



House of Commons
Health and Social Care
Committee

**The Health and Social
Care Committee's
Expert Panel: Evaluation
of the Government's
progress against its
policy commitments in
the area of maternity
services in England**

First Special Report of Session 2021–22

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to be printed 30 June 2021*

Health and Social Care Committee

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Report from the Committee's Expert Panel on Maternity Services

The Committee's Expert Panel

1. In 2020, we established and commissioned a panel of experts (known as the Committee's Expert Panel or "Expert Panel") to evaluate—independently of us—progress the Government has made against its own commitments in different areas of healthcare policy. The framework for the Panel's work was set out in our Special Report: [Process for independent evaluation of progress on Government commitments](#) (HC 663), published on 5 August 2020. Part of that evaluation would be a CQC-style rating for each of the commitments under evaluation.

2. The Core members of the Expert Panel are **Professor Dame Jane Dacre** (Chair), **Sir Robert Francis QC**, **Dr Charlotte Augst**, **Dr Meerat Kaur**, **Professor John Appleby**, **Professor Anita Charlesworth** and **Professor Stephen Peckham**.

3. We asked the Expert Panel to undertake its first evaluation into maternity services in England. For this evaluation, the core Expert Panel members were joined by maternity specialists **Professor Soo Downe**, Professor of Midwifery Studies at University of Central Lancashire, **Professor Alexander Heazell**, Director of Tommy's Stillbirth Research Centre, University of Manchester, **Sarah Noble**, Associate Director of Midwifery at South Warwickshire NHS Foundation Trust and **Professor Dame Lesley Regan**, Head of Obstetrics and Gynaecology at St Mary's Hospital, London.

4. We thank the members of our Expert Panel for their work and the important contribution they have made in support of the Committee's scrutiny of the Department for Health and Social Care.

The Expert Panel's evaluation

5. With our agreement, the Expert Panel focussed on the following the commitments:
- **Maternity Safety:** By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.
 - **Continuity of Carer:** The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.
 - **Personalised Care:** All women to have a Personalised Care and Support Plan (PCSP) by 2021.

- Safe Staffing: Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable.
6. The Expert Panel’s evaluation is appended to this Report. Although its evaluation was undertaken without input from the Committee, we expect the Department to respond to it within the standard two-month period for responses to select Committee reports.



The Health and Social Care Committee's Expert Panel:

**Evaluation of the Government's progress
against its policy commitments in the area
of maternity services in England**

The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England

Introduction

Governments often make well-publicised policy commitments with good intentions to improve services for the public. While such policy commitments are made frequently, it is often difficult to evaluate or monitor the extent to which these commitments have been met or are on-track to be met. For this reason, formal processes of evaluation and review are essential, not only to hold the government to account but to allow those responsible for policy implementation to critically appraise their own progress; identify areas for future focus; and to foster a culture of learning and improvement. Such a process can also promote improvement in the quality of commitments made.

Improvement is an iterative process during which the impact and success of innovations are identified, modified, and reviewed and this is already in good use within the NHS. The concept has also been used successfully in education, by OFSTED, and in health and social care, by the Care Quality Commission (CQC). To apply this approach to health policy, the House of Commons Health and Social Care Select Committee established and commissioned a panel of experts to support its constitutional role in scrutinising the work of the government. The Expert Panel is chaired by Professor Dame Jane Dacre and is responsible for conducting a politically impartial evaluation of the Government's commitments in different areas of healthcare policy, which is independent from the work of the Committee.¹

We will produce a report after each evaluation which will be sent to the Committee to review. The final report will include a CQC-style rating of the progress the Government has made against achieving its own commitments. This is based on the "Anchor Statements" (see Appendix) set out by the Committee.² The intention is to identify instances of successful implementation of Government policy so that it can assess whether its commitments are on track to be met and to ensure support for resourcing and implementation are available to match Government aspirations. It is hoped that this process will promote learning about what makes an effective commitment, identify how commitments are most usefully monitored, and ultimately improve healthcare. Where appropriate, we will revisit and review policy commitments to encourage sustained progress. This is the first report conducted by the Expert Panel and evaluates Government commitments in the area of maternity services in England.

¹ [First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments \[21 July 2020\] p. 1](#)

² [First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments \[21 July 2020\] p. 6](#)

Members of the Expert Panel

The Expert Panel is chaired by Professor Dame Jane Dacre and is comprised of core members and subject specialists. Core panel members were recruited for their generic expertise in policy, with a broad understanding of qualitative and quantitative research methods and the evaluation of evidence. Subject specialists were recruited to bring direct experience and expertise to the policy area under evaluation by the Expert Panel. All Expert Panel members have been officially appointed by the House of Commons Health and Social Care Select Committee.

Core members of the Expert Panel are:

- Professor John Appleby;
- Dr Charlotte Augst;
- Anita Charlesworth CBE;
- Sir Robert Francis QC;
- Dr Meerat Kaur; and
- Professor Stephen Peckham.

Maternity specialist members of the Expert Panel are:

- Professor Soo Downe OBE, Professor of Midwifery Studies at University of Central Lancashire;
- Professor Alexander Heazell, Director of Tommy's Stillbirth Research Centre, University of Manchester;
- Sarah Noble, Associate Director of Midwifery at South Warwickshire NHS Foundation Trust; and
- Professor Dame Lesley Regan, Head of Obstetrics and Gynaecology at St Mary's Campus, Imperial College London.

Further information on the Expert Panel is set out in the Health and Social Care Committee Special Report: [Process for independent evaluation of progress on Government commitments](#) (5 August 2020). The latest information relating to the Expert Panel can be found on its webpage [here](#).

Members of the Expert Panel secretariat:

Previn Desai (Head of Secretariat)
Florence Young
Alison Lacey
James McQuade
Sandy Gill
Siobhan Conway

Acknowledgements:

We would like to thank the Department of Health and Social Care and NHS England and Improvement for their engagement with our evaluation. We are also grateful to those who have supported our work and, in particular, to colleagues from the National Audit Office and Patient Experience Library. We would like to give special thanks to the midwives and obstetricians who took part in our roundtable events, to the women who shared their experiences during our focus group session, and to the stakeholders who provided written submissions to support our evaluation.

Executive Summary

The Health and Social Care Committee commissioned a review of evidence for the effective implementation of the Government's policy commitments relating to maternity services. Our report has been produced independently of the Committee's own inquiry into *the safety of maternity services in England*.³ Our report has been reviewed by the Committee and supports the Committee's inquiry.

A panel of experts has been established consisting of members with recognised expertise in quantitative and qualitative research methods, and policy evaluation. This core group was complimented by four clinicians with a working knowledge and experiences of maternity services delivery.⁴

Evaluations and judgements in this report are summarised in a CQC-style rating of particular Government policy commitments for maternity services. While these are in the style of ratings used by national bodies such as the CQC, the ratings in this report have been determined by us and do not reflect the opinion of the CQC. The commitments under review are interconnected allowing an overall rating to be given relating to a combined assessment against all four commitments. Separate ratings have also been given to each commitment and its main questions. All ratings are informed by a review process using robust research and evaluation methods.

Published data and other sources of evidence, including written submissions from stakeholders, focus groups and round table discussions have been used to provide evidence for review by the Expert Panel.

The Department of Health and Social Care have been invited to contribute to the process at each stage of evaluation.

³ Health and Social Care Committee, [Safety of Maternity Services in England](#)

⁴ [First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments \[21 July 2020\]](#)

Selected Commitments

On 14 December 2020, the Department of Health and Social Care provided the Panel with its [main policy commitments for maternity services](#). Using this information and wider policy documentation, we selected the four commitments we identified as the most important and appropriate sample for review and agreed to evaluate the Government's progress against these commitments. The commitments are:

1. **Maternity Safety:** By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.
2. **Continuity of Carer:** The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.
3. **Personalised Care:** All women to have a Personalised Care and Support Plan (PCSP) by 2021.
4. **Safe Staffing:** Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.

For each commitment under review, The Health and Social Care Committee set out main questions to guide the Expert Panel's evaluation. We then developed a set of sub-questions relating to specific areas of the commitment. These main questions and sub-questions were incorporated into a final framework referred to as the *Expert Panel's planning grid*.⁵ The planning grid was shared with the Department and formed the basis of the Department's formal written response.⁶ We used the key questions in the planning grid, as well as our own thematic analysis of written submissions, transcripts from focus groups and roundtable events, as the basis for this evaluation.

The main questions set out in the planning grid are:

- A. Was the commitment met overall? Or is the commitment on track to be met?
- B. Was the commitment effectively funded (or resourced)?
- C. Did the commitment achieve a positive impact for women?
- D. Was it an appropriate commitment?⁷

The ratings for all commitments and main questions are summarised in Table 1. An analysis of each sub-question, as described in the planning grid, can be found in annexes A-D. We invited the Department of Health and Social Care to respond to all main questions and sub-questions in its written response.⁸

⁵ [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#)

⁶ Department of Health and Social Care ([EPE0026](#))

⁷ [First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments \[21 July 2020\], p. 3](#)

⁸ Department of Health and Social Care ([EPE0026](#))

CQC-style ratings for the commitments under evaluation are summarised in the table below:

Table 1: CQC-style ratings

Commitment	A. Commitment met	B. Funding / Resourcing	C. Impact	D. Appropriate	Overall
OVERALL RATING across all commitments					Requires improvement
Maternity Safety	Stillbirths: Good Neonatal deaths: Good Brain injury: Requires Improvement Maternal deaths: Inadequate Pre-term births: Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement
Continuity of Carer	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement
Personalised Care	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate
Safe Staffing	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement

The overall CQC-style rating across all four commitments is **Requires Improvement**.

This overall rating relates to how the Government has progressed against all four commitments based on guidance outlined in the anchor statements (Appendix). We have summarised the key evidence used to determine the rating for each commitment in Table 2. While an overall rating of progress against all four commitments is challenging to determine, the evidence we assessed shows that the Government’s commitments for maternity services require improvement. We have identified systematic issues in the way the commitments have been set out and resourced, with recurrent issues in establishing a robust and timely method of data collection to allow evaluation of progress towards achieving numerical targets. When setting commitments, it is vital that the Government develops appropriate data collection strategies to monitor progress where relevant data are not currently available.

Achievement against all four commitments is highly interconnected, for example successful roll-out of Continuity of Carer will undoubtedly lead to improved attainment towards the commitment to improve maternity safety outcomes. However, a key finding of this report is that none of the other commitments can be achieved without ensuring that maternity services have the right number of staff, in the right place, at the right time and with the right skills.

Persistent health inequalities and negative birthing experiences for women from minority ethnic and socio-economically deprived backgrounds were evident throughout our assessment. To address this issue, we have included an additional chapter that draws together our findings relating to health inequalities for all commitments.

The overall CQC-style ratings for each commitment are:

Maternity Safety: Requires Improvement

To improve birth outcomes for women and babies, significant focus has been directed towards improving maternity safety, with promising trends in reducing unnecessary deaths and disability. However, changes to the way progress is measured makes it difficult to attribute improvements to Government intervention. Significant health inequalities for women from minority ethnic and socio-economically disadvantaged backgrounds persist, which have not been adequately addressed in current improvement plans.

Continuity of Carer: Requires Improvement

This is an important commitment with a strong evidence base. Effort has been directed towards achieving this target, but lack of clarity over its definition, lack of reliable data collection method to evidence progress, and lack of clear resources and organisational support for its implementation has made it difficult to evidence and achieve. Continuity of Carer represents a major change to maternity services and further support is required to ensure Trusts are enabled to successfully manage this scale of organisational change.

Personalised Care and Support Plans (PCSPs): Inadequate

This is an important aspiration and is likely to improve safety and satisfaction for women. However, there has been inadequate consideration of ways to mitigate potential barriers to impactful care planning. PCSPs represent a significant change in workplace culture and aim to empower women as lead decision makers in their own care. However, lack of clarity about how plans will be used to inform service delivery planning has resulted in PCSPs becoming a potentially time-consuming tick box exercise.

Safe Staffing: Requires Improvement

There is a consistent message in the range of sources we evaluated that staffing across the whole area of maternity services requires improvement. While there have been recent improvements in the number of midwifery staff, persistent gaps in all maternity professions remain. Current recruitment initiatives do not consider the serious problem of attrition in a demoralised and overstretched workforce and do not adequately value professional experience and wellbeing. Staffing deficits undermine the ability of Trusts to achieve improvements in all areas.

Equality in Maternity Outcomes:

Throughout this evaluation, we have been struck by the persistent health inequalities experienced by women and babies from disadvantaged groups. Women from minority ethnic or socio-economically deprived backgrounds continue to experience poorer outcomes across all commitments we evaluated. To address this issue in more detail we have provided an additional chapter on health inequalities for each of the commitments included in this review.

The key evidence to support the CQC-style rating for each commitment and our findings relating to inequalities in experience and outcome is outlined in the table below:

Table 2: Key evidence to support the CQC-style ratings for each commitment

Chapter	Rating	Evidence
Maternity Safety	Requires Improvement	<ul style="list-style-type: none"> • There has been significant progress in reducing rates of stillbirths and neonatal deaths with a 25% and 30% reduction since 2010 respectively. • Small reductions in pre-term birth rates from 2017 will need to accelerate to meet the 2025 target. • While efforts have been made to reduce the rate of brain injuries occurring during or soon after birth, there is little evidence targets are on course to be met. • There has been no significant progress in reducing the rate of maternal death. • Despite improvements on some measures, across all targets there remain inequalities for some minority ethnic groups and in the most socioeconomically deprived areas of the country. • There has been a range of new funds and resources to support maternity safety outcomes, but current levels of funding are insufficient and not clearly linked to demonstrable targets.
Continuity of Carer	Requires Improvement	<ul style="list-style-type: none"> • The policy is supported by robust research evidence and has the potential to improve quality of care at scale. • However, the target for the majority of women to receive CoC by 2021 has not been achieved. • CoC has only been received by a minority of women with considerable variation by Trust in reported experiences of care. • Progress has been slow due to a lack of vision about how a CoC model should be implemented at scale. Some Trusts have interpreted CoC as just antenatal or postnatal CoC. Persistent conflicting messages have led to implementation challenges, patchy care for women, and variable overall success. • There has been insufficient funding, resources, staff, and leadership to support implementation with support tools only recently developed. • Insufficient data has been collected to enable assessment of who received CoC and in what form.
Personalised Care	Inadequate	<ul style="list-style-type: none"> • Personal Care and Support Plans are critical for improving women’s experience and outcomes and to embed the legal principle of informed

		<p>consent within maternity care. However, the current commitment is too limited because it does not specify the philosophy or content of personalised care, or outcome and delivery targets.</p> <ul style="list-style-type: none"> • Evidence shows that while many staff at a national level are working hard to operationalise this commitment, without monitoring content and delivery there is unlikely to be meaningful change. • Personalised care and support planning at a local level risks becoming a time-consuming tick-box exercise that is not fully integrated into women’s care planning and provision. • There is no ringfenced budget for PCSPs. Professional responses suggest there is insufficient funding, training and time to support and ensure good quality PCSPs. • Only a very small percentage of women were reported as having PCSPs. We were shown no evidence to assess the extent to which they were enacted or if they resulted in improved care or outcomes.
Safe Staffing	Requires Improvement	<ul style="list-style-type: none"> • There has been an increase in the number of midwives and consultants in obstetrics employed in the NHS over the last decade. However there has also been a sharp increase in the complexity of maternity cases in England during this period. • Despite improvements in numbers, staffing shortages persist across all maternity professions. • High attrition limits the impact of recruitment initiatives and means valuable professional skills and experience are lost. • Frontline staff and stakeholders reported significant ongoing issues in maternity staffing with minimum staffing levels not being met on a daily basis, either due to funding not being agreed or an inability to recruit into posts. • Staffing shortages limit progress towards all other maternity commitments we reviewed; notably Continuity of Carer and PCSPs. • It cannot be assumed that meeting recommended staffing levels in isolation will automatically result in safe and consistent staffing. It is a combination of the right numbers and <i>skill</i> of practitioners, alongside effective deployment to enable an agile, flexible and responsive model of care to meet the variable activity levels in maternity.

<p>Equality in Maternity Outcomes</p>	<p>N/A</p>	<ul style="list-style-type: none"> • Data provided by the Department demonstrate an increased risk of neonatal death, stillbirth and maternal death for women and babies from some minority ethnic and socio-economically deprived backgrounds. • The disparity in safety outcomes for disadvantaged women and babies has persisted since 2010. • Written submissions and testimonies from our focus group illustrate that women from disadvantaged backgrounds are more likely to have disproportionately negative birthing experiences. • Evidence from our roundtable events demonstrates a lack of centralised resourcing and support for targeted initiatives to reduce inequalities in maternity experiences and outcomes.
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Method of Evaluation

Our approach to evaluation was to review quantitative and qualitative data provided by the Department along with relevant research evidence to establish causative links, as well as evidence from other sources via a call for written submissions. We triangulated this evidence with testimonies from those with lived experience via roundtables and a focus group. Our approach was not a formal technical evaluation of the impact of different interventions on the policy aspirations and should not be viewed as a substitute for government commissioning these evaluations via the National Institute for Health Research (NIHR).

We received a formal response to our planning grid⁹ from the Department on 20 April 2021.¹⁰ This response, along with information gathered during subsequent meetings and letters, forms the basis for this report.

Evidence was reviewed from several non-governmental sources. Key stakeholders were identified and invited to submit their own written response to the planning grid. Written submissions were analysed using a framework method for qualitative analysis in health policy research.¹¹ We also conducted two 90-minute roundtable events with midwifery and obstetric staff, and a 2.5-hour focus group with women from East African backgrounds. This group of women was chosen as an illustrative example to reflect the views and experiences of women from a community that evidence shows experience persistent health inequalities relating to these commitments. The focus group aimed to test the feasibility of alternative and accessible spaces for people who did not provide evidence through written submissions. Deductive thematic analysis was used to analyse transcripts from the focus groups and roundtable events. We employed a realist review approach¹² to the integration of evidence from all sources into the main report.

A full list of evidence is outlined at the end of the report.

Evidence from the Department:

- Written information requested from the Department and associated bodies¹³
- Meetings with the Department and NHSE/I officials¹⁴

⁹ [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#)

¹⁰ Department of Health and Social Care ([EPE0026](#))

¹¹ Gale, N.K., Heath, G., Cameron, E. *et al.* Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol* 13, 117 (2013). <https://doi.org/10.1186/1471-2288-13-117>

¹² Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review—a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy*. 2005;10 Suppl 1:21–34. doi:10.1258/1355819054308530. See also HM Treasury, Magenta Book Annex A: Analytical methods for use within an evaluation, March 2020

¹³ [Letter from Rt Hon Matt Hancock MP, Secretary of State, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the work of the Expert Panel \[14 December 2020\]](#); Department of Health and Social Care ([EPE0026](#))

¹⁴ 25 March 2021; 29 April 2021; 15 June 2021; Transcript of Expert Panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

- Additional written information received from the Department¹⁵

Evidence from service users:

- Focus group with women from East African backgrounds¹⁶
- Consultation with the Patient Experience Library and review of relevant research documents¹⁷

Evidence from clinicians:

- Two roundtable events with midwifery and obstetric staff¹⁸

Evidence from stakeholders

- 23 written submissions (see complete list at the end of this report)

This report provides an analysis of all information provided.

The analysis is structured around the four commitments and the four main questions (A-D) within each commitment. In depth analysis of each commitment by sub-question can be found in the Annex A-D.

¹⁵ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the maternity workforce gap \[22 April 2021\];](#)

[Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Cheryl Mackrory MP, regarding baby loss prevention and data reporting \[15 April 2021\];](#)

[Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\];](#) and [Annex A \[7 June 2021\];](#)

[Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

¹⁶ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

¹⁷ [Patient Experience Library \(patientlibrary.net\)](#)

¹⁸ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#)); Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

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 - v) Pre-term births
- B. Was the commitment effectively funded (or resourced)?
- C. Did the commitment achieve a positive impact?
- D. Was it an appropriate commitment?

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- A. Was the commitment met overall? Or is the commitment on track to be met?
- B. Was the commitment effectively funded (or resourced)?
- C. Did the commitment achieve a positive impact for women?
- D. Was it an appropriate commitment?

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Appendix: Anchor Statements for CQC-style ratings (150)

Chapter 1: Maternity Safety

In this section we provide an assessment of the Government's commitment to Maternity Safety provided to us by the Department of Health and Social Care, which states:

"By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025."¹⁹

Overall Commitment Rating and Overview for Maternity Safety:

Requires Improvement

In 2015 the Government announced the National Ambition which committed to halving the 2010 rate of stillbirths; neonatal deaths; maternal deaths; and brain injuries that occur during or soon after birth by 2030, with an interim target of a 20% reduction of these rates by 2020. The Department of Health and Social Care state that following the provision of additional funding and support in 2017, it brought the deadline for meeting these targets forward to 2025 and added the additional target to reduce pre-term birth rates from 8% to 6% by 2025.²⁰ This is an ambitious and important commitment with clear deadlines.

There has been significant progress towards achieving the targets relating to stillbirths and neonatal deaths. However, little to no progress has been made on reducing rates of brain injury; pre-term birth; or maternal deaths.

Although many written submissions and discussions at roundtable events with clinicians indicate clinical guidance on improved safety practices has been clear and well received by staff, we have found that an issue consistently raised is that insufficient resources and staffing numbers preclude the training opportunities required to learn and implement the recommended guidance.

We understand that the full impact of the COVID-19 pandemic on maternity safety is yet to be reflected in the data and anticipate that renewed efforts will be needed to overcome the expected setbacks on progress towards these targets.

The improvements in rates of stillbirths and neonatal deaths are good but are not shared equally among all women and babies. Babies from minority ethnic or socio-economically deprived backgrounds continue to be at significantly greater risk of perinatal death than their white or less deprived peers.²¹ An in-depth discussion of the inequality in maternity safety outcomes is included in Chapter 5 (pages 78-96).

¹⁹ [Letter from Rt Hon Matt Hancock MP, Secretary of State, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the work of the Expert Panel \[14 December 2020\]](#)

²⁰ Department of Health and Social Care ([EPE0026](#)), para 1; Department of Health, [Safer Maternity Care - The National Maternity Safety Strategy, Progress and Next Steps](#), 2017

²¹ MBRRACE-UK, [Perinatal Mortality Surveillance Report: UK Perinatal Deaths for Births from January to December 2017](#)

There needs to be greater targeted efforts, resources and funding to reduce the disparity in outcomes between women and babies from different backgrounds and to maintain or improve the current rates of progress towards the targets within this commitment for all women.

Analysis of Maternity Safety

This section provides an analysis of the commitment to halve the rate of stillbirths; neonatal deaths; maternal deaths; and brain injuries that occur during or soon after birth; and to reduce the pre-term birth rate from 8% to 6% by 2025. This analysis is based on the main questions set out in the planning grid. An analysis of each sub-question, as described in the planning grid, can be found in Annex A.

A. Was the commitment met overall? Or is the commitment on track to be met?

In this section, for clarity, we have provided our individual ratings and overviews for the Government's progress against each of the targets contained within the commitment to halve the rate of (i) stillbirths; (ii) neonatal deaths; (iii) brain injuries that occur during or soon after birth; (iv) maternal deaths; and (v) to reduce the pre-term birth rate from 8% to 6% by 2025.

For the following sections B-D, analysis, overviews, and ratings are provided for the commitment overall and are not broken down by individual target.

i) Stillbirths

Rating: **Good**

The Department of Health and Social Care has made excellent progress towards achieving a 50% reduction in stillbirths by 2025. The Department has achieved the interim target of a 20% reduction earlier than the 2020 deadline. However, increased efforts are required to meet the final target in 2025, particularly as the COVID-19 pandemic may worsen stillbirth rates for 2020. These efforts must also include an increased focus on reducing the disparity in stillbirth rates for babies from disadvantaged backgrounds, as discussed in Chapter 5 (pages 78-96).

The Department of Health and Social Care (hereafter 'the Department') and NHS England and Improvement (NHSE/I) have achieved the intermediate 2020 target of a 20% reduction in stillbirths ahead of schedule, with data provided by the Department showing a 25% reduction from the 2010 baseline rate of stillbirths by 2019.²² Several written submissions corroborate the Department's assessment that good progress has been made towards meeting the target to halve stillbirths by 2025.²³

While this achievement is commendable, it is too soon to determine whether the data for 2020 will sustain this progress. Stillbirth rates for 2020 during the COVID-19 pandemic are not yet available and a UK-based study has shown that contracting COVID-19 increases the risk of stillbirth.²⁴

²² Department of Health and Social Care ([EPE0026](#)), paras 6-7

²³ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Dr Bill Kirkup ([EPE0005](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Birthrights ([EPE0019](#))

²⁴ Gurol-Urganci, Ipek; Jardine, Jennifer E; Carroll, Fran; Draycott, Tim; Dunn, George; Fremeaux, Alissa; Harris, Tina; Hawdon, Jane; Morris, Edward; Muller, Patrick; Waite, Lara; Webster, Kirstin; VAN DER Meulen, Jan; Khalil, Asma; (2021) Maternal and perinatal outcomes of pregnant women with SARS-CoV-2 infection at the time of birth in England: national cohort study. American journal of obstetrics and gynecology. ISSN 0002-9378 DOI: <https://doi.org/10.1016/j.ajog.2021.05.016> (In Press)

Furthermore, our analysis shows that the current rate of reduction will need to increase to meet the 2025 target of a 50% decrease in stillbirths, as shown in Figure 1. Many written submissions also emphasise that a further increase in efforts is needed to achieve the 2025 target.²⁵ Therefore, further evidence of increased efforts is required to support the Department’s statement that this commitment is on track to be met.²⁶ Moreover, we anticipate that the greater complexity of the remaining population of stillbirth cases each year will lead to diminishing improvements in stillbirth rates from current initiatives. Therefore, sustaining the current rate of decrease in stillbirths will become progressively more challenging.

Whether the progress against this target can be attributed to the commitment set out by the Government in 2015,²⁷ is not clear. Our analysis shows progress since 2015 may instead be attributable to the continuation of an existing trend towards lower stillbirth rates (see Figure 1).

Lastly, national improvements in stillbirth rates are not consistent between different groups of women and their babies. It has been established for over twenty years that babies from ethnic minority or socio-economically deprived backgrounds are at greater risk of stillbirth than their white or less deprived peers. However, this knowledge has not led to improvements in outcomes in this group. The inequality in outcomes for marginalised women is discussed further in Chapter 5 on page 78-96.

