under scrutiny, and expert opinion is not necessarily as expert as one would like. Furthermore, enquiries have, in our experience, been far from timely. The costs of HSIB per report are high, prompting many to suggest that a more appropriate way to spend money is to invest in training for staff in how to review care properly, and in providing external reviewers. In other words, better more cost-effective reviews may be achieved if use is made of local maternity systems (LMS) where external reviews can be obtained from across the region.

44. HSIB is also designed, correctly, to engage with the parents. However, when safety issues are raised, unrelated or at least not of any causative significance, parents can be led to believe, erroneously, that clinical negligence has taken place.

45. For HSIB to succeed the nature, quality and timeliness of enquiry needs to be improved. Of note, a bad enquiry is still bad even if it is produced in a timely manner.

CONCLUSIONS

46. For maternity safety to improve, lessons must be learnt from past mistakes – identified all too clearly in reports such as the Morecombe Bay Investigation. External measures alone, fuelled by an array of data from various agencies, are insufficient by themselves to achieve improvement. We do not need more data collection or new investigative agencies.

47. Instead, a new approach is required to promote improvements in a culture which nurtures good practice. Essential to this is a recognition that obstetricians and midwives are in it together, and look after all mothers, irrespective of risk. Mutual respect, training together, and strong visible leadership are important for maternity units to overcome the many challenges they face.

48. Ultimately, it is mothers' views and opinions that are central - informed by balanced counselling from midwives and obstetricians. Recognition that maternity care should be mother-centred care is essential. Antenatal parentcraft classes needs restructuring to ensure mothers are better informed, and hence better prepared for their pregnancy, delivery and postnatal recovery.

49. We emphasise the worrying lack of available time and resource required to embed multidisciplinary skills-drills training within maternity services. Better staffing levels will facilitate the ability to ensure that training is provided for *all* members of the maternity team, on a rolling basis. Skilled teams that train and work together, improve safety and ensure better outcomes for mothers and babies.

50. However, the BMFMS firmly believes that no measures aimed at improving maternity safety will succeed if staffing levels remain poor. Unless this is changed, fault lines will become chasms, core professionals driven apart, and history repeat itself.

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