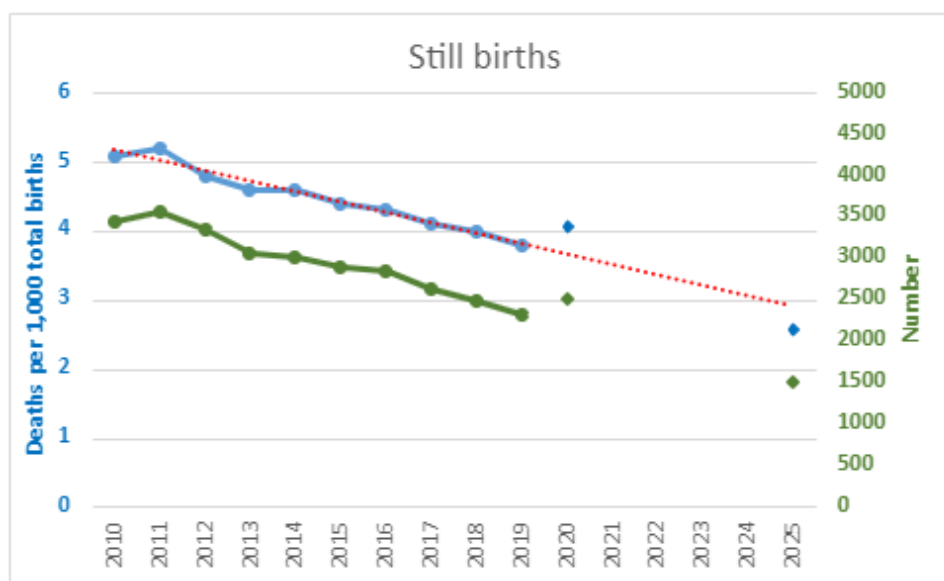


Figure 1. Annual rate or total number of stillbirths in England. The blue line and data points indicate stillbirths per 1,000 live births; the green indicate total number of stillbirths; the diamonds for the years 2020 and 2025 indicate the target rate or number of stillbirths; the red dashed line indicates the projected trend in stillbirth rate. Absolute numbers for targets based on trend projections of total births based on 2010-2019 data and applying target rates. Source: The Office for National Statistics (ONS) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 (live births and stillbirths).²⁸

²⁵ The Royal College of Pathologists ([EPE0004](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Caesarean Birth ([EPE0023](#))

²⁶ Department of Health and Social Care ([EPE0026](#)), para 7

²⁷ Department of Health, [Safer Maternity Care – Next steps towards the national maternity ambition](#), 2016

²⁸ [The Office for National Statistics’ \(ONS\) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 \(live births and stillbirths\)](#)

ii) Neonatal deaths

Rating and Overview: **Good**

Good progress has been made towards achieving a 50% reduction in neonatal deaths by 2025. However, it has been difficult to determine the full extent of the Government's progress due to a change in the measure of progress against the National Maternity Ambition on neonatal deaths, with concerns expressed about the validity and unintended consequences of this change. This change in measuring progress has potentially inflated the achievement in the data analysed and may inadvertently exclude extremely pre-term babies from the on-going national efforts to improve neonatal outcomes. We encourage the Department to continue to measure and drive progress towards reducing mortality in both the population of babies born before and after 24-weeks' gestation. Ongoing efforts must also include an increased focus on reducing the disparity in neonatal death rates for babies from disadvantaged backgrounds, as discussed in Chapter 5 (page 78-96).

The original measure of progress on reducing neonatal death rates, as set out by the Department and NHSE/I in the National Ambition in 2015, includes babies across all gestational ages.²⁹ When using this original measure of neonatal death rates, our analysis of the ONS data³⁰ demonstrates that the target for reduction in neonatal deaths is not on track to be met, as shown in Figure 2 below and described in detail in Annex A, sub-question 3.

The Department has stated that a change in care practice for the perinatal management of extreme preterm birth (<27 weeks of gestation) was introduced by British Association of Perinatal Medicine in 2019.³¹ It states that this change in care practice results in a greater number of extremely pre-term babies, which are at the highest risk of death, being classified as live births where they may have previously been classified as a late fetal loss.³² The Department propose that this change in classification may have contributed to the increase in neonatal mortality rate between 2014 and 2019. As a result, the Department has revised the population of babies included in the target to reduce neonatal deaths to include only babies born at greater than or equal to 24 weeks' gestation.³³

By this revised measure, our analysis shows that the reduction in neonatal deaths is on track to be met by 2025, as shown in Figure 3. The maternity charities SANDs and Bliss have expressed concern over the validity and unintended consequences of this change.³⁴ The charities emphasise the importance of not excluding babies born before 24 weeks' gestation in the UK's ambition and work to reduce deaths. These charities state that it must be made clear, particularly to parents whose babies fall into the omitted gestational age, that these premature babies still matter, that efforts are still being made to reduce mortality in this group of babies, and that opportunities to improve care and outcomes are not missed. Although

²⁹ Department of Health and Social Care ([EPE0026](#)), paras 10-12

³⁰ [The Office for National Statistics' \(ONS\) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 \(live births and stillbirths\)](#)

³¹ [Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation \(2019\) | British Association of Perinatal Medicine \(bapm.org\)](#)

³² Department of Health and Social Care ([EPE0026](#)), para 11

³³ Department of Health and Social Care ([EPE0026](#)), paras 12-13

³⁴ Sands ([EPE0012](#)); Bliss ([EPE0020](#))

there may be a reasonable justification for revising the population of babies included in the target for reduction in neonatal death rates, such a change would significantly alter the Department’s approach to monitoring and improving the safety of maternity services.

As with stillbirth, the national improvements in neonatal death rates are not consistent between different groups of women and their babies. For example, babies from ethnic minority and socio-economically deprived backgrounds are at greater risk of neonatal death than their white or less deprived peers. The inequality in outcomes for marginalised women and babies is discussed further in Chapter 5 on page 78-96. Furthermore, the charity Campaign for Safer Births report that high neonatal death rates in multiple pregnancies have persisted,³⁵ suggesting that interventions are not achieving equal improvements across all groups.

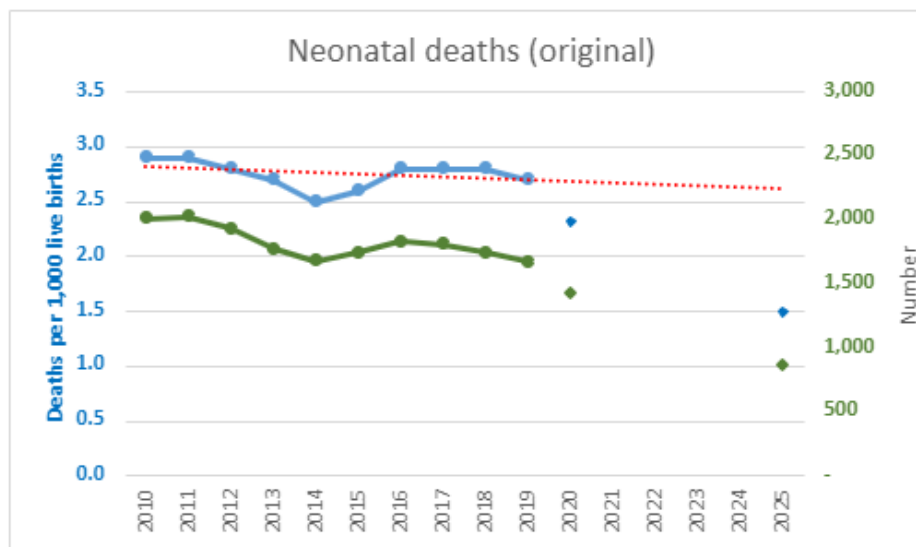


Figure 2. Annual rate or numbers of neonatal deaths in England based on the original definition of neonatal death. The original definition includes babies born across all gestational ages. The blue line and data points indicate neonatal deaths per 1,000 live births; the green indicate total number of neonatal deaths; the diamonds for the years 2020 and 2025 indicate the target rate or number of neonatal deaths and are based on projections of live births based on data from 2010 to 2019; the red dashed line indicates the projected trend in neonatal death rate. Source: The Office for National Statistics (ONS) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2018 (neonatal deaths) and 2010 to 2019 (live births and stillbirths).³⁶

³⁵ Campaign for Safer Births ([EPE0009](#))

³⁶ [The Office for National Statistics’ \(ONS\) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 \(live births and stillbirths\)](#)

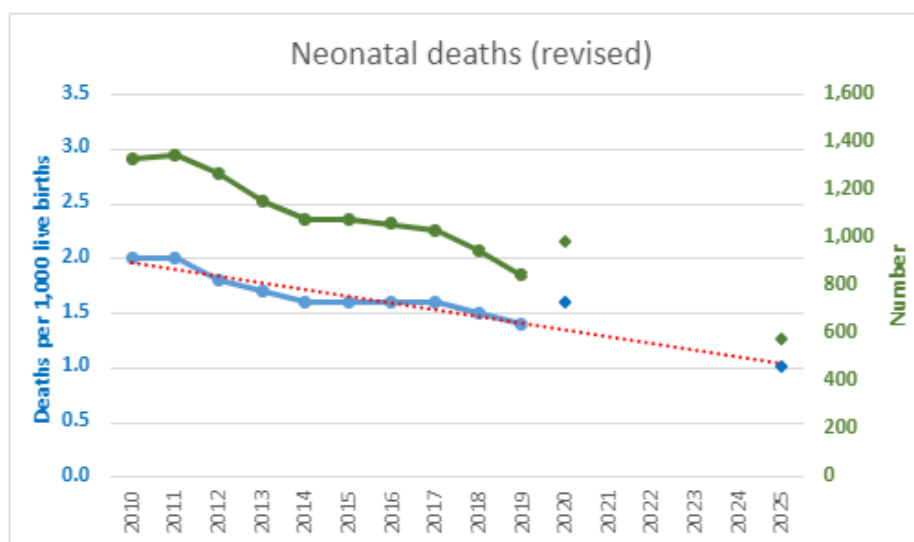


Figure 3. Annual rate or numbers of neonatal deaths in England based on the revised definition of neonatal death. The revised definition only includes babies born showing signs of life at greater than or equal to 24 weeks gestation. The blue line and data points indicate neonatal deaths per 1,000 live births; the green indicate total number of neonatal deaths; the diamonds for the years 2020 and 2025 indicate the target rate or number of neonatal deaths and are based on projections of live births based on 2010-2019 data; the red dashed line indicates the projected trend in neonatal death rate. Source: The Office for National Statistics’ (ONS) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2018 (neonatal deaths) and 2010 to 2019 (live births and stillbirths).³⁷

iii) Brain injuries occurring during or soon after birth

Rating and Overview: **Requires Improvement**

A sustained increase in efforts will be needed to reduce brain injury rates occurring during or soon after birth in order to meet the 2025 target of a 50% reduction from the 2010 rate. Data based on the bespoke definition of brain injury, developed in 2017, demonstrate that the target is not currently on track to be met, with injury rates initially increasing.

The Department stated that when the target was set in 2015 there was no agreed definition of ‘brain injuries occurring during or soon after birth’.³⁸ In order to monitor progress against this target, The Department convened an expert group to develop a bespoke definition of brain injury.³⁹

At a meeting with Department and NHSE/I officials on 29 April 2021,⁴⁰ we expressed concern that the 2017 definition of brain injury only includes “brain injuries that are detected during

³⁷ [The Office for National Statistics’ \(ONS\) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 \(live births and stillbirths\)](#)

³⁸ Department of Health and Social Care ([EPE0026](#)), para 16

³⁹ Imperial College London, [Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health](#), 2017

⁴⁰ An informal meeting was held between members of the Expert Panel and officials from the Department of Health and Social Care and NHSE/I regarding Government commitments in the area of maternity services [29 April 2021]

the neonatal unit stay”.⁴¹ This time period omits potential late manifestations of brain injury (for example, cerebral palsy) and therefore this definition may give an underestimate of peripartum brain injury. In further correspondence, NHSE/I officials have clarified that the bespoke definition was designed as a compromise, needing to capture reliable and complete information on brain injury while only using existing and back dated data.⁴² Thus, according to Gale *et al.* (2017), the definition agreed in 2017 is intentionally broad enough to capture both acute neurological dysfunction and markers of potential for brain injury, such as hypoxic ischaemic encephalopathy (HIE),⁴³ to avoid the requirement of long-term follow-up and assessment in childhood during data collection.⁴⁴ We are satisfied that the definition captures potential late manifestations of brain injury to the greatest extent that is possible within the constraints placed on data collection.

Using this definition, the data provided by the Department shows that the target for reduction of brain injuries occurring during or soon after birth is not on track to be met.⁴⁵ Written submissions confirm that the commitment to reduce brain injury is not on track.⁴⁶ Based on Each Baby Counts criteria, the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists (RCM/RCOG) jointly state that the annual number of babies suffering from severe brain injury has not changed since the ambition was set in 2015 (854 babies in 2015; 859 babies in 2018).⁴⁷ Information on brain injury rates broken down by ethnic or socio-economic background has not been made available during this inquiry.⁴⁸ Therefore, it is not possible to assess whether trends in brain injury rates are equivalent across all groups.

While there has been no overall reduction in the rate of brain injuries per 1,000 live births between 2012 and 2019, the data represents a trend towards a reduction in brain injuries since the ambition was set in 2015, although this has not yet reached statistical significance, as shown in Figure 4. In addition, the Department states that there has been a 15% reduction in infants specifically suffering from hypoxic ischaemic encephalopathy between 2014-2019, which it states may indicate an improvement in quality of perinatal care.⁴⁹ We recognise the complexity in reducing the rate of brain injury occurring during or soon after birth and

⁴¹ Imperial College London, [Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health](#), 2017

⁴² [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁴³ Hypoxic ischaemic encephalopathy occurs when an infant’s brain doesn’t receive enough oxygen and blood. This condition can be a marker of brain injury in infants.

⁴⁴ Gale C, Statnikov Y, Jawad S, Uthaya SN, Modi N; Brain Injuries expert working group. Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database. *Arch Dis Child Fetal Neonatal Ed.* 2018 Jul;103(4):F301-F306. doi: 10.1136/archdischild-2017-313707. Epub 2017 Oct 22. Erratum in: *Arch Dis Child Fetal Neonatal Ed.* 2021 May;106(3):e1-e4. PMID: 29180541; PMCID: PMC6047140.

⁴⁵ Department of Health and Social Care ([EPE0026](#)), paras 16-18. The data is commissioned by the Department from the Neonatal Data Analysis Unit (NDAU) and derived from the National Neonatal Research Database (NNRD).

⁴⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); British Association of Perinatal Medicine (BAPM) ([EPE0022](#))

⁴⁷ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁴⁸ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁴⁹ Department of Health and Social Care ([EPE0026](#)), para 19

welcome the establishment of the Healthcare Safety Investigation Branch’s Maternity Branch⁵⁰ and the commitment to the Perinatal Mortality Review Tool⁵¹ in establishing a consistent monitoring approach for continued and shared learning.

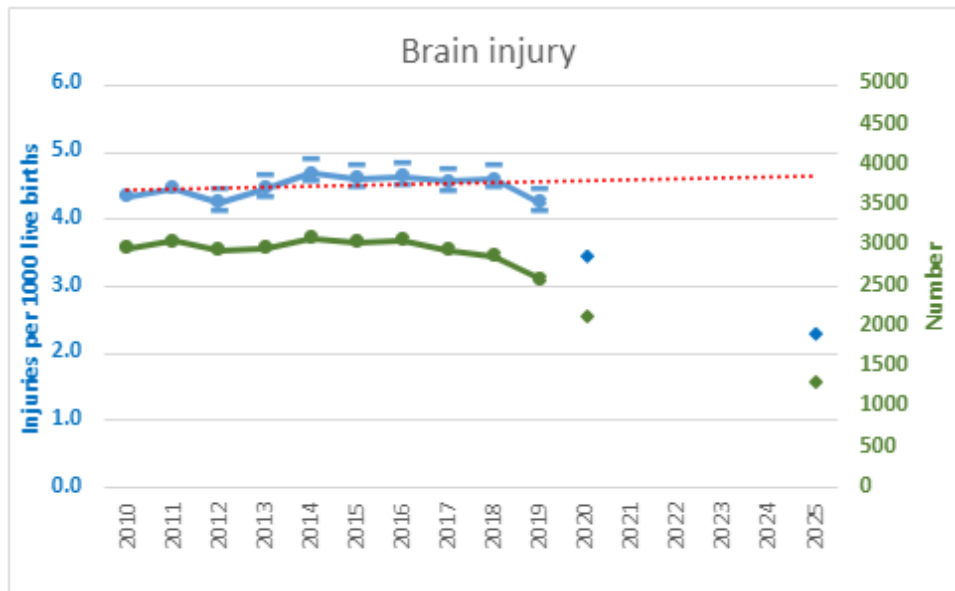


Figure 4. Annual rate or numbers of brain injury occurring during or soon after birth based on the bespoke definition of brain injury.⁵² The blue line and data points indicate brain injuries per 1,000 live births; the blue bars around each blue data point indicate 95% confidence intervals; the green line and data points indicate total number of brain injuries; the diamonds for the years 2020 and 2025 indicate the target rate or number of brain injuries with absolute numbers for targets based on projections (2010-2019) for live birth; the red dashed line indicates the projected trend in brain injury rate. Source: Annual incidence and rates of brain injury - 2018 and 2019 national report and the Correction to: Annual incidence and rates of brain injury - 2010 to 2015 data report from the Neonatal Data Analysis Unit, Imperial College London.⁵³

⁵⁰ Department of Health and Social Care ([EPE0026](#)), para 28

⁵¹ *Ibid.*

⁵² Imperial College London, [Correction to: Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health](#)

⁵³ Imperial College London, [Brain injury occurring during or soon after birth: annual incidence and rates of brain injuries to monitor progress against the national maternity ambition 2018 and 2019 national data](#); Imperial College London, [Correction to: Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health](#)

iv) Maternal deaths

Rating and Overview: **Inadequate**

No discernible progress has been made towards reducing the 2010 rate of maternal deaths by 50% by 2025. The factors contributing to maternal deaths are predominantly indirect, such as existing disease, and therefore complex to address. Tackling the causes of maternal death will require concerted efforts, with a focus on pre-conception interventions and improved post-natal support, particularly relating to mental health support (see page 32). In addition, the worsening disparity in risk of maternal death for women from minority ethnic and socio-economically deprived backgrounds needs to be urgently addressed. The issue of equitable outcomes for women is discussed further in Chapter 5 on pages 78-96.

The data provided by the Department show that the target for reduction in maternal deaths is not on track to be met, although an assessment of recent progress is not possible as the data for 2017-2019 and 2018-2020 are not available⁵⁴ (see our analysis in Figure 5 and supporting figures in Annex A). Many written submissions corroborate the observation that this commitment is not on track to be met,⁵⁵ with the charity the Obstetric Anaesthetist Association (OAA) observing that the rate of maternal deaths has remained largely unchanged since 1985.⁵⁶

Both the written submissions and our own analysis (Figure 5) demonstrate that the current causes of maternal deaths are predominantly due to indirect factors, such as existing disease, or disease that developed during the pregnancy rather than direct obstetric causes.⁵⁷ Although trend lines in Figure 5 appear to indicate a decrease in total and indirect deaths since 2009-2011, this trend is unlikely to be significant as evidenced by the wide confidence intervals for each year shown in Figures 14-16 (see Annex A).

Addressing the indirect causes of maternal deaths is a complex issue that the Department acknowledge will require further concerted efforts if the 2025 ambition is to be met.⁵⁸ Evidence from written submissions⁵⁹ and the 2016 NHS England National Maternity Review: Better Births⁶⁰ suggests these efforts will need to focus on pre-conception interventions and post-natal support.

⁵⁴ Department of Health and Social Care ([EPE0026](#)), para 22-24. Data sourced from the annual MBRRACE-UK confidential enquiries in maternal death and morbidity reports

⁵⁵ Obstetric Anaesthetists' Association ([EPE0008](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Baby Lifeline ([EPE0021](#))

⁵⁶ Obstetric Anaesthetists' Association ([EPE0008](#))

⁵⁷ Obstetric Anaesthetists' Association ([EPE0008](#)); Baby Lifeline ([EPE0021](#))

⁵⁸ Department of Health and Social Care ([EPE0026](#)), paras 24 -25

⁵⁹ Obstetric Anaesthetists' Association ([EPE0008](#)); NCT (National Childbirth Trust) ([EPE0014](#))

⁶⁰ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

Evidence from the Department⁶¹ and consecutive MBRRACE-UK reports⁶² demonstrates that the risk of maternal death is not only higher for women from minority ethnic and socio-economically deprived backgrounds, but also increasing (see Figures 10 and 13, pg 86 and 90, respectively). Reducing this disparity in maternal death rates requires urgent action and is discussed further in Chapter 5 on page 78-96.

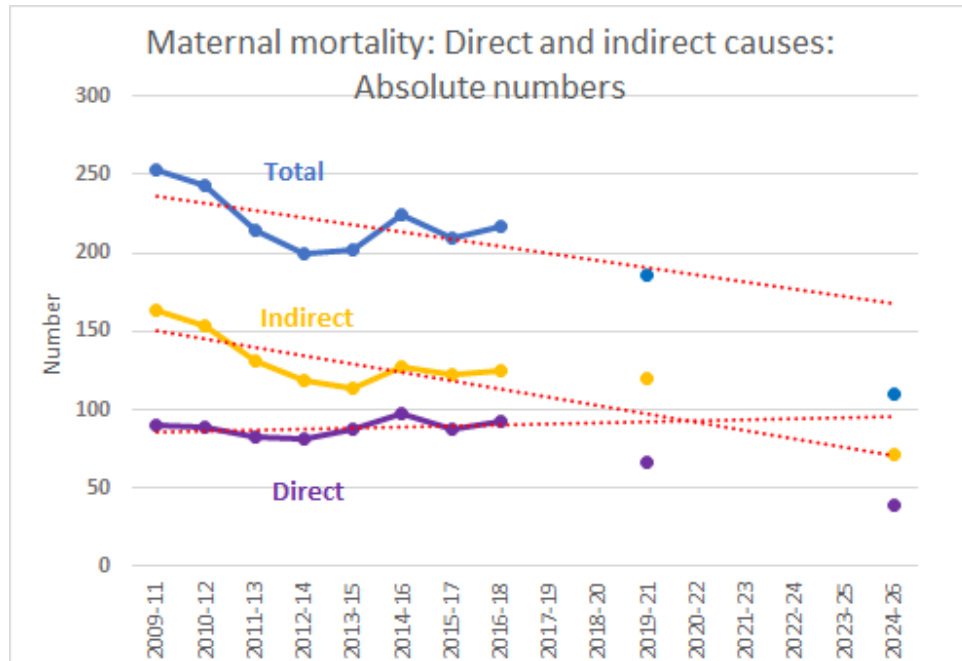


Figure 5. Annual number of maternal deaths. Due to the low numbers of deaths per year data is represented triennially. The blue line and data points represent all deaths; the yellow represent deaths by indirect causes; the purple represent deaths by direct causes; the red dashed lines indicate projected trends. Given the wide confidence intervals on historic data, the projected trend is unlikely to show any statistically significant change by 2024/26 (see Figure 14-16, Annex A). The points at 2019-2021 and 2024-2026 indicate the target rates of maternal deaths based on projections (2009/11 to 2016/18) of maternities. Source: the MBRRACE-UK Maternal Report Dec 2020 v10.⁶³

⁶¹ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

⁶² [Confidential Enquiry into Maternal Deaths | NPEU \(ox.ac.uk\)](#)

⁶³ [MBRRACE-UK Maternal Report Dec 2020 v10 ONLINE VERSION 1404.pdf \(ox.ac.uk\)](#)

v) Pre-term births

Rating and Overview: **Requires Improvement**

While data do not show progress towards achieving the target to reduce pre-term birth rates from 8% in 2015 to 6% in 2025, we note that this target was only added to the National Ambition in 2017. Therefore, the window for newly introduced measures to impact on the data is very narrow. It is therefore not surprising that progress is yet to be achieved. While the initiatives currently being implemented by the Department are welcomed, we anticipate that increased efforts will be required to counteract the setbacks to reducing pre-term birth rates arising from the COVID-19 pandemic in 2020.

ONS data provided by the Department show that the target for reduction in pre-term births is not on track to be met.⁶⁴ However, this target was only added to the National Ambition in 2017, and the data provided only extends to 2019 giving a very narrow window for newly introduced measures to take effect and be reflected in the data (see our analysis in Figure 6). The written submission from the charity Wellbeing of Women⁶⁵ also noted this limitation.

The Department have stated that evidence-based initiatives to reduce pre-term births are currently being implemented, such as the establishment of pre-term birth clinics and the roll-out of the Continuity of Carer model of maternity care (see Chapter 2), suggesting it foresees greater reductions in pre-term birth rates in the coming years than the current rate of decrease would imply.⁶⁶ Given the limited time since the target was introduced, it is too soon to determine whether the slight trend towards reduced pre-term birth rates shown in Figure 6 can be attributed to the commitment. Continued efforts to reduce pre-term birth rates are vital, as experiencing pre-term birth can lead to considerable distress and harm to women.

A participant at our focus group with East African women who have recently accessed maternity services stated that:

"I had my third pregnancy, and at 32 weeks [...], my blood pressure was very high, and I went to [hospital], and they told me they need to take the baby out by C-Section. Straightaway they told me that the baby is not going to live"⁶⁷

Moreover, a recent study has indicated that contracting COVID-19 increases the risk of pre-term birth.⁶⁸ Therefore, data for 2020 may be negatively impacted by the COVID-19 pandemic and we anticipate the need for renewed efforts if the target to reduce pre-term births to 6% by 2025 is to be met.

⁶⁴ Department of Health and Social Care ([EPE0026](#)), paras 14-15. Data sourced from the ONS.

⁶⁵ Wellbeing of Women ([EPE0017](#))

⁶⁶ Department of Health and Social Care ([EPE0026](#)), para 15

⁶⁷ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

⁶⁸ Gurol-Urganci, Ipek; Jardine, Jennifer E; Carroll, Fran; Draycott, Tim; Dunn, George; Fremeaux, Alissa; Harris, Tina; Hawdon, Jane; Morris, Edward; Muller, Patrick; Waite, Lara; Webster, Kirstin; VAN DER Meulen, Jan; Khalil, Asma; (2021) Maternal and perinatal outcomes of pregnant women with SARS-CoV-2 infection at the time of birth in England: national cohort study. American journal of obstetrics and gynecology. ISSN 0002-9378 DOI: <https://doi.org/10.1016/j.ajog.2021.05.016> (In Press)

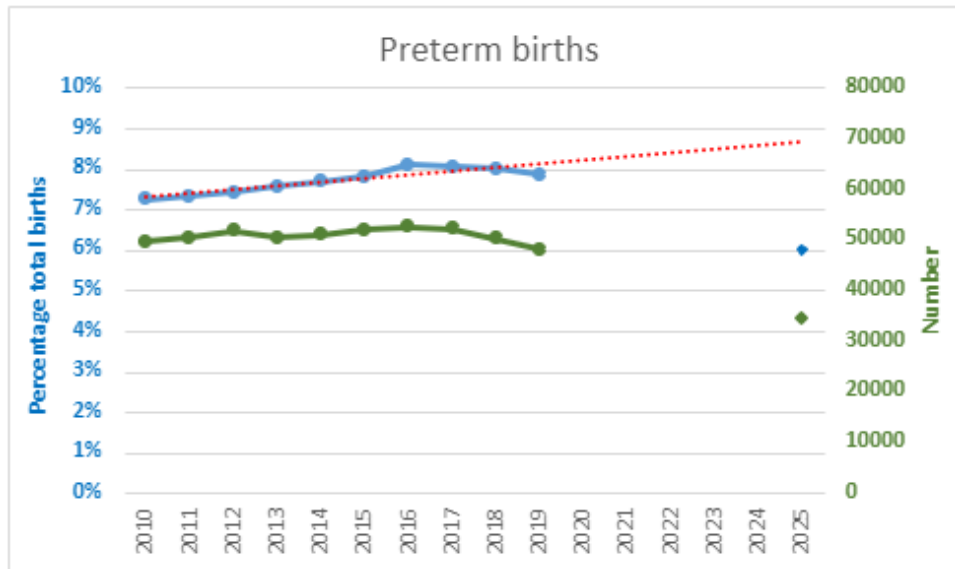


Figure 6. Annual rate or numbers of preterm births in England. Births are considered pre-term at gestational ages between 24+0 and 36+6 weeks. The blue line and data points indicate pre-term births as a percentage of total births; the green indicate total number of pre-term births; the diamonds for the year 2025 indicate the target rate or number of pre-term births (the latter based on projections (2010 to 2019) of total births); the red dashed line indicates the projected trend in percentage pre-term births. Source: The Office for National Statistics' live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2018 (neonatal deaths) and 2010 to 2019 (live births and stillbirths).⁶⁹

⁶⁹ [The Office for National Statistics' \(ONS\) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 \(live births and stillbirths\)](#)

B. Was the commitment effectively funded (or resourced)?

Rating and Overview: **Requires Improvement**

While the range of new funds and resources is greatly welcomed, many stakeholders and clinicians at our roundtable events deemed the current level of funding insufficient. Clinicians stated that current resources and staff numbers are insufficient to adequately implement national guidance and provide opportunities to train in latest clinical best practice, thus impeding progress on this commitment. Moreover, funding was not clearly set out against demonstrable targets. We conclude that the commitment has not been effectively funded thus far and that clarity is needed on the purpose of the funds awarded.

The Department stated that it has launched a range of new and distinct funds associated with delivering elements of Maternity Safety:⁷⁰

- The NHSE/I package of **£90.05 million** to fund Local Maternity Systems (LMSs) across three years (18/19: £18.16 million; 19/20: £38.99 million and 20/21: £32.9 million). This supported initiatives including: Saving Babies Lives Care Bundle version 2 (SBLCBv2) aiming to reduce stillbirth and to minimise unnecessary intervention, reduce pre-term birth; and new Maternal Medicine Networks (MMNs) to give specialist medical help for women with significant medical problems in pregnancy.
- NHSE/I Maternity Investment: **£95.6 million** to target the three overarching themes identified in the Ockenden Report: workforce numbers, training and development programmes to support culture and leadership, and strengthening board assurance and surveillance to identify issues earlier, thereby enabling rapid intervention.
- **£9.4 million** was awarded in the 2020 Spending Review to improve maternity safety, which includes a brain injury reduction programme.
- A **£8.1 million** maternity safety training fund to support Trusts to drive improvements in maternity safety.⁷¹
- A **£250,000** maternity safety innovation fund to support local maternity services to create and pilot new ideas.⁷²
- Health Education England transformation fund **£1 million** for LMS's to map their existing maternity support workforce.
- **£500,000** was allocated for the development of a standardised Perinatal Mortality Review Tool (PMRT), which supports local and national learning to improve care and prevent future deaths.
- Each Baby Counts (EBC) programme: **£431,000** between 2014 -2021 for the Royal College of Obstetricians and Gynaecologists (RCOG) EBC programme. Having established the successful EBC programme, the Department agreed to provide additional funding of **£1.7 million** over three years to provide support for the RCOG

⁷⁰ Department of Health and Social Care ([EPE0026](#)), para 28; [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁷¹ <https://www.hee.nhs.uk/our-work/developing-our-workforce/maternity-safety-training-funding>

⁷² <https://www.gov.uk/government/publications/maternity-safety-innovation-fund-application-form>

and Royal College of Midwives (RCM) to launch the 'Each Baby Counts Learn and Support', a programme to support multi-professional learning and clinical leadership, improve joint working and drive innovation from within the NHS.

- Funding for the Healthcare Safety Investigation Branch's (HSIB) Maternity Investigations Programme, including **£10,272,000** in 2018-19, **£16 million** in 2019-20 and **£16 million** in 2020-21. This programme investigates all cases of intrapartum stillbirth, neonatal death, maternal death and intrapartum brain injury to identify common themes and changes to improve safety.
- **£3.75 million** has been made available through the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), which aims to improve capacity and capability in all maternity units in England).
- **£50,000** in 2016/17, **£106,000** in 2018/19, and **£106,000** in 2019/20 has been provided to Sands, the Stillbirth and Neonatal Death charity to work with other baby loss charities and Royal Colleges to produce and support the roll-out of a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the NHS.

It is not clear whether these funds and resources, and other funding for initiatives such as Continuity of Carer that may improve safety outcomes indirectly, constitute effective funding for this commitment. Moreover, the listed funds and resources have not been clearly allocated to identifiable and measurable actions and initiatives, preventing a meaningful assessment of their impact. Although written submissions emphasised that the existing funding provisions are very welcome, many suggested that current funding is insufficient and highlighted areas that require additional funds.⁷³ Furthermore, Baby Lifeline gives a clear and concerning account of misuse of the Health Education England Maternity Safety Training fund.⁷⁴

During roundtable events we held with clinicians, several participants raised the point that insufficient funds to increase staffing levels in the maternity services has a direct negative impact on training capacity and service safety (see Chapter 4: Safe staffing). For example, participants stated that:

*"The list for training requirements 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 your 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."*⁷⁵

*"Sheep dipping"⁷⁶ people to do things is not the right way to bring about change in practice."*⁷⁷

⁷³ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); The Royal College of Pathologists ([EPE0004](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Wellbeing of Women ([EPE0017](#)); Baby Lifeline ([EPE0021](#)); British Association of Perinatal Medicine (BAPM) ([EPE0022](#))

⁷⁴ Baby Lifeline ([EPE0021](#))

⁷⁵ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

⁷⁶ Sheep dipping refers to the practice of taking staff out of the workplace, putting them into a classroom style training environment for a day or two and then expecting them to come back to the workplace to implement their new learnt skills.

⁷⁷ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

C. Did the commitment achieve a positive impact for women?

Rating and Overview: **Requires Improvement**

Commendable efforts, focus, and resources have gone into maternity safety in an attempt to meet this commitment. The reductions in stillbirth rates and neonatal death rates in babies born at <24 weeks will undoubtedly have achieved a positive impact for the families whose babies have survived where they might otherwise have died. However, the resulting positive impact has been diminished by insufficient increases in workforce numbers to support training in and implementation of new processes and guidance. Moreover, improvements have not been achieved equally, with women and babies from minority ethnic or socio-economically deprived backgrounds continuing to be at increased risk of stillbirth, neonatal death and maternal death (see Chapter 5, pages 78-96). In addition, the continued dismissal of women's concerns and the insufficient involvement of women in their care is an important and overlooked safety outcome that we conclude is not being adequately measured or prioritised in this commitment. The longstanding nature of this dismissal was captured by the testimony of a participant at our focus group, who described the negative pregnancy experiences of both her own pregnancy and her daughter's many years later, where both had their concerns ignored. Given the discrepancy in outcomes for women and babies from different ethnic and socio-economic backgrounds (see Chapter 5, pages 78-96), it is clear that this commitment has not yet had a positive impact for all.

Both the Department's response and written submissions highlight many improvements processes and guidance aimed at achieving the National Ambition to halve the 2010 rate of stillbirths; neonatal deaths; brain injuries that occur during or soon after birth; maternal deaths; and to reduce the pre-term birth rate from 8% to 6% by 2025 (see Annex A).⁷⁸

Conversations with clinicians at our roundtable events suggested that the changes in processes and guidance have been clear and well received. Participants stated:

*"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."*⁷⁹

*"The guidance is very clear and very descriptive."*⁸⁰

However, as discussed previously, completing the prescribed training and implementing this guidance is challenging due to insufficient resourcing and staffing numbers.⁸¹

Since the commitment was set in 2015, the rates of stillbirth and neonatal deaths in babies born at greater than or equal to 24 weeks have reduced, (see: pages 15-19) which will have

⁷⁸ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); Birth Trauma Association ([EPE0013](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); Wellbeing of Women ([EPE0017](#)); Birthrights ([EPE0019](#)); Bliss ([EPE0020](#)); Department of Health and Social Care ([EPE0026](#))

⁷⁹ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

⁸⁰ *Ibid.*

⁸¹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

had a positive impact for women. For example, the Department have explained that the reduction in stillbirth rates during the commitment window has led to more than 750 fewer stillbirths than if the rate had remained constant since 2010.⁸² In addition, the Department provide data supporting a small improvement in patient experience based on CQC Maternity Survey.⁸³ For example, the Department state that:

*"88% of women reported that they (and / or their partner or a companion) were not left alone at all at a time when it worried them during labour and birth, up by 1.4 percentage points since 2018 (77%) and 4.5 percentage points higher than in 2013 (74%)."*⁸⁴

Women not being left alone is associated with better outcomes relating to maternal deaths and morbidity.⁸⁵ Therefore, the reported reduction in the percentage of women experiencing this during labour and birth is welcomed. However, as discussed, whether any of these improvements can be attributed to the commitment remains unclear.

Furthermore, written submissions, the Patient Experience Library and evidence from MBRRACE-UK reports indicate that any positive impact was not achieved equally across different groups of women, such as women with disabilities or women from minority ethnic or socio-economically deprived backgrounds.⁸⁶ This observation was confirmed by further correspondence from the Department, following our request for data to be broken down by women's ethnic and economic background.⁸⁷ The persistence of inequitable outcomes for women from disadvantaged backgrounds is discussed further in Chapter 5 on page 78-96.

The written submissions from the charities National Childbirth Trust (NCT) and Association for Improvements in the Maternity Services (AIMS) also raised concerns that the focus on numerical targets may increase interventions or induction rates and dismiss the women's voice, leading to poorer birth experiences.⁸⁸ In addition, the written submission from the charity Birthrights reports that 1 in 4 women who access maternity leave traumatised by their experience.⁸⁹ Birthrights states that improving women's involvement in their care and listening to their concerns will improve this safety outcome, as women who are included in their care are more likely to experience birth as "safe" regardless of how it unfolded.

⁸² Department of Health and Social Care ([EPE0026](#)), para 7

⁸³ Department of Health and Social Care ([EPE0026](#)), para 46

⁸⁴ *Ibid.*

⁸⁵ [Maternity-Incentive-Scheme-year-3-guidance-FINAL-revised-April-2021.pdf \(resolution.nhs.uk\)](#)

⁸⁶ British Maternal & Fetal Medicine Society ([EPE0006](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Birth Trauma Association ([EPE0013](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Birthrights ([EPE0019](#)); British Association of Perinatal Medicine (BAPM) ([EPE0022](#)); [WhatPriceSafeMotherhoodFINAL.October-1.pdf \(maternityaction.org.uk\)](#); [Mothers' Voices: Exploring experiences of maternity and health in low income women and children from diverse ethnic backgrounds \(maternityaction.org.uk\)](#); [Confidential Enquiry into Maternal Deaths | NPEU \(ox.ac.uk\)](#); [Perinatal Mortality Surveillance | NPEU \(ox.ac.uk\)](#)

⁸⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

⁸⁸ NCT (National Childbirth Trust) ([EPE0014](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁸⁹ Birthrights ([EPE0019](#)); <https://www.makebirthbetter.org/>

Not only will heeding the concerns of women lead to improved birthing experience, it will also help identify failings in maternity care. Dr Bill Kirkup states that the voices of women and their families are often the first sign of failing maternity services and yet are frequently ignored.⁹⁰ The joint written submission from the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives reports an improvement in parent inclusion in reviews following infant death or injury, although the Colleges note that 7% of parents are still not invited to contribute to such reviews.⁹¹

The dismissal of women's concerns is a longstanding issue that continues to negatively impact women's safety and experiences, as evidenced by a participant at our focus group with women from East African backgrounds, who stated:

"I became pregnant again with my fourth baby and [...] my blood pressure rose and the baby died. I lost two babies. And I've asked the doctor so many times, why it happened, give me the reason as I need to follow up what happened to me, especially after 34 and 36 weeks. He didn't me any reason, he just ignored me and told me that the answer was that the food doesn't reach the child at that time. I was so upset, and I feel that they neglected me. I had a lack of treatment and no follow up at all. [...] The same thing happened for my oldest daughter [...] She gave birth last year [2020]. She went through the same experience; she had a rise in blood pressure. They took her to the [...] hospital, and they told her that you have to go home. You have to come back when the contractions are every three minutes, not ten minutes, and she said when she went home, she was crying and was saying that it was very painful. She told them she had to come to the hospital, and they told her no. [...] When I got to the hospital with my daughter, straightaway they took her to the operation. My daughter is unconscious, and her baby's heartbeat has become low. In less than half an hour they took her to the operation."⁹²

⁹⁰ Dr Bill Kirkup ([EPE0005](#))

⁹¹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁹² Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

D. Was it an appropriate commitment?

Rating and Overview: **Good**

The commitment on maternity safety is appropriate. However, there have been some unintended consequences and omissions in the scope of the commitment.

We anticipate that reductions in maternal death rates will increasingly require early intervention at the pre-conception stage and increased post-natal support, particularly including mental health support, to address the indirect causes of maternal deaths. Therefore, the commitment to reduce maternal deaths is undermined by a lack of consideration of pre-pregnancy health, the inclusion of maternity-focused pre-conception intervention strategies and an increase in mental health support in its scope.

We also note that there is a legitimate debate for a change in focus towards avoidable deaths, which could help identify and address at-risk units and areas of maternity care where change in practice could prevent avoidable deaths or harm. A target to reduce avoidable perinatal deaths would also reduce the increasing pressure on maternity services to push for intervention, for example in instances where that is not the wish of the parents. We anticipate that this change in focus would therefore yield greater improvements in women's experiences within maternity services.

Lastly, we conclude that a specific and increased target on improving outcomes for women and babies from minority and socio-economically deprived backgrounds within this commitment is called for, in light of the inequitable outcomes discussed further in Chapter 5 on pages 78-96.

The Department's commitment to halve the 2010 rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth; and to reduce the pre-term birth rate from 8% to 6% by 2025 is admirable, particularly when considering this commitment by international standards. Prior to the commitment being set in 2015, the UK rated poorly on stillbirth and neonatal mortality rates in the first MBRRACE-UK report on perinatal deaths in 2013, by comparison with other European countries.⁹³ In addition, several inquiries at the time highlighted serious failings in certain maternity services across the country.⁹⁴

Against this backdrop, we believe the National Maternity Safety Ambition announced in 2015 to half rates of stillbirths, neonatal and maternal deaths and neonatal brain injuries occurring during or soon after birth by 2030, with an interim ambition of a 20% reduction in these rates by 2020 is an appropriate commitment. The appropriateness of this commitment was reviewed in 2017.⁹⁵ The Department state that the target's deadline was brought forward to 2025 and

⁹³ Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK: [MBRRACE-UK Perinatal Surveillance Report 2013 - AK -27-05.indd \(ox.ac.uk\)](#); Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Department of Health and Social Care ([EPE0026](#)), paras 61-63

⁹⁴ Department of Health and Social Care ([EPE0026](#)), para 61;
<https://publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf>;
<https://www.gov.uk/government/publications/morecambe-bay-investigation-report>

⁹⁵ Department of Health and Social Care ([EPE0026](#)), para 1

the commitment to reduce pre-term birth rates added, following the provision of additional funds.

While this commitment was appropriate from a patient perspective, clinicians at our roundtable events raised concerns over the burden that this commitment has placed on maternity staff. While the latest guidance was generally welcomed, the increased training burden placed on an already overstretched workforce has made learning and implementing new guidance challenging.⁹⁶ Conversations with clinicians at our roundtable events suggested that staff are frequently expected to train in their own time, which contributes to workforce burnout and attrition rates. One participant stated that:

*"[...] increasingly for development opportunities staff are finding that they're being asked to do training in their own time, because Trusts are again not valuing the training or recognising that the continual training of staff is as integral to safety as having the right numbers of staff present."*⁹⁷

In addition, some omissions in the scope of this commitment are outlined by the written submissions. Of particular importance are missed intervention opportunities in addressing maternal deaths, a lack of focus on avoidable deaths in maternity care, and the need to improve outcomes in underperforming 'outlier' NHS Trusts, whose failings can be masked by improvements in national averages.⁹⁸

Interventions to reduce maternal deaths

In its written response, the Department acknowledged that improving maternal death rates will depend on pre-conception healthcare initiatives as there are "limited opportunities for maternity services to optimise maternal health during the pregnancy pathway."⁹⁹

Written submissions have highlighted that the majority of maternal deaths are due to indirect causes, as discussed previously in section A.¹⁰⁰ This shift in causal factors has occurred in the context of increasing maternal complexity, due to increased maternal age and obesity, and other socioeconomic changes.¹⁰¹ The charity Birthrights expressed concern over 'blame' for these factors in maternal deaths being placed on mothers without acknowledging the societal pressures that contribute to them, which are often associated with disadvantage.¹⁰²

Given the increasing complexity of the maternal population, the evidence we have received demonstrating the dismissal of some women's voices in their maternity care will no doubt exacerbate the contribution of these indirect factors to maternal death rates, as these women may not be able to communicate their personal health needs to their clinicians. Our focus

⁹⁶ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

⁹⁷ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁹⁸ Dr Bill Kirkup ([EPE0005](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Obstetric Anaesthetists' Association ([EPE0008](#)); Campaign for Safer Births ([EPE0009](#)); Birthrights ([EPE0019](#)); Caesarean Birth ([EPE0023](#))

⁹⁹ Department of Health and Social Care ([EPE0026](#)), para 64

¹⁰⁰ Obstetric Anaesthetists' Association ([EPE0008](#)); Baby Lifeline ([EPE0021](#))

¹⁰¹ Obstetric Anaesthetists' Association ([EPE0008](#))

¹⁰² Birthrights ([EPE0019](#))

group¹⁰³ and written submissions¹⁰⁴ suggest that the dismissal of the concerns and choices of women from minority ethnic and socio-economically deprived backgrounds may be a contributing factor in some of the disparities in outcomes these women experience, including being at greater risk of maternal death, as discussed in Chapter 5 pages 78-96.

In follow up correspondence¹⁰⁵ the Department stated that health interventions in the pre-conception period fall within the scope of the maternity safety commitment, but as part of a larger piece of work being undertaken across the Department and its Arms' Length Bodies in relation to public health. This includes work on smoking cessation, promoting a healthy lifestyle and healthy eating. However, these health interventions are not specific to the maternity services.

A further cause of maternal deaths that requires greater focus is the contribution of mental health issues and suicide to maternal deaths. The charity Better Births report that 23% of [late maternal] deaths were due to mental health related causes, with one in seven women dying through suicide.¹⁰⁶ The 2019 CQC Maternity survey states that combating poor mental health of pregnant women is a significant factor in preventing maternal death.¹⁰⁷ The survey data indicates that information on mental health at the postnatal stage could be improved. Women experiencing mental health difficulties may not necessarily identify them correctly, therefore the CQC suggest a well distributed description of the symptoms might help women to recognise mental health problems and encourage them to disclose these to their health professional.

The need for psychological support following pregnancy was highlighted by a participant from our focus group who suffered a recent traumatic pregnancy loss and when asked if she believed she may need counselling she stated:

*"Yes, because I'm blaming myself a lot."*¹⁰⁸

The scope of this commitment did not address the contribution of mental health difficulties in maternal deaths, contributing to the lack of progress towards this target.

¹⁰³ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

¹⁰⁴ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Birthrights ([EPE0019](#)); Caesarean Birth ([EPE0023](#))

¹⁰⁵ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#);

¹⁰⁶ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

¹⁰⁷ [20200128_mat19_statisticalrelease.pdf \(cqc.org.uk\)](#) page 27

¹⁰⁸ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

Avoidable deaths and the role for medical examiners in investigations:

The importance of avoidable harm is a recurring theme in the written submissions.¹⁰⁹ Professor Tim Draycott (referenced by Caesarean Birth)¹¹⁰ and Campaign for Safer Births,¹¹¹ cite the 2020 Each Baby Counts' finding that 75% of term intrapartum still births and deaths were potentially avoidable with different care.¹¹²

Not all serious incidents in the maternity services are preventable. Therefore, delineating between avoidable and unavoidable deaths or harm will allow Trusts to achieve greater progress towards numerical safety targets. Dr Bill Kirkup proposes that avoidable perinatal and maternal death rates are a more sensitive marker of Trust performance than total death rates.¹¹³ Therefore, by aiming to reduce avoidable deaths rather than total deaths, Trusts will be able to more accurately monitor improvements in outcomes attributable to improved quality of care. Focusing on avoidable deaths would also aid the identification of at-risk maternity services for targeted assessment and intervention, as discussed in the subsequent section on identifying at risk units.¹¹⁴

The recommendations by Dr Bill Kirkup and Campaign for Safer Births for each avoidable death to be subject to full investigation and independent review¹¹⁵ align with evidence from the Royal College of Pathologists of an omission in scope of this commitment: the failure to commit to changes in post-mortem processes to stillbirths that would place them under the jurisdiction of medical examiners (MEs) and allow stillbirths to be subject to coronial investigation where appropriate.¹¹⁶

A target to reduce avoidable perinatal deaths rather than total deaths would also avoid the unintended consequence of increasing pressure on maternity services to intervene with maternities, when that may not be the mother's wishes. However, we acknowledge that caution is needed to avoid the perception of value judgements being made on unborn babies that could imply that avoidable deaths are more important than the unavoidable deaths. Moreover, at a meeting with NHSE/I officials on 15 June 2021, the National Clinical Director for the Maternity Review and Women's Health for NHS England, Matthew Jolly, expressed concern that a focus on avoidable harm would lead to an increase in blame culture, stating that:

*"If you start to score trusts on the number of avoidable deaths, and start to dig into that, you start to drift into a blame culture and there are a lot of unforeseen consequences to that. There would be a risk of people women shaming, with comments like 'you smoked' or 'you're obese' or because they made lifestyle choice."*¹¹⁷

¹⁰⁹ The Royal College of Pathologists ([EPE0004](#)); Dr Bill Kirkup ([EPE0005](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Campaign for Safer Births ([EPE0009](#)); Caesarean Birth ([EPE0023](#))

¹¹⁰ Caesarean Birth ([EPE0023](#))

¹¹¹ Campaign for Safer Births ([EPE0009](#))

¹¹² Each Baby Counts: [ebc-2020-final-progress-report.pdf \(rcog.org.uk\)](#) page 12, figure 11

¹¹³ Dr Bill Kirkup ([EPE0005](#))

¹¹⁴ *Ibid.*

¹¹⁵ Dr Bill Kirkup ([EPE0005](#)); Campaign for Safer Births ([EPE0009](#))

¹¹⁶ The Royal College of Pathologists ([EPE0004](#))

¹¹⁷ Transcript of Expert Panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

Identifying at risk units and improving underperforming outlier Trusts

A key omission in scope highlighted by Dr Bill Kirkup is the lack of progress in identification of at-risk units and addressing issues in these poor performing trusts, rather than improving national figures by improving the “middling majority.”¹¹⁸

Dr Kirkup suggests that addressing this issue will require the development of a performance outlier tool akin to other specialties.¹¹⁹ Inadequate digitisation of patient records and data collection strategies in the maternity services are highlighted in the written submissions and may hinder progress on such a tool.¹²⁰

In particular, Dr Kirkup highlights the importance of monitoring and reporting on unexpected perinatal deaths in identifying at risk maternity services:

“Better independent scrutiny of all unexpected perinatal deaths would be a very significant step forward, helping to identify poorly performing services before they cause scandals, and contributing to the national ambition to improve maternity safety further.”¹²¹

Dr Kirkup recommends reviewing unexpected perinatal death rates as a performance metric, rather than relying on self-detection and reporting by Trusts. However, as previously mentioned, assessing this metric is not currently included in the National Ambition.¹²² We suggest that expanding the maternity safety metrics being monitored should not only relate to unexpected outcomes for the fetus, but should also include maternal deaths.

The Royal College of Pathologists support the significance of unexpected death rates in detecting poorly performing NHS Trusts. It suggests that a further benefit of expanding the jurisdiction of MEs to include stillbirths would be their ability to provide independent scrutiny of maternity services, including speaking to relatives to hear their views.¹²³

In a meeting with NHSEI officials on 15 June, the Chief Midwifery Officer for NHS England, Jacqueline Dunkley-Bent, indicated that new measures were being introduced to address this omission. She stated that NHSE/I have:

“...developed and implemented and operationalised a new quality surveillance model. And that’s really designed to proactively support Trusts that require support before a serious issue arises. [...] This model provides, should provide, a consistent and methodological oversight of all services, specifically concerning safe maternity of course, and so the model helps with gathering, learning, insight to inform improvements. That is implemented now across all the local maternity systems, and is very new, very embryonic. At present it’s shown to be working effectively. It’s highlighting some of the soft intelligence that we wouldn’t get through just data alone. And as Matthew frequently talks about, if Morecambe Bay has taught us anything it’s taught us that we cannot rely on data in itself, we have to have that intelligence. We also then, in relation to the quality surveillance across all maternity providers, we also have the Maternity Safety Support Programme and that’s a programme that we provide for any maternity provider that has been recognised by the CQC [Care Quality Commission] as for

¹¹⁸ Dr Bill Kirkup ([EPE0005](#))

¹¹⁹ *Ibid.*

¹²⁰ Dr Bill Kirkup ([EPE0005](#)); Campaign for Safer Births ([EPE0009](#)); Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

¹²¹ Dr Bill Kirkup ([EPE0005](#))

¹²² Department of Health and Social Care ([EPE0026](#)), para 1

¹²³ The Royal College of Pathologists ([EPE0004](#))

*example, required improvement or inadequate, or indeed of concern to HSIB [Healthcare Safety Investigation Branch] or CQC [Care Quality Commission], or any form of warning notice applied to them or any form of inquiry. And what we've done in recent times, so that we can focus upstream with capturing services before they end up with a CQC [Care Quality Commission] inadequate rating, we've changed our criteria by which a Trust would enter onto the programme too. So our criteria is broader, and we are focusing on services through that soft intelligence and other metrics show us that they need support before they have a CQC [Care Quality Commission] inadequate. So that's the Maternity Safety Support Programme in a nutshell. It's supported by heads of midwifery and obstetricians who will go into an organisation and help them on their improvement journey."*¹²⁴

¹²⁴ Transcript of Expert Panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

Chapter 2: Continuity of Carer

In this section we provide an assessment of the Government's commitment to implement Continuity of Carer, provided to us by the Department of Health and Social Care, which states:

"The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period."¹²⁵

Overall Commitment Rating and Overview for Continuity of Carer:

Requires Improvement

Continuity of Carer (CoC) is defined as women being cared for by the same midwife, or small team of midwives, throughout pregnancy, birth and post-natal care.¹²⁶ Implementation of this model of care was a key recommendation of *Better Births; the NHS England National Maternity Review* published in 2016.¹²⁷ There is a robust body of evidence to support CoC, including multiple Cochrane reviews which attribute improved maternal and fetal safety outcomes to CoC,¹²⁸ as well as CQC surveys indicating improved birthing experiences of women in receipt of CoC compared with women receiving traditional models of care.¹²⁹

Baroness Cumberlege and Sir Cyril Chantler, authors of *Better Births*, describe CoC as central to improvements in personalised care and safety, and we fully support the commitment to extend roll-out of this model of care. In their written submission Baroness Cumberlege and Sir Cyril Chantler stated:

***"Continuity of carer is at the heart of achieving the "Better Births" ambition of a more personal and safer maternity service. The Cochrane reviews of 2016, 2018 and 2020 have shown that it improves both clinical outcomes and women's experience of care."*¹³⁰**

The Department committed to delivering Continuity of Carer to the majority of women by 2021, with an interim target of 20% of women by March 2019.¹³¹ This is a sensible ambition. However, CoC roll-out estimates are based on the capacity

¹²⁵ [Letter from Rt Hon Matt Hancock MP, Secretary of State, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the work of the Expert Panel \[14 December 2020\]](#)

¹²⁶ Implementing Better Births: Continuity of Carer, Five year forward view, December 2017, [implementing-better-births.pdf \(england.nhs.uk\)](#)

¹²⁷ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

¹²⁸ https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

¹²⁹ Department of Health and Social Care (EPE0026), para 79; https://www.cqc.org.uk/sites/default/files/20190129_mat18_outliers.pdf

¹³⁰ Baroness Cumberlege and Sir Cyril Chantler (EPE0001)

¹³¹ [Letter from Rt Hon Matt Hancock MP, Secretary of State, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the work of the Expert Panel \[14 December 2020\]](#)

of NHS Trusts to book women onto the CoC pathway rather than the number of women who receive CoC, as data are not currently available for this more sensitive and accurate measure.¹³² This makes it difficult to assess progress. Estimates based on NHS Trusts' capacity to roll-out CoC are likely to over-estimate the true figure of CoC receipt but even by this less sensitive proxy measure, data indicate that this commitment is not on track to be met.¹³³

The scale of the organisational changes required to successfully implement CoC were not adequately considered at the outset. Consequently, there has been insufficient resourcing and training at a managerial, Trust and Local Maternity System level to support implementation. This has led to delayed, uneven, and unequal roll-out of this beneficial model of care. The challenges of running two parallel maternity care models (CoC and traditional) during the transition period were not adequately considered. This has resulted in increased pressure and stress on an already overstretched workforce causing recruitment problems in some teams and increased risk of attrition. In some areas progress on this commitment has been further delayed by the COVID-19 pandemic.¹³⁴

An additional target was added in 2019 as part of the NHS Long Term Plan, which committed to ensuring "75% of women from BAME communities and a similar percentage of women from the most deprived groups receiving Continuity of Carer by 2024."¹³⁵ This target is likely to be central to improving the experiences and outcomes for these women, although improved data collection and additional targeted initiatives to reduce the disparity in outcomes for these groups will also be required (see Chapter 5 pages 78-96).

Given the strong evidence for the effectiveness of CoC in improving women's experiences and outcomes, it is vital that additional centralised support is provided to ensure successful implementation and robust evaluation. Discussions with clinicians at our roundtable events emphasised the importance of consistent local, regional, and national CoC leads. Clear guidance and effective communication of the value of CoC to all stakeholders, including Trust executives, will improve successful implementation.

¹³² Department of Health and Social Care ([EPE0026](#)), paras 73-75

¹³³ Department of Health and Social Care ([EPE0026](#)), paras 67-68

¹³⁴ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); Birthrights ([EPE0019](#)); Department of Health and Social Care ([EPE0026](#)), para 66

¹³⁵ Department of Health and Social Care ([EPE0026](#)), para 70

Analysis of Continuity of Carer

This section provides an analysis of the commitment to ensure “the majority of women receive Continuity of Carer by 2021” and the secondary commitment that “75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care by 2024.” This analysis is based on the main questions set out in the planning grid. An analysis of each sub-question, as described in the planning grid, can be found in Annex B.

A. Was the commitment met overall? Is the commitment on track to be met?

Rating: **Inadequate**

It is not currently possible to determine how many women received Continuity of Carer (CoC) by the target deadline of March 2021, but it is likely to have been significantly fewer than the majority. CoC roll-out estimates are based on survey data from NHS Trusts on the number of women who are booked on to the CoC model of care rather than the number of women who receive CoC. This makes it difficult to assess progress against this commitment. Estimates based on NHS Trusts’ capacity to roll-out CoC are likely to over-estimate the true figure of CoC receipt but even by this less sensitive proxy measure, data indicate that this commitment is not on track to be met. This lack of appropriate data collection strategy at the point the commitment was made undermines the hard work of NHS staff at both Trust and national level to support the roll-out of CoC.

In addition, an initial lack of implementation guidance led to confusion about interpretation and implementation of CoC across England which has resulted in variable CoC provision. While effective implementation can improve staff morale,¹³⁶ poor implementation, especially in the context of inadequate staffing levels, can have a negative impact on morale for some staff (see Chapter 4, Safe Staffing). CoC is an important and well-evidenced commitment that requires effective national implementation plans and processes supported by adequate staffing levels to enable the required organisational change.

Survey data from October 2020 provided by the Department show that 108 Trusts had the capacity to offer Continuity of Carer (CoC) to approximately 94,000 women across 347 CoC maternity teams.¹³⁷ This figure equates to 15.9% of pregnant women based on 2019 birth rates, falling short of the 2019 interim target of 20% and significantly below a majority of women. Written submissions from SANDS and RCM/RCOG corroborate this finding based on the Safer Maternity Care Progress Report 2021.¹³⁸ The lack of data on CoC provision in other years means that it is not currently possible to establish a reliable progress trajectory.¹³⁹

There has been a lack of progress towards establishing appropriate systems to collect relevant data on the number of women who receive CoC, which would allow accurate assessment of progress against this target and support roll-out of this model of care. Although the

¹³⁶ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

¹³⁷ Department of Health and Social Care ([EPE0026](#)), para 67

¹³⁸ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#))

¹³⁹ Department of Health and Social Care ([EPE0026](#))

commitment sets targets for women to 'receive' CoC, the Department's response reports on NHS Trusts' capacity to roll-out this model of care; not on the number of women who currently have access to the model.¹⁴⁰ The Department cites its intention to record the number of women in receipt of CoC routinely through MSDSv2 but acknowledge that NHS Trusts' capacity to evidence continuity of care is an issue.¹⁴¹ The charities SANDs and AIMS also highlight the confusion caused by the collection of data on capacity to provide, rather than receipt.¹⁴²

During the meeting 29 April 2021,¹⁴³ the Department provided additional context for the lack of meaningful data against this commitment. Following the establishment of the commitment to CoC, the Maternity Services Dataset (MSDSv1) was updated (MSDSv2) so that, rather than collecting information on women booked onto CoC programmes (v1), it will capture entry onto CoC pathway and receipt through digital records of appointment attendance by maternity team (v2). Although the infrastructure for the precise measuring of receipt of CoC is now in place, NHS Trusts are at different levels of digital maturity in moving away from paper records, which has delayed data acquisition. In the interim, NHSE/I have been running surveys to assess progress, which they are confident show work is progressing positively. The 'summer' data promised in point 68 of the Department's response¹⁴⁴ refers to the latest survey data and should provide numbers on CoC receipt across the whole pregnancy pathway. However, this data has not been made available to us in time for this report.

Information received from The Patient Experience Library suggests that receipt of CoC may be substantially lower than estimates of capacity. Citing 2020 CQC survey data, they state that "only 9% of women said that at least one of the midwives who cared for them postnatally had also been involved in both their labour and antenatal care."¹⁴⁵ However, CoC involves small teams of midwives so women may see different midwives from within their continuity team at different stages of care. Thus, this CQC figure may not be a precise indicator of whether a woman has received CoC. However, it does provide a useful benchmark as we know that establishing a trusting relationship with a midwife is an important aspect of continuity care.

Regarding the secondary commitment to ensure provision of CoC to disadvantaged women, the Department states that of the 347 established CoC teams, 60% are in areas of high deprivation with around half serving areas with high black population.¹⁴⁶ This figure suggests that the number of women from these backgrounds receiving CoC is likely to be increasing, however it is clear that this is not on track to meet the target of 75%. The absence of a coherent data collection strategy for women receiving CoC precludes a more precise assessment of this target.

The scale of organisational change required for midwifery teams to adapt safely to a Continuity of Carer (CoC) model was raised as an important issue in a number of written submissions

¹⁴⁰ Department of Health and Social Care ([EPE0026](#)), para 67

¹⁴¹ Department of Health and Social Care ([EPE0026](#)), para 74

¹⁴² Sands ([EPE0012](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

¹⁴³ An informal meeting was held between members of the Expert Panel and officials from the Department of Health and Social Care and NHSE/I regarding Government commitments in the area of maternity services [29 April 2021]

¹⁴⁴ Department of Health and Social Care ([EPE0026](#)), para 68

¹⁴⁵ [20200128_mat19_statisticalrelease.pdf \(cqc.org.uk\)](#)

¹⁴⁶ Department of Health and Social Care ([EPE0026](#)), para 67

and at our roundtable events, highlighting the need for more effective implementation support. Baroness Cumberlege and Sir Cyril Chantler, authors of Better Births, stated:

*“There have been problems with its introduction because to do it successfully, requires a change in the way midwifery teams work both within the community and in hospital. That is why some areas have been more successful than others.”*¹⁴⁷

This view was shared by other stakeholders. The written submission from Donna Ockenden and her maternity review team suggested that current implementation support is not adequate to support this level of change and that existing pressures on staff represent a challenge to future roll-out.¹⁴⁸ The joint submission from RCM and RCOG said that the significant shift in working practices required for successful transition should be considered in any implementation plan. They commented:

*“The development of midwifery continuity of carer as the central model of care requires a very significant shift in the way in which maternity services are delivered.”*¹⁴⁹

Clinicians at our roundtable events stated that while guidance about the meaning and evidential basis of CoC, as laid out in Better Births,¹⁵⁰ was clear, guidance and support for implementation was less so, and that maternity services were expected to interpret and implement this change individually. For example, one participant told us:

*“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.”*¹⁵¹

This lack of clear guidance also applied to implementing continuity of obstetrician within teams, with one participant saying:

*“I think for the obstetrics part of the team there’s been very little [guidance], if any, and therefore it’s very complex to provide obstetric continuity, especially with most units having obstetricians in training as part of the team.”*¹⁵²

The Department has recently taken steps to support and provide clarity on implementation of CoC. A workforce tool was developed by NHSE/I to allow staffing calculations for CoC teams.¹⁵³ Although this tool only became available in late 2020, participants in our roundtable events commented on recent improvements in clarity and increased centralised support:

*“I think recently the clarity has come back and there seems to have been more steer from the national team.”*¹⁵⁴

*“The appointment of a national lead has really helped, especially in our region.”*¹⁵⁵

¹⁴⁷ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

¹⁴⁸ Donna Ockenden ([EPE0025](#))

¹⁴⁹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

¹⁵⁰ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

¹⁵¹ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

¹⁵² *Ibid.*

¹⁵³ <https://continuityofcarer-tools.nhs.uk/>

¹⁵⁴ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

¹⁵⁵ *Ibid.*

Another participant suggested that CoC implementation can be supported through clearer communication of the benefits of this model to NHS Trusts' executive teams:

*"We've been doing Continuity of Carer assurance type visits or places where they've got low percentage rates. [...] 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."*¹⁵⁶

Regional variability in roll-out was raised as a concern in several written submissions.¹⁵⁷ The charity AIMS (Association for Improvements in the Maternity Services) described roll-out as "patchy"¹⁵⁸ while Birthrights commented that access to the pathway varies not only by geographical location but according to clinical status with women identified as higher risk less likely to be offered CoC. They commented:

*"This has led to huge variation across England. The situation is even more complicated for women requiring consultant led care."*¹⁵⁹

There were also reports of some teams having difficulty recruiting to continuity teams due to the requirement to be confident working in all specialties, from ante-natal care, labour ward, and into the post-natal period.¹⁶⁰ This requirement was also associated with increased pressure to work on-call and during anti-social hours. RCM and RCOG stated that:

*"Midwives have expressed unwillingness to work in a full pathway continuity model. This has been due to the unpopularity of on call rather than shift-based working; concerns over burnout due to unmanageable caseload sizes, arising from midwifery staffing shortages; lack of time, support and training to adapt to new ways of working and providing care in unfamiliar settings."*¹⁶¹

Appropriate support and training for staff to manage the transition are needed to ensure CoC is an attractive proposition for staff as well as women. During our roundtable event clinicians described the potential for increased job satisfaction and autonomy following well-implemented CoC. She said:

*"I think the issue of continuity is a really important one. I think some people are fearful of what it means, but if it is introduced properly in a co-produced way with staff, actually it can increase control and agency of midwife so that they become the autonomous practitioners that they expected to be. But it does require implementation to be very much focused on working with teams, not just imposing a model on them."*¹⁶²

RCM and RCOG also commented that CoC is likely to be worth the wait, but again emphasised the importance of effective implementation that is sensitive to Trusts' capacity to adapt, and which includes careful consideration of staffing needs. They commented:

¹⁵⁶ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

¹⁵⁷ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

¹⁵⁸ *Ibid.*

¹⁵⁹ Birthrights ([EPE0019](#))

¹⁶⁰ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

¹⁶¹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

¹⁶² Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

“The potential benefits of midwifery continuity of carer for women, families and midwives, make it worth the effort of putting these conditions in place to support the implementation of a safe and sustainable midwifery continuity of carer service. Unfortunately, we do not believe that all of these conditions are in place as yet.”¹⁶³

Given the strong evidential basis that CoC improves women’s maternity experiences and outcomes, the lack of a centralised process to support roll-out is regrettable.¹⁶⁴ We acknowledge recent efforts to improve implementation, but more support is needed to ensure all women have access to this important model of care. The successful implementation of 347 continuity teams around the country suggests that the necessary conditions are in place in some Trusts.¹⁶⁵ Learning from places where implementation has been successful and sustained will ensure the commitment is met across all Trusts.

In their joint submission, Baroness Cumberlege and Sir Cyril Chantler commented that recent increases in staffing funding are likely to help with CoC roll-out and that as more Trusts successfully adapt, CoC is likely to become more popular with staff as well as women.

“The recent increase in funding to increase staff numbers is likely to be very helpful in achieving the ambition as will be the new ways of working which are becoming more popular as they are seen to be successful.”¹⁶⁶

¹⁶³ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

¹⁶⁴ https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

¹⁶⁵ Department of Health and Social Care ([EPE0026](#)), para 67

¹⁶⁶ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

B. Was the commitment effectively funded (or resourced)?

Rating: **Requires Improvement**

The Department state that two main funding sources were provided to support the implementation of the Continuity of Carer model. These are:

- ***The Service Development Fund within the £90.05 million NHSE/I package across three years (18/19 - 20/21),¹⁶⁷ and***
- ***£745,000 from HEE in 2018/2019, followed by HEE funding for a national training package to support Continuity of Carer in 2020/2021, at an expected cost of c.£300,000.¹⁶⁸***

While these funds are welcome and have facilitated essential training to assist implementation of CoC, greater funding and the right people with the right skill set to lead change are required to support the organisational rearrangements needed to successfully implement this model of care.

Discussions during our roundtable events with clinicians suggest that funding provided to support CoC implementation was welcome, with one participant stating that:

"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."¹⁶⁹

However, written submissions from Baroness Cumberlege and Sir Cyril Chantler, The British Maternal and Fetal Medicine Society, Campaign for Safer Births, RCM/RCOG, SANDS, and Donna Ockenden all commented that current spending plans are insufficient, and that ringfenced funding is required to support adequate staffing and training of CoC teams.¹⁷⁰ RCM and RCOG stated that:

"[current funding] has never been sufficient to enable the right conditions to be in place for Continuity of Carer to be successfully implemented. We have consistently argued that there needs to be significant investment to ensure that a safe service can continue to be provided during the transition to a continuity model, and that this should include funding to release staff for training and shadowing opportunities. Furthermore, adequate finance needs to be provided to ensure that the appropriate physical environments are created to support Continuity of Carer, such as community hubs."¹⁷¹

Moreover, the charity National Maternity Voices stated that further resources are needed to ensure CoC reaches and is taken up by disadvantaged women. They commented:

¹⁶⁷ Department of Health and Social Care ([EPE0026](#)), para 76

¹⁶⁸ Department of Health and Social Care ([EPE0026](#)), para 37

¹⁶⁹ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

¹⁷⁰ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Donna Ockenden ([EPE0025](#))

¹⁷¹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

“To ensure the policy improves equity in the service it is vital that MVPs are resourced to reach out to diverse families particularly those from ethnic minorities and those in disadvantaged areas.”¹⁷²

The Department have not provided details of the factors considered when determining funding and resources for CoC, although it has stated that it does not anticipate the CoC system to be more expensive once implemented.¹⁷³

Written submissions¹⁷⁴ and discussions with clinicians during the roundtable events¹⁷⁵ suggest that existing staffing deficiencies necessitate greater transitional support than originally anticipated to deliver the organisational changes required to achieve this commitment.

¹⁷² National Maternity Voices ([EPE0018](#))

¹⁷³ Department of Health and Social Care ([EPE0026](#)), para 76

¹⁷⁴ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

¹⁷⁵ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0029](#)); Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

C. Did the commitment achieve a positive impact for women?

Rating: **Requires Improvement**

While evidence supports the notion that roll-out of Continuity of Carer (CoC) will have a positive impact on women's experiences and outcomes of maternity services,¹⁷⁶ slow roll-out has meant that most women are still unable to access this model of care. In particular, data are not yet available to assess placement or receipt of CoC for women identified as marginalised or disadvantaged. The Department have committed to improving data quality relating to CoC¹⁷⁷ and acknowledge that much work remains to be done on this issue.¹⁷⁸ However, it is not yet possible to establish whether positive impact has been achieved equally across all groups of women. This absence of a coherent data strategy to monitor roll-out for women from black and ethnic minority, or socio-economically disadvantaged backgrounds undermines the commitment to prioritise roll-out for these groups of women.

Survey data provided by the Department show increased satisfaction and outcomes for the relatively low number of women who have received CoC compared with those receiving traditional modes of care.¹⁷⁹ Moreover, successive Cochrane Reviews¹⁸⁰ show that "women who received midwife-led continuity of care were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth: 16 per cent less likely to lose their baby, 19 per cent less likely to lose their baby before 24 weeks and 24 per cent less likely to experience pre-term birth."¹⁸¹ The survey also showed that women "seeing the same midwife postnatally as in the antenatal and intrapartum periods, were on average 15% more positive about the general information they received about key postnatal issues, and 10% more happy with the support and advice they received on breastfeeding, than those women who said they didn't receive continuity and didn't mind", with "a considerable improvement in satisfaction across all questions where this analysis applies."¹⁸²

Several written submissions agreed that the Continuity of Carer model is likely to improve outcomes and experiences for women, especially those from minority ethnic and/or socio-economically disadvantaged backgrounds.¹⁸³ Moreover, a written submission from SANDS

¹⁷⁶ https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early;

https://www.cqc.org.uk/sites/default/files/20190129_mat18_outliers.pdf

¹⁷⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

¹⁷⁸ Department of Health and Social Care ([EPE0026](#)), para 74

¹⁷⁹ Department of Health and Social Care ([EPE0026](#)), para 79

¹⁸⁰ Department of Health and Social Care ([EPE0026](#)), para 78

¹⁸¹ Department of Health and Social Care ([EPE0026](#)), para 82

¹⁸² *Ibid.*

¹⁸³ Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); National Maternity Voices ([EPE0018](#))

stated that bereaved parents who had been on a continuity pathway found having a known contact helpful following their loss.¹⁸⁴

During our roundtable events, clinicians broadly agreed that CoC is likely to be associated with demonstrable benefits for women. One participant told us:

*"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."*¹⁸⁵

Participants also discussed emerging local-level data analysis which may indicate potential outcome improvements related to CoC. One midwife explained that:

*"We're looking at whether women have been in Continuity of Carer models, to see if it's made any difference to outcomes which will be really interesting. [...]one of our providers reported that they had five stillbirths, and I happened to ask her if they're on Continuity of Carer models and none of them were, so we've started to look at that across the whole region now."*¹⁸⁶

In our focus group with women from East African backgrounds one woman described the benefits of having a known midwife with whom to build a relationship and to share concerns and experiences. She felt this would increase her confidence and make her less scared of how she may be received by unknown professional staff. She said:

*"I think that would be a great idea, because I felt like every time I had to face a new person and I felt a bit scared, because I wondered, what are they going to say now or what are they going to do to me now? [...] So, in my view having one midwife might be helpful and also having somebody that can understand us and our culture's views. Just someone who understands what human rights is."*¹⁸⁷

The value of having a consistent known carer was also acknowledged by clinicians in our roundtable events who described CoC as an important opportunity to build the relationship needed for more personalised maternity care. She said:

*"Midwifery continuity can make a huge contribution, because you don't have to have these repetitive conversations that drain women, having to tell their story over and over again and actually you do build a complex relationship where there is understanding of what that family actually wants."*¹⁸⁸

Stakeholders commented that to achieve meaningful improvements, there should be an additional focus on the competence as well as the continuity of carer. For example, the British Maternal and Fetal Medicine Society stated that:

*"Continuity of the wrong type of care will not result in improvements. Whilst continuity of care/carers is an important aim, ensuring the competence of carers is more so."*¹⁸⁹

¹⁸⁴ Sands ([EPE0012](#))

¹⁸⁵ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

¹⁸⁶ *Ibid.*

¹⁸⁷ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

¹⁸⁸ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0029](#))

¹⁸⁹ British Maternal & Fetal Medicine Society ([EPE0006](#))

This view was supported by discussions in our focus groups with women from East African backgrounds. One woman described having a very positive experience of CoC because her midwife was able to speak her language and understood her culture. However, she told us that women receiving care from midwives without similar cultural understanding struggled to access the same benefits. She said:

*"I was so lucky choosing a Somali speaking midwife, because there have been some friends that I know who haven't had a choice or were not able to speak their language or that they can relate to. Even though I didn't need interpretation, I just felt like I wanted somebody from my culture, and I had the best experience. But what they have told me is that even though they selected one midwife, the experience that they came across was not the same as my one. They really struggled."*¹⁹⁰

While it is not possible to ensure women have access to a midwife who speaks the same language, the assumption of cultural competency for all staff should be prioritised in CoC training, along with resources to provide adequate translation and advocacy support.

In the context of ongoing staff shortages, the impact of CoC roll-out on staff must also be fully considered to avoid deterioration of morale in an already overstretched workforce. Our evidence suggests that, where implemented properly, the impact of Continuity of Carer has generally been positive for women with the potential to increase morale and job satisfaction for staff especially where the transition has been well-managed and well-resourced. However, roll-out has varied significantly between Trusts and access has not been equal for different groups of women. Furthermore, there is a lack of a centralised tool to assess impact, experiences and outcomes for women.

¹⁹⁰ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

D. Was it an appropriate commitment?

Rating: **Good**

We agree that Continuity of Carer is an important commitment with the potential to significantly improve women's experiences of maternity services, as well as to contribute to improved safety outcomes. In many ways it represents an outstanding mode of practice. However, the implementation of CoC involves a fundamental change in working practices, culture, and organisational processes and structures. To achieve the full benefits of CoC, robust transformational support is required to support staff to adapt to new ways of working and to ensure there is appropriate focus on wellbeing. This will involve increased focus on positive ways to change practice.

The Continuity of Carer commitment was based on consultation with service users and evidence provided by the National Perinatal Epidemiology Unit as part of the development of the National Maternity Review. This model of maternity care is likely to achieve meaningful improvement with evidence showing that Continuity of Carer improves women's outcomes and experiences.¹⁹¹ Given the poorer outcomes and experiences of women from minority ethnic or socio-economically disadvantaged groups,¹⁹² we particularly welcome the additional element of the commitment placing an emphasis on provision for these women.

Written submissions from SANDS, The Birth Trauma Association, The National Childbirth Trust, the Nursing and Midwifery Council, AIMS, National Voices, Birthrights, Caesarean Birth, and RCM/RCOG agree that the commitment is appropriate given its strong evidential basis.¹⁹³ National Voices describes it as a commitment "with the potential to revolutionise families' experience of maternity services."¹⁹⁴

However, some stakeholders raised important caveats, including concerns that pressure to meet roll-out targets may not match the capacity of Trusts to manage the transition properly. RCM and RCOG raised concerns about the appropriateness of roll-out targets, especially within the context of near-universal staff shortages.¹⁹⁵ Continuity of Carer represents a radical change to midwifery practice and NHS Trusts need the time and resources to ensure safe and sustainable service delivery.

CoC has the potential to effect positive change both in safety outcomes and in improving women's experience of personalised care. However, there has not been adequate acknowledgement of the scale of organisational change required for successful roll-out nor

¹⁹¹ https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

¹⁹² Department of Health and Social Care (EPE0026), para 63

¹⁹³ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (EPE0010); Sands (EPE0012); Birth Trauma Association (EPE0013), NCT (National Childbirth Trust) (EPE0014); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) (EPE0015); AIMS - Association for Improvements in the Maternity Services (EPE0016); National Maternity Voices (EPE0018); Birthrights (EPE0019); Caesarean Birth (EPE0023)

¹⁹⁴ National Maternity Voices (EPE0018)

¹⁹⁵ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (EPE0010)

has there been appropriate focus on the support required for staff and Trusts to successfully meet these challenges.

In their written submissions, some stakeholders identified several unintended consequences of inadequately supported roll-out. RCM/RCOG, Donna Ockenden, and the charity Campaign for Safer Births refer to a two-tier system during the transition to CoC whereby women on CoC pathways have been prioritised over women on traditional care models leading to safety concerns for these women.¹⁹⁶ Campaign for Safer Births attribute this to a culture of “chasing targets.”¹⁹⁷ Given a two-tiered system is inevitable as any model transitions from the old to new, Trusts that have successfully implemented CoC will have considered this limitation and transitioned quickly.

In some Trusts CoC roll-out has been limited by ongoing staff shortages. RCM/RCOG stated that increased staffing shortages, particularly on labour wards, have been observed as a consequence of CoC roll-out. Citing feedback from members, they stated:

*"As continuity teams are increased, and the core staffing numbers in hospital labour wards are thereby decreased, the number of staff available at any one time on labour ward is significantly reduced and can impede the ability of the service to respond rapidly to an emergency or rapid increase in admissions."*¹⁹⁸

Stakeholders also raised concerns about the impact of CoC on workforce morale and staff retention where the impact on staff had not been appropriately considered.¹⁹⁹ During roundtable events, clinicians echoed these concerns. For many staff, the 75% target for roll-out to economically disadvantaged women represents a prioritisation of complex cases and an associated change in job description which many staff may find difficult during transition.

*"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."*²⁰⁰

The application of the 75% CoC target varies between Trusts depending on the demographics of the areas they serve. In some areas, minority groups will be a majority and additional support and funding for these areas should be considered.

Campaign for Safer Births and SANDS commented that there should be a named obstetrician for each woman on a CoC pathway while Caesarean Birth raised the concern that midwife-only CoC may result in women finding it more difficult to access consultant-led care.²⁰¹

SANDS and AIMS commented that the target to roll-out the model to ‘the majority’ of women may limit ambition and could result in Trusts who record 51% of women on CoC as

¹⁹⁶ Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

¹⁹⁷ Campaign for Safer Births ([EPE0009](#))

¹⁹⁸ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

¹⁹⁹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

²⁰⁰ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

²⁰¹ Campaign for Safer Births ([EPE0009](#)); Sands ([EPE0012](#)); Caesarean Birth ([EPE0023](#))

having successfully implemented the model. They commented that the ambition stated in Better Births was for all women, not the majority, to have access to CoC.²⁰²

Quality and competence of care, as well as guidelines outlining minimum standards were also raised as important omissions in the current commitment.²⁰³

“There has been a lot of focus on the continuity aspect and perhaps less on the quality of the continuity and care. Being looked after by someone who is supportive, who listens, who communicates well, who has good clinical skills and understands the ethics of consent is just as important but seems to have received less focus.”²⁰⁴

It is clear to us that successful implementation of CoC involves in-depth consideration of these additional factors to ensure all women have access to the benefits of this model of care.

²⁰² Sands ([EPE0012](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

²⁰³ Birth Trauma Association ([EPE0013](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

²⁰⁴ Birth Trauma Association ([EPE0013](#))

Chapter 3: Personalised Care

In this section we provide an assessment of the Government's commitment to ensure women receive personalised care, which states:

*"All women to have a personalised care and support plan by 2021" (revised target March 2022).*²⁰⁵

Overall Commitment Rating and Overview for Personalised Care:

Inadequate

Personalised care is vital to improving women's experiences of maternity services and to fully embed the principle of informed consent into service delivery.²⁰⁶ Personalised care is likely to be particularly important for women from marginalised groups and is central to several Immediate and Essential Actions (IEAs) outlined in the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (Ockenden review).²⁰⁷ We agree that the commitment for all women to have a Personalised Care and Support Plan (PCSP) is an important and worthwhile aim. However, the commitment does not extend beyond the development of the plan itself to a broader consideration of whether and how plans might reasonably be enacted.

Without a simultaneous target to monitor quality and delivery, the commitment is unlikely to achieve meaningful change. While guidance released by the Government in March 2021 states that "all staff should have access to training in personalised care, informed decision making, risk communication and in choice conversations"²⁰⁸ there is no budget ringfenced for this purpose nor does the Department outline how this training will be assessed and monitored.²⁰⁹

Adequate staffing and training are critical to the effective achievement of this commitment. The Department does not fully consider barriers to non-judgemental and unbiased care advice, or potential conflicts between the policies of individual Trusts and women's care choices. In the absence of a coherent training plan to address the range of choices available to women and the attitudes and behaviours required for non-judgemental enactment of PCSP content, we do not anticipate that the current target will achieve its aims. We are also concerned that there does not appear to have been any consideration by the Department or NHS England and

²⁰⁵ [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#)

²⁰⁶ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

²⁰⁷ Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: Our First Report following 250 Clinical Reviews (2020) [OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST \(publishing.service.gov.uk\)](#)

²⁰⁸ Personalised care and support planning guidance, Guidance for local maternity systems Version 1, March 2021, para 5.4. [Report template - NHSI website \(england.nhs.uk\)](#)

²⁰⁹ Department of Health and Social Care ([EPE0026](#))

Improvement of how PCSPs may impact wider service delivery and consequently it is likely that women's care plan choices will be restricted by lack of appropriate services. Significant progress will need to be made on the offer of standard choices before this commitment is likely to be met.

Analysis of Personalised Care

This section provides an analysis of the commitment to ensure all women have a personalised care and support plan by 2021 (revised target March 2022). This analysis is based on the main questions set out in the planning grid. An analysis of each sub-question, as described in the planning grid, can be found in Annex C.

A. Was the commitment met overall? Is the commitment on track to be met?

Rating: **Inadequate**

The original commitment for all women to have a personalised care and support plan by 2021 was revised to March 2022 due to the COVID-19 pandemic.²¹⁰

The Department report that 115 of 125 providers currently have Personalised Care and Support Plans (PCSPs) in place for at least one part of the pregnancy pathway, benefitting 50,340 women.²¹¹ Although the commitment is limited to the formulation of plans and does not specify associated outcome or service delivery targets, even at this low level this equates to only 8.5% of pregnant women based on NHS Digital 2019 birth rate data. Given this rate and the fact that there is currently no clear definition of what is required to confirm that a PCSP has been effectively set up, the target to increase the offer to all women by March 2022 appears unlikely, especially considering that digital apps to allow women to interactively access their maternity records are not likely to be ready before 2024.²¹² The lack of training across all staff groups working in maternity care on possible care options and on the attitudes and behaviours required for non-judgemental enactment of the plan, also mitigates against the likelihood of achieving the target.²¹³ Practical limitations to choices fundamental to Better Births recommendations,²¹⁴ such as choice of place of birth, or elective caesarean deliveries, mean that without a target to provide a specific range of care options the commitment is unlikely to be an effective measure of truly personalised care.

Guidance to support delivery of PCSPs was published in March 2021.²¹⁵ However, this guidance does not include timescales for the expected roll-out to professional staff. Furthermore, the Department has not provided information about how NHS Trusts will be supported to integrate PCSPs into existing workloads, for example through training programmes, or by implementing an effective infrastructure to ensure smooth delivery. The significant benefits associated with personalised care²¹⁶ are unlikely to be achieved unless there are clear standards and expectations of what PCSPs should involve; integration within existing workloads supported

²¹⁰ Department of Health and Social Care ([EPE0026](#)), para 133

²¹¹ Department of Health and Social Care ([EPE0026](#)), para 132

²¹² Department of Health and Social Care ([EPE0026](#)), para 130

²¹³ Department of Health and Social Care ([EPE0026](#))

²¹⁴ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

²¹⁵ Personalised care and support planning guidance, Guidance for local maternity systems Version 1, March 2021. [Report template - NHSI website \(england.nhs.uk\)](#)

²¹⁶ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

by ongoing professional training; and ongoing investment to ensure PCSPs are meaningfully related to outcomes.

Several written submissions commented on lack of progress against this commitment.²¹⁷ The joint submissions from Baroness Cumberlege and Sir Cyril Chantler, authors of Better Births, and RCM/RCOG described a lack of definitional clarity and poor data collection as contributing to the slow progress to date. However, recent interest from NHSE/I leadership and progress in digitisation over the next 18 months were cited as sources of optimism for future roll-out.²¹⁸ Baroness Cumberlege and Sir Cyril Chantler anticipate that PCSPs may be available to the majority of women by April 2023, stating:

*"There has been progress and as continuity of carer improves and the digital care plan and record is introduced, along with the better organisation of services within the Local Maternity Systems, we believe that by April 2023 it should be available to the vast majority pregnant women in England."*²¹⁹

The joint submission from RCM/RCOG also attributed lack of progress to poor dissemination to staff and a lack of investment in staff training, roll-out, and digitisation. Ongoing staff shortages were also cited as an important limiting factor. RCM/RCOG state that:

*"Implementation has been hindered by a lack of investment, particularly staff training and resources for digital improvement. The way in which the policy commitments have been developed and disseminated is questionable and the definitions of personalisation have been vague, open to interpretation and poorly communicated to frontline staff."*²²⁰

Submissions from AIMS, the Association for Improvements in Maternity Services charity, and Birthrights, a charity promoting human rights in pregnancy and childbirth, noted that guidance to support PCSP delivery was only published in March 2021, 5 years after the Better Births recommendations and cited evidence that personalised care continues not to be the experience of many women. AIMS state that reports of poor personalised care experiences to their helpline:

*"...allow us to say with certainty that many women still do not have personalised care but are instead increasingly being expected to conform to standard hospital procedures. Others are being bullied into agreeing to plans that they are not happy with."*²²¹

This raises questions about the extent to which current guidance is sufficient to meaningfully promote women's choices when they do not align with NHS Trust priorities or procedures. Potential bias within care-giving settings was also highlighted in a written submission from Birthrights. Referring to their 2020 joint survey with Mumsnet, Birthrights cited results relating to the personalised care experiences of 1145 women. Of these women:

"74% said they were given the opportunity to discuss the benefits of a vaginal delivery, but only 42% said they were given the opportunity to discuss the benefits of a caesarean section."

²¹⁷ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); Birthrights ([EPE0019](#)); Birth Trauma Association ([EPE0013](#)); Caesarean Birth ([EPE0023](#))

²¹⁸ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

²¹⁹ *Ibid.*

²²⁰ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²²¹ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

61% said they discussed the benefits of giving birth on a hospital ward, but only 38% said they were given the opportunity to discuss the benefits of giving birth at home, despite NICE guidance.”²²²

These results indicate that personalised care is likely to present additional challenges for professionals working within a culture with its own interpretation of what constitutes optimal or desirable birthing choices.

²²² Birthrights ([EPE0019](#))

B. Was the commitment effectively funded (or resourced)?

Rating: **Inadequate**

The Department refers to £95 million recently allocated to implement Ockenden report recommendations to support progress against this target.²²³ However, information provided in relation to workforce targets (Chapter 4: Safe Staffing)²²⁴ show that most of this budget is ringfenced for specific workforce improvements. Of the £95 million, only £37.7 million is potentially available to support PCSP delivery and there is no budget ringfenced specifically for PCSPs. The Department state that "there is no evidence that personalised care is a more resource-intensive model of care."²²⁵ However, costs of implementation, integration, digitisation and training have not been adequately considered. The joint submission from RCM/RCOG regard current funding as "inadequate."²²⁶

The £95 million budget to implement Ockenden report recommendations is broken down into the following areas:

- £46.7 million (49%) to fund 1000 new midwife posts.
- £10.6 million (11%) to increase consultant time.
- £26.5 million (28%) to improve multidisciplinary working.
- £11.2 million (12%) to fund continued 'consistent, sustainable' improvements within maternity services.²²⁷

Current budget allocations do not address the costs of model integration or staff training on the skills, attitudes and behaviours needed to work in partnership with women, especially when they decide to take a different approach to their pregnancy, labour, birth and postnatal period than the one recommended by staff. We could not see evidence of widespread service reviews or similar activities to ensure that meaningful and reasonable care options are available to women. Indeed, it is unclear if any money will be made available specifically for PCSPs. Although training programmes were promised by April 2021, these appear to be limited to short online tutorials²²⁸ and we have not received details about how programmes will be delivered to staff.

In correspondence received on 18 June 2021, the Department outlined the anticipated training and service delivery requirements associated with PCSPs. They stated that:

"Maternity services must have an excellent understanding of their patient demographic and ensure there is adequate supply of appropriate services to enable the implementation of support plans. This includes but is not limited to, ensuring appropriate access to mental health services such as the Improving Access to Psychological Therapies (IAPT), specialist perinatal mental health community teams and in-patient Mother and Baby Units (MBUs), sufficient midwifery support for vulnerable and bereaved women (continuity of carer or specialist midwives and nurses), a networked approach to maternal medicine available to women with medical complexities and sufficient community midwifery services to support births in low-risk

²²³ Department of Health and Social Care ([EPE0026](#)), para 136

²²⁴ Department of Health and Social Care ([EPE0026](#)), paras 110-111

²²⁵ Department of Health and Social Care ([EPE0026](#)), para 136

²²⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²²⁷ Department of Health and Social Care ([EPE0026](#)), paras 110-112

²²⁸ [Your learning options \(personalisedcareinstitute.org.uk\)](https://www.personalisedcareinstitute.org.uk)

settings. All healthcare professionals working in maternity services will require training on personalised support and care planning."²²⁹

However, the cost implications for Trusts to meet these requirements have not been incorporated into existing spending plans.

The joint submission from RCM/RCOG also raised concerns about the lack of ringfenced funding, commenting that lack of investment in staff training risks poor quality PCSPs. RCM/RCOG state that

*"...it is unclear at this stage how much of this funding will be directed towards resourcing the commitments on personalisation and choice, including staff training."*²³⁰

The charity Birthrights noted an imbalance in investment relating to safety outcomes compared with staffing and personalised care. They also commented that the recommendation for Personalised Care budgets outlined in Better Births does not feature in current spending plans. Birthrights describe these budgets as the "transformative" element of personalised care, without which plans may not have the necessary impact to effect meaningful change. The charity stated:

*"Better Births recommended that all women should have a personalised care budget; the transfer of money, even if notional, being the "transformative" element, providing some clout to the longstanding idea that women and birthing people should be able to choose where and how they gave birth. This element of Better Births has been dropped and it has taken five years to issue guidance on personalised care and support plans. The contrast with the immense effort put behind achieving the safety targets under commitment 1 (safety) is stark."*²³¹

Clinicians taking part in our roundtable events described a widespread lack of access to professional training which, while not specific to PCSPs, suggests that it is unlikely staff will be able to easily access PCSP training. One consultant described staff being discouraged from attending training due to staffing pressures:

*"Training is nominally available, but if there is a rota gap a junior trainee is not going to be encouraged to go, in fact they will be discouraged...It's a general rule that service becomes everything whilst training and development opportunities are reduced."*²³²

²²⁹ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

²³⁰ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²³¹ Birthrights ([EPE0019](#))

²³² Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

C. Did the commitment achieve a positive impact for women?

Rating: **Inadequate**

Good quality personalised care has the potential to radically change women's maternity experiences for the better and is likely to particularly benefit women from marginalised or disadvantaged backgrounds who we know do not currently have access to the same range of choices as other women. However, the commitment does not currently include plans to measure outcomes comparing the experiences of women with PCSPs with those without. This lack of specific outcome data makes it difficult to assess the impact of the commitment on women's outcomes and experiences. Written submissions from a range of organisations and roundtable discussions with health care providers undertaken for this review, indicate that current PCSP guidance does not adequately consider important barriers to effective plans, and that PCSPs risk becoming a tick-box activity with quantity not quality being measured.

Clinicians at roundtable events agree that improvements in personalised care should be a Government priority:

"I absolutely welcome the focus on personalised care. I think one of the things that we've heard from women for too long is that they've been told they can't do this, they can't do that and the universal application of something that is supposed to be a guide as a policy. So, I think that's excellent."²³³

However, in the absence of a meaningful infrastructure to enact women's choices patient groups are reported to be cynical about the plans.²³⁴ Furthermore, there do not appear to be plans to monitor the uptake and impact of PCSPs for all women, including women from marginalised or disadvantaged backgrounds who are less likely to report choice and autonomy during maternity care. Where there are significant language and cultural obstacles to high quality personalised care, additional support will be required to ensure parity of roll-out for all women. For more details on the implications of PCSPs for women from disadvantaged backgrounds see Chapter 5, pages 78-96.

Clinicians involved in our roundtable events commented that effective integration of PCSPs into existing workloads requires the development of systems to "make the right way the easy way"²³⁵ and should aim to reduce the bureaucratic burden of the booking appointment:

"Let's make it easy for people to do this personalised care planning. Let's integrate the Tommy's app that we've been working on, let's integrate other systems into standard practice, so it's actually easier. If you look at the information you have to provide at booking these days, it's about a two-day appointment as far as I can work out in the community, so let's make it easy by integrating some of these aids and tools into our standard care, so that it is easy for women and it's easy for professionals to get this personalised care planning. Let's make it easy to do."²³⁶

²³³ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²³⁴ NCT (National Childbirth Trust) ([EPE0014](#))

²³⁵ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²³⁶ *Ibid.*

Another clinician commented that midwives and women need time away from administrative tasks to develop positive relationships that underpin effective personalised care.

"So, the clue for me is in the name. It's personalised and how do you get to know a person? You spend time with them, you listen, there's trust and respect each way. The current system isn't affording that, and therefore that's where disillusionment sets in, because it's not personalised, it's a tick box exercise, so we need time to do this."²³⁷

²³⁷ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

D. Was it an appropriate commitment?

Rating: **Requires Improvement**

Personalised care is likely to be associated with improved outcomes for women, especially women from marginalised groups, and is central to recommendations in the Ockenden review.²³⁸ However, benefits are unlikely unless there are clear standards and expectations of what PCSPs should involve. This includes support to integrate PCSPs within existing workloads; ongoing investment in professional training, including attitudes and behaviours; and coordinated investment in service delivery to ensure PCSPs lead to meaningful changes of women's care experiences and outcomes. The Department has not anticipated many of the potential barriers to effective PCSP delivery. During our focus group with women from East African backgrounds there was a common theme of women not being listened to and, in some cases, examples of interventions being administered without appropriate explanation or consent (see Chapter 5, pages 78-96). During roundtable events, clinicians discussed the role of risk assessment in personalised care and referred to a potential conflict with Trust guidelines and procedures. One midwife described a culture that is fearful of offering choice to women and commented that, unless this fear is adequately addressed, PCSPs are unlikely to be associated with meaningful change:

"My hope is that in implementing this approach to care what we are doing is focusing again on the culture of units and how implementation is facilitated and held back. Because I think if we don't, it risks becoming a tick box exercise bureaucratic thing, where we just have a bit of paper that we tick a few boxes and write a few stock phrases, rather than really getting under the skin of what matters to practitioners. We really need to be unpicking the culture that leads practitioners to be feeling, perhaps what is described anecdotally, as fearful of offering choice to women."²³⁹

A nuanced definition of personalised care that extends beyond the narrow frame of risk assessment is possible. However, it is not sufficiently clear to us, based on the evidence we have seen, that current guidance and PCSP activity has the capacity to effectively communicate this to the professionals charged with developing plans.

Quality of PCSPs is likely to depend on enthusiastic uptake from midwifery and obstetric staff; high quality training, including a consideration of potential conflicts with existing NHS Trust practice and protocols; and coordinated service delivery strategies to ensure availability of resources. It will be important to address the training challenges involved in the requirement for staff to provide unbiased advice, particularly as we know staff train and work within a culture that has its own strong views of what constitutes a 'good' birth which may be very different from the women they serve.

A written submission from Caesarean Birth commented that potential barriers to effective planning need to be more fully considered. This is particularly important when women's

²³⁸ Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: Our First Report following 250 Clinical Reviews (2020). [national-maternity-review-report.pdf](https://www.national-maternity-review-report.pdf) ([england.nhs.uk](https://www.england.nhs.uk))

²³⁹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

choices do not align with clinicians' preferences, or where there may be a conflict of interests. For example, where Trusts are incentivised to reduce caesarean section rates. Caesarean Birth suggest the question of "*how to ensure women are supported to make an informed decision when medical science conflicts with the art of midwifery*"²⁴⁰ should be central to this commitment.

We note that the PCSP audit tool included within the guidance published in March 2021 is only currently available in hard copy. The development of an online audit tool could enable a more seamless experience for women and professionals and could provide a system-level view of PCSP roll-out and delivery. This could be an important way to monitor progress against this target and to provide an assessment of how PCSPs relate to women's outcomes and experiences in different groups.

There are ongoing problems in maternity services relating to ineffective responses to patient feedback, in particular a tendency to dismiss patient feedback as anecdotal and a failure to act on concerns. While PCSP guidance does refer to improving communication and collaboration between women and midwives,²⁴¹ there is no guidance for when things go wrong, or how professionals are expected to support women who experience poor care or poor outcomes.

Written submissions commenting on this issue agreed that personalised care is an important way to improve women's experiences and to embed the principle of informed consent into maternity services.²⁴² Personalised care is also central to improving safety outcomes: National Maternity Voices state that most serious incidents involve miscommunication and poor knowledge of patient history. However, while the evidence base for personalised care is not in doubt, stakeholders reported concerns that current guidance is not sufficiently robust to ensure plans are of consistently high quality to ensure meaningful improvements. National Maternity voices conclude that:

*"A personalised care plan is an experience, not a tick in a box or some words on a piece of paper or a computer system."*²⁴³

²⁴⁰ Caesarean Birth ([EPE0023](#))

²⁴¹ Personalised care and support planning guidance, Guidance for local maternity systems Version 1, March 2021. [Report template - NHSI website \(england.nhs.uk\)](#)

²⁴² AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); National Maternity Voices ([EPE0018](#))

²⁴³ National Maternity Voices ([EPE0018](#))

Chapter 4: Safe Staffing

In this section we provide an assessment of the Government's commitment to ensure safe staffing levels, which states:

Safe staffing – “Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.”²⁴⁴

Overall Commitment Rating and Overview for Safe Staffing:

Requires Improvement

Improving maternity care through workforce investment is essential. Professional staff are our most valuable asset, and it is vital that maternity units have the appropriate number and mix of staff to deliver high quality care for all women. Staffing shortages make it difficult for NHS Trusts to meet the preceding commitments relating to Maternity Safety, Continuity of Carer, and Personalised Care and Support Plans. Therefore, the Department is right to focus on this issue and any initiative to improve maternity care should have strategies to improve staffing at its core. While there have been improvements in midwifery staffing levels over the past decade, these are not yet sufficient to meet the Birthrate Plus average recommendation of one midwife for every 24 births (1:24). High attrition limits the effectiveness of staffing strategies that rely on the recruitment and training of new staff and is associated with the loss of valuable professional experience. In this context, the Government's commitment lacks the timescales and measurable targets to achieve the necessary improvements and has ultimately hindered progress in this area. Evidence from written submissions suggests that the lack of clarity contained within this commitment reflects a poor “policy grip”²⁴⁵ about what safe staffing might mean in practical terms across the full range of maternity professionals. Midwives and obstetricians at our roundtable events told us that ongoing staff shortages have taken the “joy”²⁴⁶ out of maternity care for many professionals and described staffing gaps as both a cause and consequence of high attrition. In developing our planning grid and sub-questions, we sought to clarify key terms referred to in this commitment, including what the Department understands by “appropriate mix and number of clinical professionals.”²⁴⁷ Where initiatives are in place to increase staffing numbers, these are not matched by similar efforts to improve staff retention. Consequently, staffing numbers are unlikely to reach the levels needed to meet identified shortfalls.

We conclude that the commitment is not sufficiently robust to support necessary changes in this area and have therefore rated it as Requires Improvement. While

²⁴⁴ [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#)

²⁴⁵ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²⁴⁶ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁴⁷ [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#)

we recognise that recent spending commitments do address some areas of identified staffing need, these initiatives are not sufficiently targeted or broad enough in scope to facilitate meaningful change.

Analysis of Safe Staffing

This section provides an analysis of the commitment to ensure NHS providers are staffed with the appropriate number and mix of clinical professionals. This analysis is based on the main questions set out in the planning grid. An analysis of each sub-question, as described in the planning grid, can be found in Annex D.

A. Was the commitment met overall? Is the commitment on track to be met?

Rating: **Inadequate**

The commitment lacks quantifiable measures or targets making it difficult to assess progress in this area. The only measurable outcomes relate to midwifery staffing levels based on the Birthrate Plus recommended ratio of 1 midwife for every 24 women.²⁴⁸ The use of the 1:24 ratio is a guide, based on the evidence from 55 recent studies, that can be used at a national level to inform the assessment of midwifery staffing requirements for services in England.²⁴⁹ As such it is not a standard to be applied to every midwifery service because it is a mean ratio derived from a range of local ratios, which themselves reflect variations in local caseloads, levels of complexity and acuity, models of care, skill-mix and other factors. Instead, the particular staffing needs of local services for all births are likely to be somewhere within the range of 21.5 to 27.8 midwives to births.²⁵⁰

While data provided by the Department²⁵¹ indicate that there have been improvements in midwifery staffing ratios between 2016 and 2019 these increases are not yet sufficient to meet the average Birthrate Plus recommended ratio of 1 midwife for every 24 women. There is currently no equivalent tool to assess safe levels of obstetric staff, although we acknowledge the fact that a tool is currently in development by the Royal College of Obstetricians and Gynaecologists and expected to be ready by Autumn 2021.²⁵² However, there are currently no available data relating to safe staffing levels for other maternity professionals nor has the Department been able to provide an overall assessment of the "appropriate mix of clinical professionals" required for safe staffing in maternity units. While the Department refer to "on-going actions"²⁵³ to improve the retention of skilled staff and increase the numbers transitioning from training to employment, it is not clear what these actions involve and what steps are being taken in practice. The Department also does not address issues of regional variation or provide recommendations for units serving women with more complex needs. 'Better

²⁴⁸ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the maternity workforce qap \[22 April 2021\]](#)

²⁴⁹ *Ibid.*

²⁵⁰ [Home - Birthrate Plus®](#)

²⁵¹ Department of Health and Social Care ([EPE0026](#))

²⁵² [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the maternity workforce qap \[22 April 2021\];](#)

²⁵³ Department of Health and Social Care ([EPE0026](#)), para 95

Births' report (2016) cites "variation across the country in terms of the outcomes for women and babies and the quality of the services they receive."²⁵⁴ It is not clear how the current commitment on staffing will take into account regional variation and ensure that local service delivery appropriately reflects demand.

Clinicians at our roundtable events told us that staff redeployment and sickness during the COVID-19 pandemic has exacerbated pre-existing issues relating to the understaffing of maternity services. One participant stated that:

"COVID has disrupted the whole system. [...] 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."²⁵⁵

The average Birthrate Plus assessment of optimal midwife staffing ratio is one midwife for every 24 births.²⁵⁶ Based on Health Education England (HEE) data gathered in January and February 2021, as part of the National Midwifery Workforce Survey, the Department report a vacancy rate of 844 Full Time Equivalent (FTE) midwifery posts nationally, with an additional gap of 1088 FTE midwifery posts between existing number of funded posts and the Department's Birthrate Plus calculation,²⁵⁷ giving a total gap of 1932 between midwives currently in post and the Department's estimate of safe midwifery staffing levels. However, the Department have not provided the birth rate data on which their Birthrate Plus calculation was based, making it difficult to verify this gap. Given the importance of accurately tracking midwifery staffing, it is vital that the Department publish standardised metrics to allow for effective monitoring of this target. In their joint written submission, RCM/RCOG estimated the midwifery gap to be closer to 3000 midwives, although they acknowledge falling birth rates may have reduced this figure for 2021. They stated:

"Based on the total number of births in England in 2019 (the most recent whole year that birth figures are available for), the evidence from these studies indicates that NHS providers in England were 3,069 full-time equivalent (FTE) midwives short of what is required to provide all women with one-to-one midwifery care. Since it is likely (although not yet confirmed) that there has been a further fall in the number of births in England in 2020, along with a net increase in the number of midwives in post, our preliminary assessment for 2021 is that the shortage may now be closer to 2,000 FTE midwives."²⁵⁸

Over the last decade, the ratio of midwives to women has improved due to a combination of staffing increases and a declining birth rate (see Figure 7).

²⁵⁴ Better Births: Improving outcome of maternity services in England. A Five Year forward view for maternity care (2016): 2.7. [national-maternity-review-report.pdf \(england.nhs.uk\)](https://www.nhs.uk/consult/13162n.pdf)

²⁵⁵ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

²⁵⁶ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the maternity workforce gap \[22 April 2021\]](#); The Department response to the planning grid does refer to Birthrate Plus it does not explicitly state this figure.

²⁵⁷ Department of Health and Social Care ([EPE0026](#)). It is not clear how the Birthrate Plus figure cited by Department was calculated.

²⁵⁸ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

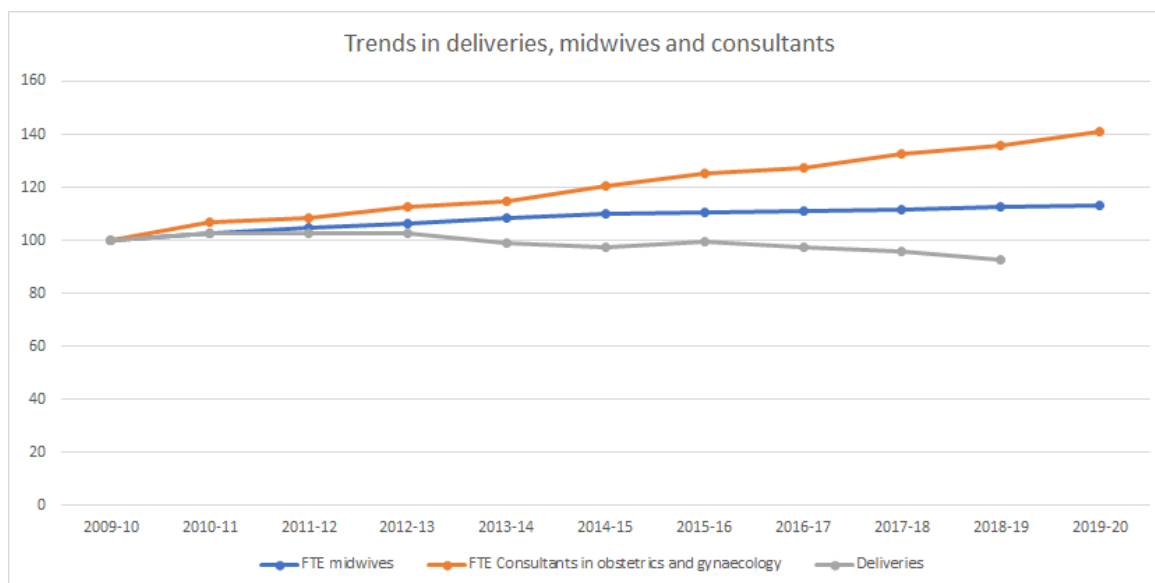


Figure 7. Percentage change in staffing trajectories and total deliveries in England since 2019. The orange line indicates full time equivalent (FTE) obstetric and gynaecology consultants. Data are not currently available to determine the numbers of obstetric consultants separately which is an important data limitation; the blue line indicates FTE midwives; and the grey shows overall birth rates. Source: NHS Digital.

The recent commitment from the Department to fund an additional 1000 FTE midwife posts in 2021/22 and the commitment to train 3650 additional midwives by 2024 is likely to further improve this ratio.²⁵⁹ Jacqueline Dunkley-Bent, Chief Midwifery Officer in England, told us that she was confident these initiatives would be sufficient to reach Birthrate Plus targets. She said:

“The £95 million that we’ve just secured from NHS England Improvement means that we will be able to recruit that deficit. So, we wrote out to every maternity unit and their Director of Midwifery, and their Trust told us how many midwives they were short based on the Birthrate Plus assessment. That helped us to know the deficit for England.”²⁶⁰

However, increases in funded positions and additional recruitment initiatives do not take into account the persistent problem of attrition for both midwifery and obstetric staff. The joint written submission by RCM/RCOG stated that, after accounting for attrition, each midwifery trainee place is likely to equate to 0.54 FTE. Using this calculation, the 4-year midwife training scheme is likely to increase the pool of available midwives by approximately 1971 overall while the 844 FTE vacancy rate suggests that recruiting to the additional posts may be challenging. While we welcome the recent investment in midwifery staff, this investment represents the beginning and not the end of the work required to address safe staffing.

Written submissions were unanimous in their assessment that staffing levels in most maternity units continues to be a major problem for service delivery.²⁶¹ NHS Providers, a membership

²⁵⁹ Department of Health and Social Care ([EPE0026](#))

²⁶⁰ Transcript of Expert Panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

²⁶¹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); NHS Providers ([EPE0007](#)); Obstetric Anaesthetists' Association ([EPE0008](#)); Campaign for Safer Births

organisation representing NHS staff, stated that the “severity and persistence of workforce gaps”²⁶² are cause for urgent attention while chronic staff shortages across professional disciplines were reported as the norm. In addition to shortages in midwifery and obstetric positions, written submissions also referred to shortages in other maternity professionals including obstetric anaesthetists, neonatal nurses, medical examiners, and other allied health professionals.²⁶³ The Obstetrics Anaesthetists Association described “inadequate staffing in maternity units” as “common”²⁶⁴ while BLISS, a charity supporting babies born prematurely or sick, commented that “neonatal services remain chronically understaffed across all specialties”.²⁶⁵ A submission from the charity, Campaign for Safer Births, identified “dangerous shortfalls” particularly during out of hours care.²⁶⁶ Donna Ockenden, current Chair of the Independent review of maternity services at the Shrewsbury and Telford NHS Trust, suggested that ongoing shortages has led to an inappropriate culture of acceptance towards staffing deficits. In her written submission, she explained:

“Every single day we are aware of labour wards that are insufficiently staffed. This is now often accepted as the norm, and this lends itself to increasing numbers of patient safety incidents. An aircraft would not take off without the correct crew, but maternity services do this every day. Why should women have to attend hospital without safe staffing levels and why should this vary depending on what day/time they come in during the week?”²⁶⁷

As a consequence of staff shortages, both midwifery and obstetric staff were reported to be routinely “overworked” and “overstretched”.²⁶⁸ Campaign for Safer Births cited frequent reports of staff not able to take regular refreshment breaks putting them at increasing risk of burnout. The charity stated that:

“The majority of maternity and neonatal staff are currently NOT getting rest or food breaks on a regular (almost daily) basis. This is not good for staff or patients.”²⁶⁹

Birthrights, a charity promoting human rights in pregnancy and childbirth, cited two recent studies commissioned by the Royal College of Midwives.²⁷⁰ Approximately 2000 midwives took part in the first of these surveys in 2018. Of this number, Birthrights reported that:

([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); Birth Trauma Association ([EPE0013](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); National Maternity Voices ([EPE0018](#)); Birthrights ([EPE0019](#)); Bliss ([EPE0020](#)); Baby Lifeline ([EPE0021](#)); Donna Ockenden ([EPE0025](#))

²⁶² NHS Providers ([EPE0007](#))

²⁶³ The Royal College of Pathologists ([EPE0004](#)); Obstetric Anaesthetists' Association ([EPE0008](#)); Sands ([EPE0012](#)); Bliss ([EPE0020](#))

²⁶⁴ Obstetric Anaesthetists' Association ([EPE0008](#))

²⁶⁵ Bliss ([EPE0020](#))

²⁶⁶ Campaign for Safer Births ([EPE0009](#))

²⁶⁷ Donna Ockenden ([EPE0025](#))

²⁶⁸ Donna Ockenden ([EPE0025](#)); Campaign for Safer Births ([EPE0009](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); Birthrights ([EPE0019](#)); Baby Lifeline ([EPE0021](#)); NHS Providers ([EPE0007](#)); National Maternity Voices ([EPE0018](#))

²⁶⁹ Campaign for Safer Births ([EPE0009](#))

²⁷⁰ <https://www.rcm.org.uk/media/2924/work-health-and-emotional-lives-of-midwives-in-the-uk-kingdom-the-uk-whelm-study.pdf>

*"83% of midwives were showing signs of burnout and... a staggering 66.6% had considered leaving the profession in the last 6 months. The two top reasons were: 'Dissatisfaction with staffing levels at work' (60%) and 'Dissatisfaction with the quality of care I was able to provide' (52%)."*²⁷¹

Birthrights also referred to a more recent RCM survey in 2020 showing that of the 980 midwives who responded to the study, *"87% of midwives had to delay going to the toilet due to lack of time, 77% skipped meals and 53% reported feeling dehydrated all or most of the time."*²⁷²

The Birth Trauma Association, a charity that supports women who have experienced traumatic birth, raised concerns that reported staffing figures may obscure deficiencies in skilled staff working in patient facing roles due to the frequent practice of including high numbers of non-frontline staff in workforce calculations. They described an overall shortage of front-line staff within a system that may not be understaffed overall.

*"The NHS is actually not that badly understaffed in overall terms. It is sometimes desperately understaffed at the working level – particularly so in respect of skilled, experienced staff because so much time is spent on work that is not of direct clinical benefit."*²⁷³

Midwifery and obstetric staff consulted during our roundtable events described significant staffing gaps in their own workplaces. One obstetrician commented that:

*"We're meant to have 16 SPRs [specialist registrars] and junior doctors here and we have 5 rota gaps at the moment. That's almost a third of our workforce that isn't present."*²⁷⁴

Another clinician estimated that there is a national shortfall of approximately 420 obstetricians after current spending commitments are taken into account, stating that:

*"There are approximately 2500 obstetricians... 20% of that is approximately 500 and 80 have been committed in the most recent Government promise, so we think we're about 420 down now."*²⁷⁵

Concerns about the effectiveness of staffing initiatives that rely exclusively on the recruitment and training of new staff but do not include a simultaneous focus on retention of existing staff were raised in both written submissions and roundtable events with clinicians. We agree that boosting staffing numbers by increasing the number of funded trainees or via the creation of new posts is unlikely to be successful without addressing the severe and persistent problem of staff attrition for both midwifery and obstetric staff. The estimate of 0.54 FTE for each trainee place after accounting for attrition²⁷⁶ shows that the NHSE/I needs to train many more midwives to keep the pool of staff sufficient to fill existing posts.²⁷⁷ The high attrition rates for obstetricians and midwives were attributed to unmanageable workloads and poor access to

²⁷¹ Birthrights ([EPE0019](#))

²⁷² *Ibid.*

²⁷³ Birth Trauma Association ([EPE0013](#))

²⁷⁴ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁷⁵ *Ibid.*

²⁷⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²⁷⁷ Baby Lifeline ([EPE0021](#))

continuing professional development and training.²⁷⁸ The Nursing and Midwifery Council, the professional regulator of almost 732,000 nurses, midwives and nursing associates, cited results from a 2019/2020 survey showing that:

*"Too much pressure and a lack of meaningful access to CPD and career development opportunities remain the top reasons for midwives leaving the register."*²⁷⁹

RCM/RCOG cited "lack of flexibility and disillusionment"²⁸⁰ as key reasons for high attrition among obstetrics and gynaecology trainees leading to increased reliance on locums in many units. Clinicians reported similar concerns during roundtable events. One obstetrician described an "exodus" of junior doctors due to poor professional development opportunities and an ongoing culture of blame:

*"The lack of learning opportunities with an increasing blame culture is a bad, bad combination. It's a terrible combination, so we're having an exodus at the junior level. My fear is that if we don't put in the return that we need now, no matter how much you plan for increasing consultant posts in the year to come, you're just not going to have the staff to fill it because they've left, they've gone."*²⁸¹

Another obstetrician raised similar issues about staff leaving at more senior levels:

*"The problem is rota gaps; just covering service without a feeling of advancement. When you are lacking staff, senior practitioners want to do more than simply hold the hand of people who are less experienced. They want to get on and deal with the complex cases. We are compromised on every level if staffing and resources are short."*²⁸²

Regarding the appropriate mix of staff mentioned in the commitment, The British Maternal and Medicine Society, a research charity working with obstetric and other maternity professionals, commented that optimal mix of professional staff has not yet been satisfactorily defined and raised concerns about the suitability of existing staffing tools to reflect the changing needs of the maternal population. The Society raised concerns that Birthrate Plus "may be too simplistic," adding that "it is not only the number of staff, which is important, but also the correct skill-mix."²⁸³ Additionally, the joint submission from RCM/RCOG commented that current funding allocations mean that NHS Trusts frequently base staffing establishments on affordability rather than safety.²⁸⁴ NHS Providers called for the Government to develop a fully costed long-term workforce plan with clear, measurable targets to support progress in this area.

*"The government must produce a fully costed and funded workforce numbers plan, with a long-term focus and strategic vision for the future size and skill mix of the NHS workforce."*²⁸⁵

²⁷⁸ Campaign for Safer Births ([EPE0009](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

²⁷⁹ Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#))

²⁸⁰ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²⁸¹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁸² *Ibid.*

²⁸³ British Maternal & Fetal Medicine Society ([EPE0006](#))

²⁸⁴ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²⁸⁵ NHS Providers ([EPE0007](#))

RCM/RCOG stated that an essential first step towards developing such a plan will be a thorough assessment of the staffing needs of maternity services serving an increasingly complex maternal population, and which acknowledges the considerable staffing considerations that will inevitably arise following the introduction of new models of working.

*"The Government does not appear to have had a clear idea of how many staff NHS providers would need to ensure the delivery of safe and high-quality care. This lack of policy grip has meant that the continuation of staffing shortages has had a negative impact on the ability of maternity services to implement other policy commitments, such as continuity of carer and personalised care, while at the same time maintaining safe staffing levels."*²⁸⁶

Clinicians attending roundtable events agreed that the increasing complexity of the maternal population is a key stressor for already overstretched teams. One obstetrician described significant additional pressures at all stages of the maternity pathway, from ante-natal to post-natal care.

*"What I notice is the increasing complexity, but not necessarily the support for managing that in a comfortable way, whether it is antenatally, peripartum or postpartum. We've seen all the stats - the women being older, heavier, with more comorbidities - and we have, as everyone has said, increased pressure due to numbers. So, you have a committed workforce that is being stretched quite thin and being asked to do more complex work. I think this is an issue right across the board from booking to the postnatal visit."*²⁸⁷

Several written submissions commented that the COVID-19 pandemic has had a major impact on maternity staffing. For example, in their joint submission, RCM/RCOG refer to significant redeployment of medical staff to COVID wards coupled with reduced staffing numbers due to sickness and/or shielding. Consequently, maternity care was limited or rationed for some women.²⁸⁸ Birthrights indicated that unfilled midwife posts rose from 1 in 10 pre-pandemic, to 1 in 5 as the pandemic took hold.²⁸⁹

Clinicians at the roundtable events described significant deterioration in staffing levels during the pandemic with one midwife referring to "staggering" shortages during this time:

*"When COVID struck, and we were facing sometimes staggering staff shortages, training courses were simply withdrawn by Trusts on a wholesale basis."*²⁹⁰

The withdrawal of training courses and professional development opportunities was reported as widespread resulting in increased staff dissatisfaction:

*"This pandemic has really shown that as soon as we are in an emergency situation all the training elements for medical staff are the first things to go because we have to pare down to the basic service. So, there is a feeling of dissatisfaction, a feeling of literally just covering the bases."*²⁹¹

²⁸⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²⁸⁷ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁸⁸ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

²⁸⁹ Birthrights ([EPE0019](#))

²⁹⁰ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁹¹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

B. Was the commitment effectively funded (or resourced)?

Rating: **Requires improvement**

In March 2021, The Department committed £95 million towards workforce improvements, including funding for 1000 new midwifery posts. Although the Department, in its formal response to the planning grid, did not initially specify workforce spending relating to obstetric consultants, evidence provided during the roundtable event with clinicians and to the Health and Social Care Select Committee's own report suggests that the £10.6 million "to increase consultant time" refers to an additional 80 consultant posts.²⁹²

Written submissions from stakeholders suggest that this funding is not likely to be sufficient to address current staff shortages. A written submission from NHS Providers states that £400 million is likely to be required to fulfil the workforce recommendations included in the Ockenden report while Birthrights calculated that £95 million will only be sufficient to fill 1/3 of midwife shortages. During roundtable events, one obstetrician estimated a 20% shortfall in obstetric posts, with around 420 posts needed after accounting for the 80 included in current government spending plans.²⁹³

The Department refer to a number of funding initiatives relating to this commitment:

- £95 million committed in March 2021 to increase workforce numbers and improve training and development programmes to support culture, leadership, and surveillance. The £95 million is broken down into the following:
 - ❖ £46.7 million (49%) to fund 1000 new midwife posts.
 - ❖ £10.6 million (11%) to increase consultant time.
 - ❖ £26.5 million (28%) to improve multidisciplinary working.
 - ❖ £11.2 million (12%) to fund continued 'consistent, sustainable' improvements within maternity services.
- £1 million committed in February 2019 to support, professionalise and standardise MSW role within Competency, Education Career Development Framework
- £5000 grant for trainee midwives, in addition to existing loan/grant entitlements introduced from September 2020.
- £15 million committed by HEE for Clinical Placement Expansion Programme (CPEP) to increase clinical placements within NHS (this is not maternity specific)

Follow-up correspondence from the Department refers to two additional schemes, although the process of funding allocation or the dates these funds were committed is not clear:

- £1 million HEE Transformation Fund to support LMSs to map existing workforce.
- £500,000 Maternity Leadership Training Fund to address leadership issues identified in the Ockenden review.²⁹⁴

²⁹² Health and Social Care Committee, [Safety of Maternity Services in England](#); Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁹³ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

²⁹⁴ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

Appropriate context to allow meaningful consideration of these schemes against wider maternity spending and costs was not provided. Where funding has been allocated to tackle specific workplace issues, for example, by improved multidisciplinary working, there is a lack of detail about how funding relates to specific initiatives to address these aims.

The Department cite the following workforce training initiatives to support progress against this commitment:

1. Plans to train 3650 extra midwives over four years, with 650 more midwives in training from September 2019, with planned increases of 1000 in subsequent years.
2. Plans to professionalise Maternity Support Worker (MSW) role.
3. Improvements to retention of doctors with Enhancing Junior Doctors' Working Lives programme which includes more flexible options for trainees.
4. Introduction of RCOG Fellow post to improve retention and quality of training.
5. 25% increase in medical school placements.
6. 5 new medical schools across England.²⁹⁵

For each of the six stated initiatives, only two relate specifically to maternity services (trainee midwifery placements and development of MSW role), and only one (midwifery training) has a defined timescale with anticipated impact not expected before 2023/24.²⁹⁶

We conclude that current spending plans do not adequately address the scale and complexity of ongoing staff shortages and do not address the persistent and serious problem of high attrition across professional disciplines.

²⁹⁵ Department of Health and Social Care ([EPE0026](#))

²⁹⁶ Department of Health and Social Care ([EPE0026](#)), para 17

C. Did the commitment achieve a positive impact for women?

Rating: **Inadequate**

The midwife training scheme and funding for 1000 additional midwifery posts is not likely to be sufficient to achieve the 1:24 staffing ratio based on current estimates in the context of high attrition. While Jacqueline Dunkley-Bent, Chief Midwifery Officer in England, told us that these initiatives will be sufficient to reach Birthrate Plus targets,²⁹⁷ stakeholders raised concerns about the loss of valuable professional experience due to unresolved issues with high attrition. Written submissions indicated that 9/10 of maternity units have persistent middle grade gaps for obstetric doctors, with high attrition attributed to unmanageable workloads and lack of professional training.²⁹⁸ Chronic staff shortages have been implicated in all recent maternity scandals²⁹⁹ and make it difficult for NHS Trusts to learn from mistakes and implement change. Evidence from written submissions state that inadequate staffing may undermine the success of both Continuity of Carer and Personalised Care and Support Plans. It is not currently possible to measure positive impact for women against this commitment partly because initiatives for which there are targets have yet to be implemented, and partly due to a lack of specificity associated with the commitment overall.

Campaign for Safer Births commented that safe staffing is a prerequisite for safe care, that 1 in 4 neonatal deaths are associated with staff shortages,³⁰⁰ and that NICU units show increased infant mortality when intensive care staffing ratios are not met.³⁰¹ NHS Providers commented that meaningful changes to working culture and practice are made very difficult within a context of ongoing staff shortages, stating that:

“Organisations find it difficult to make changes effectively amid multiple competing priorities.”³⁰²

During roundtable events, clinicians raised the issue of safe staffing extending beyond obstetric and midwifery staff. One obstetrician commented that staff at all grades and professions need to be properly considered to ensure individual team members are enabled to perform their duties at the appropriate level. The participant said:

“It’s about having the right people in the right place at the right time, and that extends beyond just obstetricians and midwives and all the other peripheral staff that play an important role. So, having ward clerks to help women get admitted to units so midwives aren’t doing that role. Having the right numbers of middle grade staff so that we haven’t got a situation where we’ve got acting downs and we’ve got the right people in the right role to provide the right leadership in that situation.”³⁰³

²⁹⁷ Transcript of Expert panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

²⁹⁸ Birthrights ([EPE0019](#))

²⁹⁹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

³⁰⁰ Campaign for Safer Births ([EPE0009](#)); Baby Lifeline ([EPE0021](#))

³⁰¹ Bliss ([EPE0020](#))

³⁰² NHS Providers ([EPE0007](#))

³⁰³ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

D. Was it an appropriate commitment?

Rating: **Requires improvement**

Financial investment in the maternity workforce is central to sustained improvements in maternity care. Staff well-being, access to training and development, and effective multi-disciplinary working must be prioritised in any workforce strategy. It is essential for the Government to have a clear focus on safe staffing to support wider improvements in maternity care. However, the lack of measurable targets and timescales included in the commitment undermine the impact and urgency of this issue. In its written submission, AIMS called for specific and achievable targets to support progress, and to properly highlight the urgency of this issue. They specifically called on us to emphasise that a proper focus on staffing is fundamental to all maternity improvements and change.

“If the Panel achieves one thing in undertaking the current evaluation, then we would suggest it is this: to underline the importance of a properly resourced maternity service to underpin improvement across a range of areas and to guide Ministers on a robust process needed to create a specific and realistic policy commitment on this key issue.”³⁰⁴

Information included in written submissions from stakeholders support our assessment that the scope of the commitment is not enough to support necessary changes in this area.³⁰⁵ In particular, the safe staffing commitment does not consider findings from recent maternity scandals and the interim Ockenden report³⁰⁶ regarding dysfunctional workplace culture, high attrition rates, and staff skill and competence.

The Department endorsed a recommendation made in the 2016 ‘Better Births’ report that:

“Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.”³⁰⁷

However, the current staffing commitment does not have sufficient clarity or defined measures and targets to address these aims and does not include an assessment of workplace culture, improvements to leadership, or how to encourage learning when things go wrong. The Department shows evidence of confusion about the remit of the commitment by including two contradictory statements in its formal response to the planning grid. It acknowledges that “safe care is not only about having the right numbers of staff” but immediately undermines this acknowledgement when it assesses its own progress exclusively in relation to staff

³⁰⁴ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

³⁰⁵ British Maternal & Fetal Medicine Society ([EPE0006](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Birthrights ([EPE0019](#))

³⁰⁶ Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: Our First Report following 250 Clinical Reviews (2020) [OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST \(publishing.service.gov.uk\)](#)

³⁰⁷ Better Births: Improving outcome of maternity services in England. A Five Year forward view for maternity care (2016). Annex A. [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

numbers “we agree that the commitment is appropriate, that ensuring the right number of staff are working in a healthy environment, will lead to safe outcomes for women.”³⁰⁸

Written submissions suggest that the commitment is not sufficiently broad in scope and should be developed further. In particular, it should include an explicit focus on both workplace culture and psychological safety, including evidence that dysfunctional workplace cultures have contributed to all recent maternity scandals including, Morecambe Bay, Shrewsbury and Telford, Cwm Taf, and the interim Ockenden report.³⁰⁹ We conclude that safe staffing is not just about staffing numbers and clinical skills but should also consider the way in which maternity staff build relationships of trust with families, particularly with women from disadvantaged backgrounds. A recent study investigating the qualities of a highly successful maternity unit identified six key areas required for safe and effective staffing:

1. Collective competence, achieved through collegiate working, blended hierarchies across disciplines, and mutual respect
2. Technical proficiency, including high expectations of staff and dynamic training
3. Distributed cognition, including shared awareness and effective role coordination
4. Clear standards of practice
5. Use of multiple sources of intelligence, including patient feedback and experience
6. Highly intentional approach to safety.³¹⁰

There is a persistent problem within maternity services of not taking women’s experiences seriously and of failing to act or appropriately respond to women’s feedback. These broader workforce issues are not currently considered by the Department in relation to this commitment.

The majority of written submissions agreed that safe staffing within maternity services is an urgent priority.³¹¹ However, stakeholders did not feel that the current commitment adequately defines safe staffing levels, nor does it provide a reasonable timescale to achieve improvements. Dr Bill Kirkup commented that dysfunctional workplace cultures, weak leadership, and closed organisational structures have been notable features of all recent maternity scandals with ongoing pressure on NHS Trusts to prioritise reputation over safety.³¹²

³⁰⁸ Department of Health and Social Care ([EPE0026](#)), para 125-126

³⁰⁹ The Royal College of Pathologists ([EPE0004](#)); Dr Bill Kirkup ([EPE0005](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); NHS Providers ([EPE0007](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Baby Lifeline ([EPE0021](#))

³¹⁰ Liberati et al. (2019) How to be a very safe maternity unit: An ethnographic study. <https://doi.org/10.1016/j.socscimed.2019.01.035>

³¹¹ Campaign for Safer Births ([EPE0009](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); Care Quality Commission (CQC) ([EPE0011](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); NHS Providers ([EPE0007](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Birthrights ([EPE0019](#)); Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Baby Lifeline ([EPE0021](#)); Bliss ([EPE0020](#)); Birth Trauma Association ([EPE0013](#)); Donna Ockenden ([EPE0025](#)); Obstetric Anaesthetists' Association ([EPE0008](#)); National Maternity Voices ([EPE0018](#))

³¹² Dr Bill Kirkup ([EPE0005](#))

Several written submissions commented that recruitment and training of new staff is not sufficient to solve the problem of staff shortages, and that more focus is needed on staff retention and well-being.³¹³ Lack of resources for staff training and professional development were identified as leading causes of attrition in addition to unmanageable workloads and poor working conditions.³¹⁴ Initiatives to improve staff retention were identified as more efficient and cost-effective in the longer term. Baby Lifeline stated that:

*"It is far cheaper to retain staff rather than train new staff, and there are also benefits to be found in areas such as workforce morale and mental wellbeing."*³¹⁵

³¹³ British Maternal & Fetal Medicine Society ([EPE0006](#)); NHS Providers ([EPE0007](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); Birthrights ([EPE0019](#)); Baby Lifeline ([EPE0021](#)); Donna Ockenden ([EPE0025](#))

³¹⁴ Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#))

³¹⁵ Baby Lifeline ([EPE0021](#))

Chapter 5: Equality in Maternity Outcomes

There is no specific pledge relating to equality of outcomes for women and babies from disadvantaged backgrounds. However, persistent health inequalities and negative birthing experiences for women from minority ethnic and socio-economically deprived backgrounds have been noted throughout this evaluation. This chapter draws together our findings relating to health inequalities for all commitments to provide this context for the overall report.

Overview

There is an urgent need to reduce the inequality that exists in maternity safety and birthing experiences in the UK. Despite national efforts to improve safety outcomes, some women and babies from minority ethnic and socio-economically deprived backgrounds remain at greater risk of stillbirth, neonatal death and maternal death when compared to their white or less deprived peers. In addition, we have found that language or literacy barriers can prevent disadvantaged women from being able to personalise their care and obtain the full benefit of initiatives aimed at improving outcomes, such as receiving Continuity of Carer, throughout their pregnancy. Further targeted efforts and a specific National Ambition to reduce avoidable harm and deaths of disadvantaged women and babies are needed to eliminate this disparity in outcomes and ensure that giving birth is a safe and personalised experience for all women.

Section A: Maternity Safety

We have found that outcomes and experiences in the maternity sector are not equitable. Women and babies from minority ethnic and socio-economically deprived backgrounds are at greater risk of stillbirth, neonatal death and maternal death when compared to their white or less deprived peers. Despite the known increased risk to mothers and babies from minority ethnic and socioeconomically deprived backgrounds, the disparity in maternity safety outcomes has persisted. Reducing this disparity in outcomes for disadvantaged groups of women and babies is of the utmost importance. We find the progress on reducing this disparity during the commitment window inadequate and support the notion that a specific target to achieve equal outcomes for disadvantaged women should have been included in the scope of the commitment on maternity safety in the National Ambition.

A letter from Nadine Dorries on 15 April 2021 acknowledges the disparities in outcomes for women from ethnic and socio-economically deprived backgrounds, evidencing the MBRRACE-UK, Perinatal Mortality Surveillance Report (2019),³¹⁶ and states that reducing these inequalities is a priority for her personally and for the Government. The letter states that in September 2020, a Maternity Inequalities Oversight Forum was established to consider and address inequalities for women and babies from different ethnic backgrounds and socio-economic groups.³¹⁷ In addition, the letter states that the Department launched a new £7.6million Health and Wellbeing Fund, which will support 19 projects to reduce health inequalities among new mothers and babies. Whilst these recent announcements and initiatives are most welcome, there has been a lack of funding and focus on reducing this disparity over the last 6 years, since the announcement of the National Ambition in 2015.

The Department has provided data broken down by ethnicity for neonatal deaths and maternal deaths, and by socio-economic deprivation for stillbirths, neonatal deaths, and maternal deaths.³¹⁸ The graphs in the following section are plotted from this data, with original sources used by the Department listed in the legends.

In a meeting with NHSE/I officials on 15 June 2021, Chief Midwifery Officer for NHS England, Jacqueline Dunkley-Bent, described recent initiatives aiming to reduce inequalities in maternity safety outcomes, which included a newly funded Starting Well Programme and signposting the focus of the Saving Babies Lives Care Bundle v2 on supporting pre-term birth rates in women from minority ethnic or socio-economically deprived backgrounds. She stated that:

"...for the Black, Asian, minority women, socio-economically disadvantaged women for example in the Saving Babies Lives care bundle 2, the pre-term birth element will specifically support Black mums and South Asian mums who are more likely to have very pre-term

³¹⁶ <https://www.npeu.ox.ac.uk/assets/downloads/mbrpace-uk/reports/MBRRACE-UK%20Perinatal%20Mortality%20Surveillance%20Report%20for%20Births%20in%202017%20-%20FINAL%20Revised.pdf>

³¹⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Cheryl Mackrory MP, regarding baby loss prevention and data reporting \[15 April 2021\]](#)

³¹⁸ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

*births. We also have an initiative for the consanguinity- close relative marriage- knowing that that does influence morbidity amongst those families that choose to have close relative marriage and that's predominately the South Asian population. So we have specific initiatives that are targeted towards those communities too and that's in relation to genetic counselling, so culturally sensitive genetic services. We're just planning that, and we've got the funding for that, and we're planning how that will be deployed for families so that they can make reproductive choices. And also the health and well-being fund, the Starting Well programme that some £7.6million will be deployed over three years to help reduce inequalities amongst new parents. And we know that COVID has shone a light on maternity inequalities and that's why last year Matthew and I wrote to maternity providers, asking them to implement four key interventions that cost nothing, but are integral to how a midwife and a doctor would work.*³¹⁹

i) Outcomes for women and babies from minority ethnic backgrounds:

Stillbirth and neonatal death rates are not equivalent between different ethnic groups of women and their babies. In the UK, babies of Asian and Asian British, or Black and Black British ethnicities are at higher risk of neonatal death and stillbirth, when compared to babies from white-ethnic groups.³²⁰

Our analysis of the data from the Department on neonatal death rates, broken down by ethnicity, confirms the assertion that babies from minority ethnic backgrounds are at increased risk of neonatal death (see Figure 8). The data also show that the disparity in outcomes has not improved since 2010, the year being used as a baseline for the National Ambition to reduce neonatal deaths by 50%.

³¹⁹ Transcript of Expert Panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

³²⁰ [MBRRACE-UK-PMS-Report-2014.pdf \(ox.ac.uk\)](#); [Microsoft Word - MBRRACE-UK Perinatal Surveillance Report 2018 - final v2 \(ox.ac.uk\)](#); [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

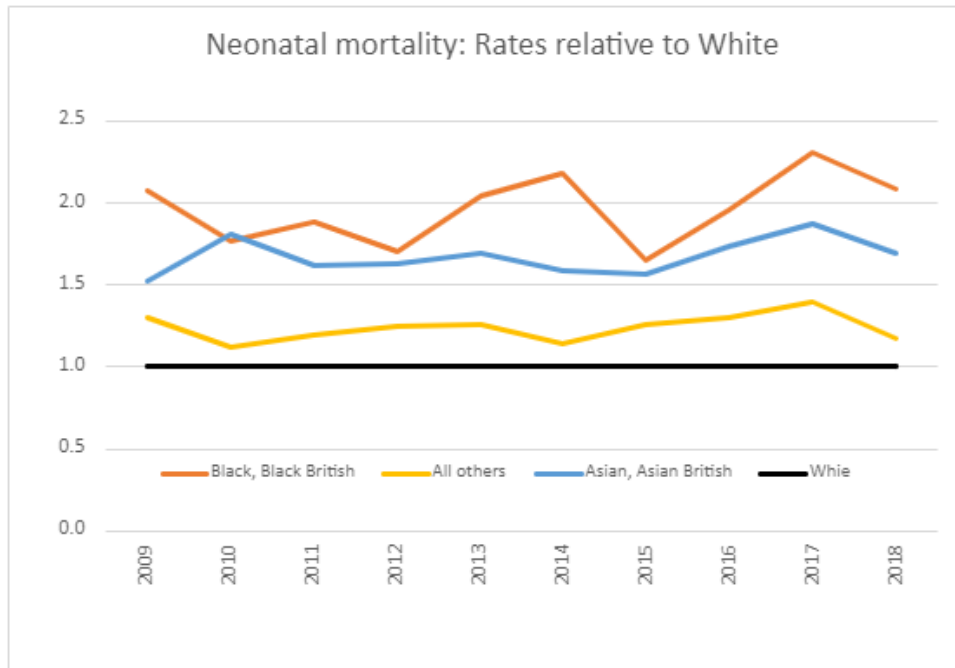


Figure 8. Comparing the relative risk of neonatal death among different ethnic groups between 2009 and 2018. Data shows the relative risk of neonatal death when compared to white ethnic groups for Black or Black British (orange line), Asian or Asian British (yellow) or Other (blue) ethnic groups. The black line shows the reference group of white ethnic groups. Source: Office for National Statistics.³²¹

Data from MBRRACE-UK corroborates our analysis of the Department’s data, although there are some key distinctions leading to discrepancies. MBRRACE-UK reports also show that the increased risk of neonatal death has persisted for babies of minority ethnic backgrounds.³²² For example, the increased risk of neonatal death in babies of Asian or Asian British ethnicity, when compared to babies from white-ethnic groups, had risen from a 38% increased risk in 2014 to 73% in 2017 before falling slightly to 59% in 2018.³²³ For Black and Black British babies, the risks have persisted, with a 43% increased risk of neonatal death in 2014 and a 45% in 2018, when compared to babies from white-ethnic groups.³²⁴ However, while the overall trend corroborates the data provided by the Department, there is a discrepancy in the values. MBRRACE-UK reports exclude terminations and babies born at <24 weeks, while the data from the Department includes neonatal deaths across all gestational ages; the original definition of neonatal deaths rather than the revised definition (see page 17). Thus, the data, while demonstrating similar trends, cannot be directly compared.

³²¹ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

³²² [MBRRACE-UK-PMS-Report-2014.pdf \(ox.ac.uk\)](#)

³²³ [Microsoft Word - MBRRACE-UK Perinatal Surveillance Report 2018 - final v2 \(ox.ac.uk\)](#)

³²⁴ [MergedFile \(maternityaction.org.uk\)](#); [MBRRACE-UK Perinatal Mortality Surveillance Report 2018 – HQIP](#)

Our analysis of the data from the Department on stillbirths, broken down by ethnicity, shows that the relative risk of stillbirth for babies from minority ethnic backgrounds, such as Black or Asian backgrounds, is greater than that of their white peers. This disparity has persisted throughout the commitment window (see Figure 9).

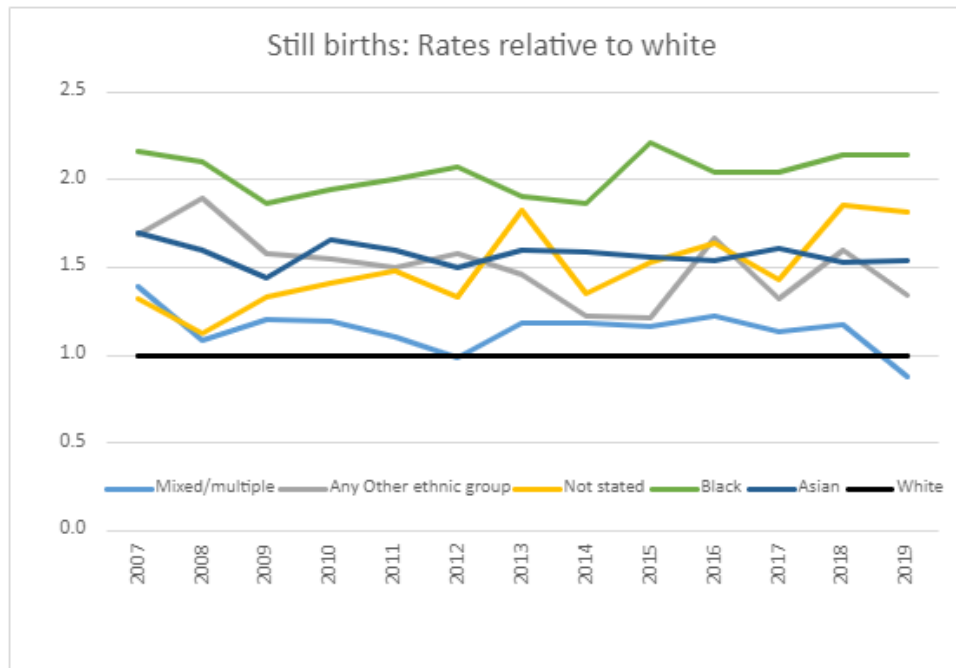


Figure 9. Comparing the relative risk of stillbirth among different ethnic groups between 2009 and 2018. Data shows the relative risk of stillbirth when compared to white ethnic groups for Black (green line), Asian (blue), mixed/multiple (blue), not stated (yellow) or other (grey) ethnic groups. The black line shows the reference group of white ethnic groups. Source: Office for National Statistics.³²⁵

MBRRACE-UK reports corroborate our finding that stillbirth rates remain disproportionately high for babies from minority ethnic backgrounds. For example, the increased risk of stillbirth in Asian and Asian British babies, when compared to babies from white-ethnic groups, was 67% in 2014 and showed only a slight reduction to 57% in 2018. For Black and Black British babies, the risks have increased since 2014, from 98% increased risk of stillbirth in 2014 to 121% in 2018, when compared to babies from white-ethnic groups.³²⁶

Despite the small amount of progress in reducing the increased risk of stillbirth for Asian and Asian British babies, the worsening ratios of neonatal deaths for babies from both ethnic groups when compared to white-ethnic babies and the increasing stillbirth risk for Black or Black British babies, suggest that interventions and resulting progress relating to this

³²⁵ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]; <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/childhealth/datasets/birthsandinfantmortalitybyethnicityenglandandwales>](#)

³²⁶ [MergedFile \(maternityaction.org.uk\); MBRRACE-UK Perinatal Mortality Surveillance Report 2018 – HQIP](#)

commitment are having a greater impact on white-ethnic babies' outcomes than on babies from ethnic minority backgrounds.

Furthermore, both our analysis of the data from the Department and the MBRRACE-UK reports indicate that maternal mortality is disproportionately high for women with Black or minority ethnic backgrounds (see Figure 10). In particular, the number of Black women who die during their maternity remains between 4-5 times higher than their white (or unknown ethnicity) peers.³²⁷

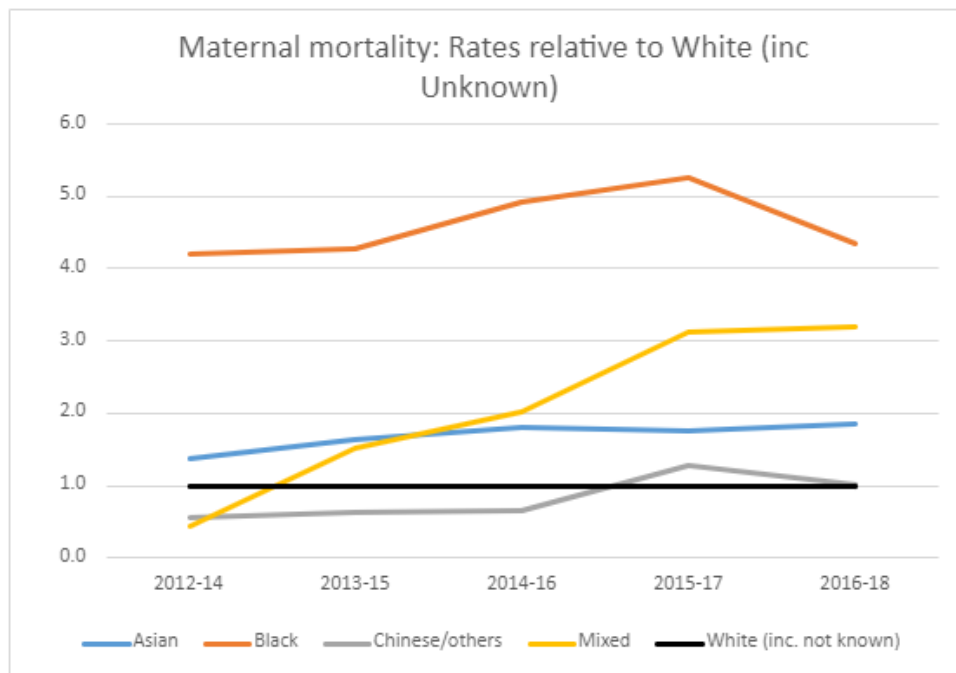


Figure 10. Comparing the relative risk of maternal death among different ethnic groups between 2009 and 2018. Data shows the relative risk of maternal death when compared to white (or unknown) ethnic groups for Black (orange line), Asian (blue line), Chinese/Other (grey line) or Mixed (yellow line) ethnic groups. The black line shows the reference group of white or unknown ethnic groups. Source: Confidential inquiry into maternal deaths, MBRRACE-UK reports.³²⁸

The MBRRACE-UK reports corroborate the finding that black women face a more than four times higher risk of maternal death,³²⁹ showing that in 2015-17, the maternal death rate per 100,000 maternities was 7.22 among white women and 38.03 among black women; more than 5 times higher.³³⁰

The poorer outcomes for women and babies from Black and Black British backgrounds were captured by some of the powerful testimonies of participants in our focus group with women

³²⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

³²⁸ *Ibid.*

³²⁹ [MBRRACE-UK Maternal Report Dec 2020 v10 ONLINE VERSION_1404.pdf \(ox.ac.uk\)](#)

³³⁰ [MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf \(ox.ac.uk\)](#)

from East African backgrounds who have recently accessed maternity services in England. Examples of participants' impressions of the NHS maternity services include:

*"It's a health service that doesn't really care about what women are going through, it doesn't investigate properly, and this is the problem that we're having."*³³¹

*"You feel like the environment is not welcoming. The care you get is not the proper care that you're supposed to get."*³³²

Poorer maternal outcomes are also found for mothers from other minority ethnic backgrounds. Both the data from the Department and the MBRRACE reports demonstrate that the increased risk of maternal death in Asian women has persisted.³³³ In addition, the Patient Experience Library cites the charity Maternity Action's report, which suggests that the disparity in maternal death outcomes also extends to other minority groups such as Gypsy and Traveller women.³³⁴

Participants at our roundtable events corroborated the disparity in outcomes. Although many participants reported the establishment of local initiatives to improve outcomes for black and minority ethnic women in their area, they stated that these efforts stem from motivation at a local level and there is a lack centralised support and resourcing. One participant suggested that:

*"...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."*³³⁵

³³¹ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

³³² *Ibid.*

³³³ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#); [MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf \(ox.ac.uk\)](#)

³³⁴ [MergedFile \(maternityaction.org.uk\)](#)

³³⁵ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

Outcomes for women and babies from socio-economically deprived areas

In addition to women from minority ethnic backgrounds, women from socio-economically deprived backgrounds are at greater risk of maternal death,³³⁶ stillbirth and neonatal death³³⁷ than women from less-economically deprived backgrounds. The Department provided a breakdown of outcomes in maternal death rates, stillbirths rates, and neonatal death rates for women and babies from socio-economically deprived backgrounds.³³⁸ We note that there is a known overlap between the groups of women from areas of high socio-economic deprivation and women from minority ethnicity backgrounds.

Our analysis of data provided by the Department on neonatal death rates (see Figure 11) and stillbirth rates (see Figure 12) broken down by deprivation quintile shows that the increased risk of perinatal death for babies from socio-economically deprived backgrounds has persisted throughout the commitment window (2010-2018).³³⁹ The data from the MBRRACE-UK reports on both stillbirth and neonatal death rates broken down by socio-economic area corroborate our finding that unequal outcomes have persisted.³⁴⁰ However, MBRRACE-UK reports for 2014 and 2018 also show that the disparity in outcomes for babies born in the most deprived areas is worsening, which differs to our own trends between 2014 and 2018 based on data provided by the Department (see Figures 11 and 12). The reports show that babies in the most deprived (5th) quintile and were at 53% increased risk of stillbirth in 2014, when compared to the least deprived quintile, and this has increased to 79% increased risk in 2018. For neonatal deaths, babies in the most deprived quintile were at a 48% increased risk in 2014, which increased to 79% increased risk of neonatal death in 2018, when compared to babies in the least deprived quintile.³⁴¹ These data suggest that the poorer outcomes for socioeconomically deprived babies have worsened during the commitment window.

However, as with the neonatal death data broken down by ethnicity, the values for relative risk of neonatal death will differ between the two datasets. This is due to the differing population of babies under assessment as the data from the Department is for all gestational ages while the data from MBRRACE-UK includes only babies born at greater than 24 weeks gestational age.³⁴² This may explain the discrepancy between the 2014-2018 trends between the two datasets. Despite this difference, both datasets demonstrate the persistence of an

³³⁶ Knight M., Bunch K., Tuffnell D., Jayakody H., Shakespeare J., Kotnis R., Kenyon S., Kurinczuk J.J. (Eds.), on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16, Oxford, National Perinatal Epidemiology Unit, University of Oxford (2018)

³³⁷ [MBRRACE-UK-PMS-Report-2014.pdf \(ox.ac.uk\)](#)

³³⁸ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

³³⁹ *Ibid.*

³⁴⁰ [MBRRACE-UK-PMS-Report-2014.pdf \(ox.ac.uk\)](#)

[Microsoft Word - MBRRACE-UK Perinatal Surveillance Report 2018 - final v2 \(ox.ac.uk\)](#)

³⁴¹ *Ibid.*

³⁴² [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#); [MBRRACE-UK-PMS-Report-2014.pdf \(ox.ac.uk\)](#)

[Microsoft Word - MBRRACE-UK Perinatal Surveillance Report 2018 - final v2 \(ox.ac.uk\)](#)

increased risk of neonatal death for babies born in the most socio-economically deprived areas.

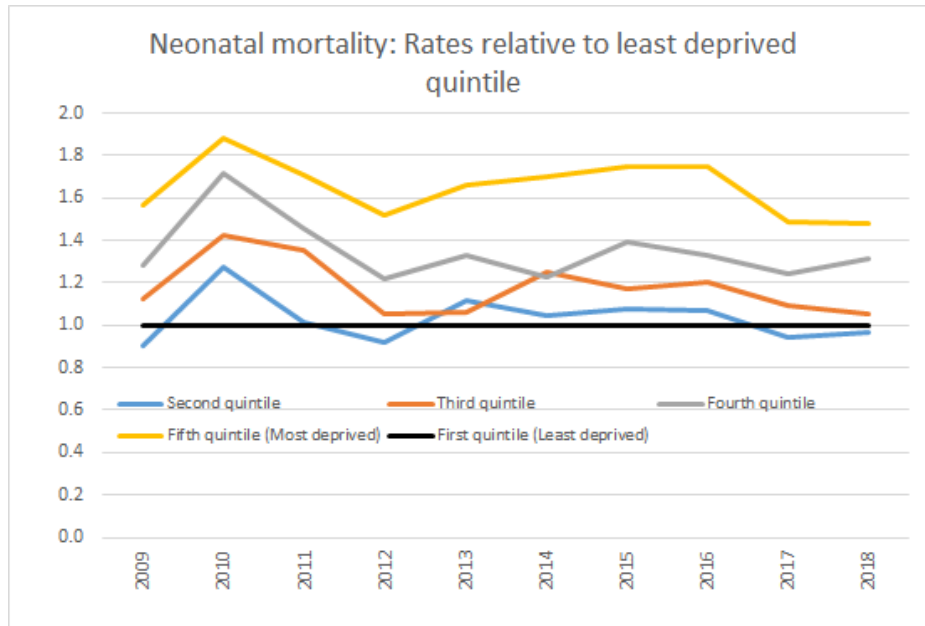


Figure 11. Comparing the relative risk of neonatal death among babies from different socio-economic backgrounds between 2009 and 2018. Data shows the relative risk of neonatal death for babies by area of deprivation from the most deprived (5th) quintile to least deprived (1st) quintile. The yellow line indicates the 5th (most deprived) quintile; grey indicates 4th; orange indicates 3rd; blue indicates 2nd; and black indicates the 1st (least deprived) quintile which is the reference group. Source: NHS Outcomes Framework indicator 1c; NHS Digital.³⁴³

³⁴³ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#); <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework>

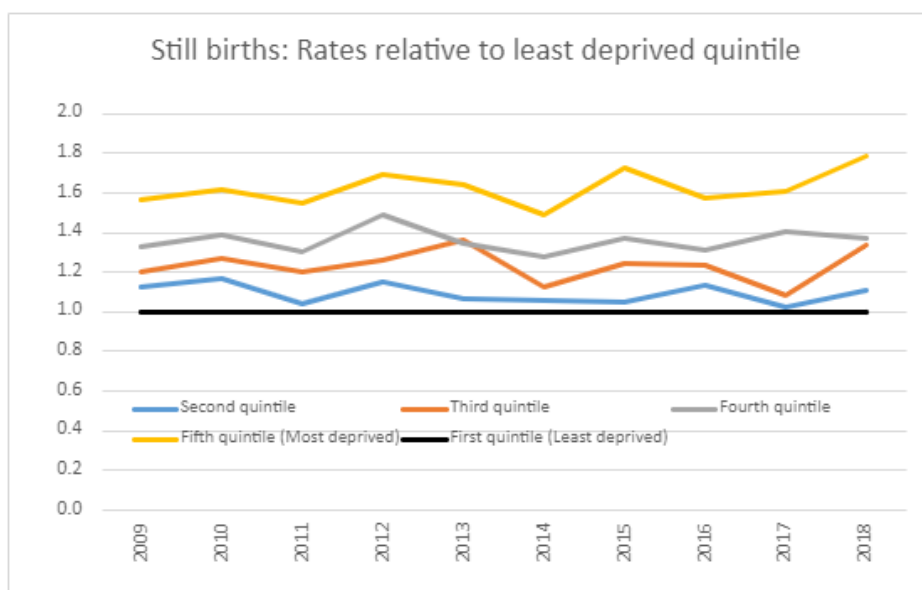


Figure 12. Comparing the relative risk of stillbirth among babies from different socio-economic backgrounds between 2009 and 2018. Data shows the relative risk of stillbirth for babies by area of deprivation from the most deprived (5th) quintile to least deprived (1st) quintile. The yellow line indicates the 5th (most deprived) quintile; grey indicates 4th; orange indicates 3rd; blue indicates 2nd; and black indicates the 1st (least deprived) quintile which is the reference group. Source: NHS Outcomes Framework indicator 1c; NHS Digital.³⁴⁴

Socio-economic deprivation also corresponds with worse outcomes for mothers. Our analysis of the Department’s data indicates that women living in the most deprived areas are at greater risk of maternal death, when compared to the least deprived quintile.³⁴⁵ This inequality has persisted between 2012-2014 and 2016-2018 (see Figure 13). MBRRACE-UK reports corroborate this finding, demonstrating that the relative risk of maternal death has worsened since 2012-2014, with women in the most deprived quintile at 123% increased risk of death in 2015-2017 up from 62% in 2012-2014, when compared to women in the least deprived quintile.³⁴⁶

The worsening disparity in outcomes for women and their babies living in the most socio-economically deprived areas of the country, despite the national rates of stillbirth and neonatal mortality reducing over time, indicate that interventions are not proving as effective for this group of women and babies as they are for those living in the least deprived areas of the country.

³⁴⁴ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#); <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework>

³⁴⁵ *Ibid.*

³⁴⁶ [MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf \(ox.ac.uk\)](#)

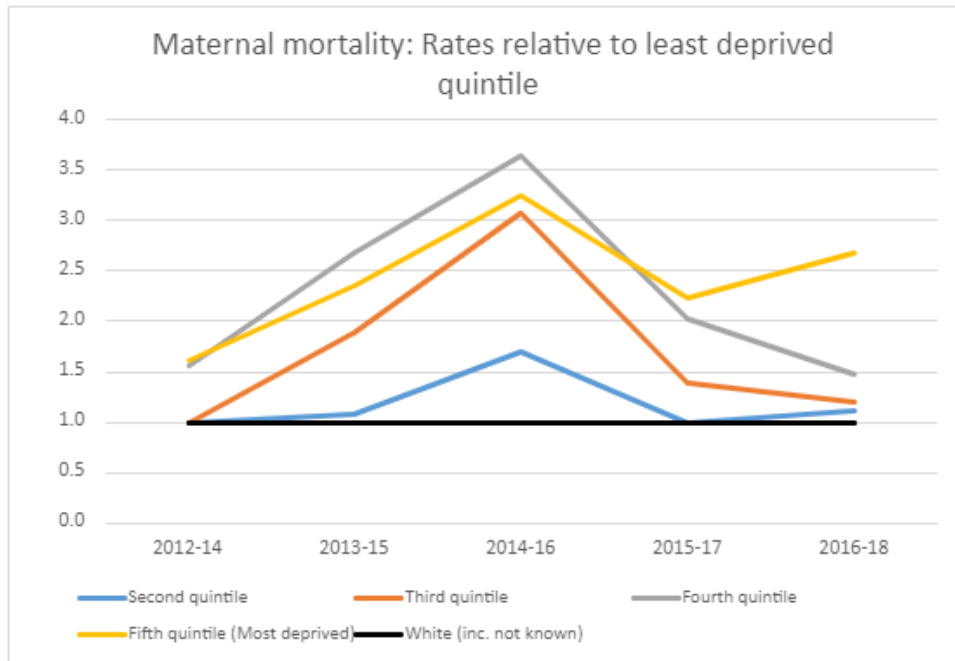


Figure 13. Comparing the relative risk of maternal death among women from different socio-economic backgrounds between 2012-2014 and 2016-2018. Data shows the relative risk of maternal death for women by area of deprivation from the most deprived (5th) quintile to least deprived (1st) quintile. The yellow line indicates the 5th (most deprived) quintile; grey indicates 4th; orange indicates 3rd; blue indicates 2nd; and black indicates the 1st (least deprived) quintile which is the reference group. Source: Confidential inquiry into maternal deaths, MBRRACE-UK reports.³⁴⁷

The Patient Experience Library includes reports addressing an overlooked source of inequality in maternity safety outcomes in the original ambitions and the Department’s response: the relationship between charging for NHS maternity care and inequitable outcomes for women from destitute or immigrant backgrounds. Poor or destitute undocumented migrant women are likely to have complex social factors as well as underlying health conditions that require regular antenatal care. In addition, these women can be from ethnic backgrounds associated with the poorest outcomes in maternal death, stillbirth and neonatal death, as previously mentioned. Therefore, it is some of the women that are most in need of maternity care that are charged for it.³⁴⁸

A study by Maternity Action found that it is more difficult for hospitals to determine eligibility for NHS care than the Department of Health guidance acknowledges and some women who are entitled to free NHS maternity care are charged in error.³⁴⁹ Reports demonstrate that women who are charged for maternity services are less willing to see a midwife or doctor for routine appointments or if unwell. Reasons given include being afraid of being billed for care they cannot afford, and the Home Office being informed, which may jeopardise their immigration applications.³⁵⁰ This reluctance can often lead to late booking and inadequate use

³⁴⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]; and Annex A \[7 June 2021\]](#)

³⁴⁸ [WhatPriceSafeMotherhoodFINAL.October-1.pdf \(maternityaction.org.uk\)](#)

³⁴⁹ *Ibid.*

³⁵⁰ [WhatPriceSafeMotherhoodFINAL.October-1.pdf \(maternityaction.org.uk\)](#)

of antenatal care, which are significant factors associated with maternal death,³⁵¹ perinatal mortality,³⁵² and stillbirths,³⁵³ exacerbating health inequalities in this group.³⁵⁴ In addition, women from low socio-economic backgrounds may struggle to follow healthy dietary and vitamin advice during antenatal care, which can impact the maternity safety outcomes of mother and child. Although the Healthy Start scheme, which provides vouchers for milk, fruit, vegetables and vitamins for pregnant women and mothers on certain benefits, has a positive impact in tackling this issue, women who book late with maternity services miss out on the full benefits of this scheme.³⁵⁵

In a meeting with NHSE/I officials on 15 June 2021, Matthew Jolly, National Clinical Director for the Maternity Review and Women's Health, NHS England suggested that clear written guidance is available, stating that:

*"The guidelines clearly say no woman should ever be denied access to maternity care, whether they can pay or not. [...] I suspect that there might be individual cases where individual people aren't aware of the guidance, and I think in an organisation this big there will always be those glitches. And we need to learn how to minimise those as much as possible."*³⁵⁶

Outcomes for women with disabilities and their babies

The Department's written response does not provide a breakdown of outcomes towards the targets contained within this commitment for women with disabilities.³⁵⁷ Nor do the written submissions comment on this overlooked group.

Evidence from the Patient Experience Library sourced from Hidden Voices of Maternity³⁵⁸ indicates that women with learning disabilities may avoid maternity care due to a lack of confidence, negative staff attitudes, lack of clear explanations of what is going on, or fear of the involvement of social services. The Department do not comment on any initiatives to improve experiences and outcomes of this marginalised group.³⁵⁹

³⁵¹ Knight, M, Tuffnell, D, Kenyon, S, Shakespeare, J, Gray, R, Kurinczuk, J (Eds.) on behalf of MBRRACE-UK. 2015. Saving Lives, Improving Mothers' Care Surveillance of Maternal Deaths in the UK 2011-13 and Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. National Perinatal Epidemiology Unit, University of Oxford, Oxford: MBRRACE-UK.

³⁵² Taylor, B, Newall, D. 2008. Maternity, Mortality And Migration: the impact of new communities. Birmingham: Heart of Birmingham Teaching NHS and West Midlands Strategic Migration Partnership.; Department of Health. 2007. Review of the Health Inequalities Infant Mortality PSA Target. London: Department of Health. Accessed March 14, 2017.

<http://www.perinatal.nhs.uk/smoking/Health%20Inequalities%20report%202007.pdf>

³⁵³ Gardosi J, Madurasinghe V, Williams M, Malik A, Francis A. Maternal and fetal risk factors for stillbirth: population based study. BMJ. 2013 Jan 24;346:f108. doi: 10.1136/bmj.f108. PMID: 23349424; PMCID: PMC3554866.

³⁵⁴ [ChargingReportMarch2017FINALcompressed.pdf \(maternityaction.org.uk\)](#)

³⁵⁵ [MergedFile \(maternityaction.org.uk\)](#), Page 24

³⁵⁶ Transcript of Expert Panel roundtable with NHSE/I on 15 June 2021 ([EPE0029](#))

³⁵⁷ Department of Health and Social Care ([EPE0026](#))

³⁵⁸ [Hidden-Voices-of-Maternity-Report-FINAL-260815-2.pdf \(patientexperiencenetwork.org\)](#)

³⁵⁹ Department of Health and Social Care ([EPE0026](#))

Section B: Continuity of Carer

The inclusion of a specific target in the goal for provision of Continuity of Carer is most welcome; for 75% of BAME women and a similar percentage of women from the most deprived groups to receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period. Continuity of Carer is likely to be crucial in reducing the disparity of outcomes for these women. However, Continuity of Carer should not be viewed as the 'fix -all' solution to inequality in outcomes. There remain barriers to women from disadvantaged backgrounds receiving the full benefit of Continuity of Carer, such as geographical displacement and language barriers. Further measures, in addition to Continuity of Carer, will be necessary to eliminate the racial and socio-economic disparity in outcomes.

Studies³⁶⁰ and written submissions³⁶¹ suggest that provision of Continuity of Carer (CoC) to women from minority ethnic and socio-economically deprived backgrounds will improve maternity safety outcomes and birthing experiences for these women. As a result, the Government announced the target for 75% of BAME women and a similar percentage of women from the most deprived groups to receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.³⁶²

Although CoC is anticipated to improve outcomes for disadvantaged women, we have found that barriers to receiving the full benefits of a model of maternity care are more frequent within these groups. Therefore, access arrangements may need to be adjusted to ensure parity of CoC roll-out. For example, evidence from the Patient Experience Library notes that asylum seeking women can be more likely to have to move to different areas multiple times during pregnancy, making receipt of CoC more difficult. Similar issues are faced by women from Travelling communities who can often be moved or evicted during their pregnancy or post-natal care.³⁶³

The Patient Experience Library emphasised another barrier to receiving CoC for women who have English as an additional language or poor literacy competency. These women are at heightened risk of exclusion from shared decision making via written notes and digital apps and may experience difficulty understanding care advice. In the context of an increased emphasis on pregnant women advocating for themselves and making informed decisions about their care during pregnancy, these women often face stigma or prejudice in their treatment and translation services are not always available.³⁶⁴

There is evidence that some maternity units have responded quickly to meet the additional needs of women who do not speak English. For example, during our roundtable events, one

³⁶⁰ https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

³⁶¹ Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); National Maternity Voices ([EPE0018](#))

³⁶² [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#)

³⁶³ [MergedFile \(maternityaction.org.uk\)](#)

³⁶⁴ [MergedFile \(maternityaction.org.uk\)](#)

midwife described the development of a specialist non-English speaking CoC team. The midwife explained:

*"We've got a non-English speaking team at the one of our providers as part of the COC 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."*³⁶⁵

However, conversations with women from East African backgrounds at our focus group demonstrated the persistence of language barriers as a major impediment to good care and positive experience. For example, one participant stated:

*"It makes me feel that I have two options; I have to speak native English or have enough money to pay for private. I'm saving to have another baby and I work 50 hours, because I want to save money. We are in Great Britain, why do we have to kill ourselves to get treatment?"*³⁶⁶

One woman also commented that while her experience of CoC was positive, this was dependant on having a skilled carer who was able to effectively communicate. She commented that women who do not have this did not associate CoC with the same benefits:

*"I had that one-person experience, I think it was piloted many years ago, where you can choose one midwife who takes you from the start all the way till you have your baby, and if you go to the hospital that midwife will have to come and help you to deliver. I was so lucky choosing a Somali speaking midwife, because there have been some friends that I know who haven't had a choice or were not able to speak their language or that they can relate to. Even though I didn't need interpretation, I just felt like I wanted somebody from my culture, and I had the best experience. But what they have told me is that even though they selected one midwife, the experience that they came across was not the same as my one. They really struggled."*³⁶⁷

³⁶⁵ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

³⁶⁶ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

³⁶⁷ *Ibid.*

Section C: Personalised Care

We found that the capacity of women to decide on and receive their preferred mode of care is also inequitable. Women from minority ethnic backgrounds and/or who are socially disadvantaged are less likely to receive the same range of choices and information as other women.³⁶⁸ The dehumanising experiences described by the women who spoke to us at our focus group serve as a harrowing example of the dismissal of choices and voices that some women from Black and minority ethnic backgrounds can experience during maternity care. We found that having an advocate from the local community who speaks the same language was crucial in establishing trust with staff and allowing the needs of women to be effectively communicated to care providers. We commend the encouragement of equality and diversity in the guidance for Personalised Care and Support Plans (PCSPs) published in 2021. For example, the recommendation to make PCSPs available in a range of languages and reading levels. However, further funding and support is needed to ensure that midwives, obstetricians, and other staff involved in the care pathway who should be included in developing and actioning PCSPs receive high-quality culturally sensitive, trauma-informed care and unconscious bias training recommended by Public Health England in 2020.³⁶⁹

Information received from the Department indicates that Personalised Care and Support Plan (PCSP) data split by ethnicity and economic disadvantage has been collected from April 2021 and will be published in July 2021.³⁷⁰ However, these data will be classed as experimental while quality is reviewed. The Department do not provide additional details of how this data is being collected.

The Department acknowledge further work is needed to ensure PCSP data are collected by disability and LGBT status.³⁷¹

PCSP guidance published in March 2021 encourages staff to ensure equality and diversity of roll-out by ensuring PCSPs are available in a range of languages and reading levels; that information is available pictorially and graphically as well as in words; and that hard copies are available for women without digital access. It also encourages staff to complete cultural competence and unconscious bias training.³⁷² However, it is not clear how these recommendations will be supported, monitored, or financed.

A 2019 Maternity Action report relating to the experiences of migrant women who are not eligible for free NHS maternity care suggests that PCSPs may be especially difficult for this group of women.³⁷³ The booking appointment is central to most women's ante-natal care and the point at which relationships with midwives are formed. It is also the point at which women

³⁶⁸ Birthrights ([EPE0019](#)); Caesarean Birth ([EPE0023](#))

³⁶⁹ Maternity high impact area: Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies (2020) Public Health England

³⁷⁰ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

³⁷¹ *Ibid.*

³⁷² Personalised care and support planning guidance: Guidance for local maternity systems, 5.5. [Report template - NHS website \(england.nhs.uk\)](#)

³⁷³ [Duty of Care: The impact on midwives of NHS charging for maternity care - Maternity Action](#)

subject to NHS Overseas Visitors charges are identified and midwives report feeling conflicted about their ethical position in these cases. The report describes an 'erosion of trust' which often precludes optimal maternity care planning, and in some cases causes women to refuse care altogether.³⁷⁴

A recent report by Public Health England (2020)³⁷⁵ refers to the need for midwives to receive high quality cultural sensitivity, trauma-informed care and unconscious bias training, and to undergo specialist healthcare training for issues such as FGM, HIV, entitlement to care, sickle cell and thalassaemia screening³⁷⁶ noting that a one-size fits all approach excludes women from minority ethnic and/or socio-economically disadvantaged groups.³⁷⁷ It also highlights a need for female interpreters and translators and for written information to be available in multiple languages.

While the principle of personalised care was welcomed by stakeholders as an important way to reduce persistent health inequalities, two written submissions noted that this will only be possible to monitor with high quality, disaggregated data for different groups of women. The submission from RCM/RCOG states that "*the absence of reliable data on ethnicity or level of deprivation makes it difficult to judge the extent to which PCSPs are being offered on an equitable basis.*"³⁷⁸

Birthrights highlighted the fact that women from Black and ethnic minority backgrounds, and/or who are socially disadvantaged are less likely to receive the same range of choices and information as other women. Persistent reports of dehumanised care and discriminatory behaviours are believed to be important contributing factors to ongoing health inequalities which Birthrights claim needs to be addressed by mandatory training. They state that:

*"Women facing severe and multiple disadvantage are less likely to be offered the same options and choices as other women and are less likely to give informed consent. This was further exacerbated amongst women who are asylum seekers, facing some of the greatest disadvantage. Too often, despite pregnancy being an opportunity to engage with individuals who might require additional support, women instead report feeling scrutiny and judged."*³⁷⁹

Caesarean Birth reported that being white is a significant predictor of successful CDMR (caesarean delivery on maternal request) and that work is needed to ensure that informed decision-making during pregnancy and childbirth extends to all groups of women.

Clinicians during the roundtable events commented that current practice guidelines do not always include the collection of ethnicity data. One obstetrician commented that "*we're missing some major risk factors like ethnicity and the concept of multiple disadvantage. It was used in the pandemic for risk but is not among the reams and reams of things that are ticked off in a personalised care book.*"³⁸⁰ Another obstetrician raised concerns that current risk assessment practice may increase health inequalities, "*it's important to point out that the current checklist worsens the health divide, and the introduction of an algorithm integrates*

³⁷⁴ [Duty of Care: The impact on midwives of NHS charging for maternity care - Maternity Action](#)

³⁷⁵ [Maternity high impact area 6: Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic \(BAME\) communities and their babies \(publishing.service.gov.uk\)](#)

³⁷⁶ *Ibid.* p. 11

³⁷⁷ *Ibid.* p. 20

³⁷⁸ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

³⁷⁹ Birthrights ([EPE0019](#))

³⁸⁰ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

*ethnicity into that risk assessment. The only way we are going to lessen the health divide in ethnicity is by introducing such algorithms that take in and integrate risk assessments and include ethnicity.*³⁸¹

During our focus group with women from East African backgrounds a number of women described poor treatment from midwifery staff which they attributed to cultural bias and racism. Women felt that they were not properly listened to or respected, and there were several reports of women being denied meaningful explanations about their care. One woman described a doctor pursuing a caesarean delivery without seeking informed consent or explaining why this was needed:

*"The doctor came in and said that it looks like I was going to have to go down the surgery route, and I said, "how can that be possible as I only came in at 11 this morning?" I asked her to at least give my body the chance to go through the labour naturally. She said, "no, we're going to have to do this quickly, I think you should have the surgery". She would have her colleagues coming in my room every hour and tell my husband, "she's in pain, I don't think she's coping, can you please sign this form for surgery?". And I would say, "I'm conscious, I can give my own consent, why do you have to ask my husband?"... Four hours later she came back and said that she was going to check how dilated I was, and without my consent she broke my water."*³⁸²

Another woman described a harrowing experience following the stillbirth of her baby during which painful medical interventions were administered without explanation, consent, or appropriate pain relief:

*"I went there and the doctor he just tried to practice on me, that's what I feel. He injected me in my back, and I was bleeding, and I said to him, "Stop!". I cried and nobody heard. At the same time, he was trying to inject, inject, inject. He wouldn't stop. I felt an electric shock in my right leg. It was too much pain, and I don't want anyone to go through this experience. I said to him "please stop, I'm bleeding."*³⁸³

While we accept that these testimonies do not reflect the attitudes or practice of the majority of midwives and obstetricians, it is clear that significant investment in staff training is needed to ensure that high quality personalised care extends to all women, regardless of culture or background. Women from marginalised backgrounds described the importance of having an advocate from the local community who speaks the same language. Women were very clear that quality of care depends on the ability to effectively communicate with care providers. One woman said:

*"It's communication. When people see that you cannot communicate properly, they do not care about the way that they treat you. I feel if you cannot communicate the way you want it and you cannot express the way you want things to be done, nobody is there to help you."*³⁸⁴

³⁸¹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

³⁸² Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

³⁸³ *Ibid.*

³⁸⁴ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

Section D: Safe Staffing

Staffing deficits and lack of training opportunities underpin all the factors influencing inequality in outcomes for disadvantaged women. Participants at our roundtable events reported that initiatives to tackle inequality were established through motivation at a local level and described a lack of centralised support and resourcing. Furthermore, overstretched staff cannot be released to undertake training aimed at reducing the disparity in outcomes, for example trauma-informed and unconscious bias training. In addition, testimonies from our focus groups raised the point that overworked, exhausted staff are less likely to demonstrate the empathy and cultural sensitivity needed to establish trust. Increased staffing and staff training opportunities will be needed to ensure women from disadvantaged backgrounds are given the opportunity to personalise their care and receive this care from trained, culturally sensitive staff who have the time to develop a trusting relationship with the women under their care.

Women from marginalised communities who took part in our focus groups described overworked staff as less likely to have compassion and empathy, or to demonstrate sensitive understanding about the needs of women from different cultures. One woman described the impact of sustained periods of overwork on the quality of care:

*"You lose that compassion and empathy for people after working for many years or losing lives because day in and day out you are going in and you are exhausted yourself."*³⁸⁵

The written submission from Birthrights highlighted that staff shortages and funding cuts to training budgets have disproportionately impacted women from Black and ethnic minority or other marginalised backgrounds.³⁸⁶ Training to mitigate against racial bias was described as essential to address serious and persistent health inequalities, with asylum seeking women among the most vulnerable. Women facing structural disadvantage were reported as being less likely to receive the same information and choices as other women, and lack of translation made delivery of quality care difficult for women with English as an additional language.

During focus group sessions with women from East African backgrounds, a number of women reported experiencing direct and indirect racist behaviour from staff which they associated with poor cultural awareness and understanding. One woman described the importance of having women on labour wards from within the community to provide advocacy and promote understanding.

*"I don't think they understand that we are human. They look at us as different and not as a human being. We look forward to having people from our community in the hospital, especially in the maternity ward, to help us, to support us, to understand us, to talk to the doctor. We need them to be with us there."*³⁸⁷

³⁸⁵ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

³⁸⁶ Birthrights ([EPE0019](#))

³⁸⁷ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

Women also agreed that to reduce health inequalities there needs to be more accountability for staff who are found to have discriminated against women based on race, language, or cultural background. This was emphasised with one participant explaining that:

"There is a lack of accountability, because if the hospitals and the members of staff are continuing to treat ladies in this way and they're not questioning them and there is no accountability, how are they going to change them?"³⁸⁸

Discussions during the focus group also highlighted problems with the accessibility of maternity units for women from marginalised backgrounds. Maternity units were described as unwelcoming and hostile environments for many non-native women, especially women who do not have English as a first language. For example, one participant said:

"As soon as you walk into the maternity ward you hardly see a doctor or consultant, but you do see the unwelcoming faces of the midwives. As soon as you walk in you feel you are in a battle stage environment, like you have to fight for everything."³⁸⁹

These troubling accounts show that much more needs to be done to reduce the known health inequalities for women from Black and ethnic minority backgrounds, and to ensure that all babies, regardless of race and or cultural background, receive the best start possible.

³⁸⁸ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

³⁸⁹ *Ibid.*

Annex A: Maternity Safety

This section contains additional information based on the sub-questions from the planning grid.

A: Was the commitment met overall? Or is the commitment on track to be met?

Sub-questions:

The following section provides further detail on the information in Chapter 1 and should be viewed as a supplement to the main report. This information was included in the Panel's debate to reach the CQC-style ratings. The information is broken down by the sub-questions that are set out in the planning grid.

1) Does the commitment have a clear and fixed deadline for implementation? If so, has the deadline been met or is it on track to be met?

Most of the targets in the commitment to halve the 2010 rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth; and to reduce the pre-term birth rate from 8% to 6% by 2025 have clear and fixed deadlines, including interim targets. However, the target on brain injury lacks clarity as the baseline data for 2010 does not exist.³⁹⁰

Only the targets to halve stillbirths and neonatal deaths are seemingly on track. However, there are the following caveats to the progress towards meeting these two targets:

Firstly, although the stillbirths interim target has been met, an increase in the rate of reduction of stillbirths over the period of 2019-2025 will be necessary to reach the 2025 target.

Secondly, regarding neonatal deaths, the interim target for 2020 has been met and the rate of reduction is on track to meet the 2025 target of 50%, but only by the revised definition that excludes very premature babies born at <24 weeks gestation. Written submissions from the maternity charities SANDs and Bliss raised concerns about the appropriateness of the revised definition and the potential negative consequences this may have on efforts to improve outcomes for premature babies,³⁹¹ which is discussed in Chapter 1.

2) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

The Department has stated that the time lag between implementation and impact has contributed to some of the commitment's interim targets not being met or being on track to meet the 2025 target.³⁹² Other mitigating factors the Department describes include the need for phased implementation and the increased complexity of the maternal population (for example, increasing rates of obesity and older mothers). It is not clear which targets these mitigating factors have influenced nor what action was taken to account for them.

³⁹⁰ Department of Health and Social Care ([EPE0026](#)), para 17

³⁹¹ Sands ([EPE0012](#)); Bliss ([EPE0020](#))

³⁹² Department of Health and Social Care ([EPE0026](#)), paras 4-5

The registered charity Obstetric Anaesthetists' Association also acknowledges the challenges presented by the increasing complexity of the maternal population, noting that a greater proportion of maternal deaths arise from indirect factors, such as existing disease, than direct obstetric causes.³⁹³

We found no evidence that sufficient action has been taken by the Department to tackle the known risk of increased maternal complexity on progress towards reducing the rate of maternal deaths.³⁹⁴ The maternity charity Campaign for Safer Births state that the Maternal Medicine Networks clinics, announced by the Department in 2017 to support care of women with more specialist needs, have not been established.³⁹⁵ The delay in launching these clinics is likely to have hampered progress towards this target.

3) Does data show achievement against the target?

In our assessment in response to this sub-question for the commitment on maternity safety, we have analysed the data provided by the Department on achievement against each target set out within commitment 1. We have calculated forecasted rates for 2025 based on the current trajectory of the data to determine whether each target is on track to be met (see Figures 1-6). These rates are calculated from national data, irrespective of ethnic or socio-economic background. Data relating to the inequitable outcomes for women with disabilities or from minority ethnic and socio-economically deprived backgrounds have been discussed in Chapter 5.

Stillbirths:

The Office for National Statistics data provided by the Department indicates that the target for reduction in stillbirth rates is likely to be met.³⁹⁶

The Department stated that the commitment set in 2015 National Ambition aimed to reduce stillbirth rates from 5.1 per 1,000 births in 2010 to 2.5 in 2025, with an intermediate target of 4.1 in 2020 (20% reduction).³⁹⁷ The intermediate target of a 20% reduction in stillbirths by 2020 has been achieved ahead of schedule, with data showing that by 2019 the rate of still births has fallen to 3.8 per 1,000 which represents a reduction of 25% during the period of 2010-2019.³⁹⁸ However, despite surpassing the interim target, if the rate of decrease between 2010-2019 (0.14 stillbirths per 1,000 births per year) were to continue then we would expect 2.9 stillbirths per 1,000 births in 2025, missing the overall target of the ambition. Our analysis of the ONS data on stillbirths shown in Figure 1 on corroborates this finding.³⁹⁹

An increase in the rate of reduction of stillbirths over the period of 2019-2025 will therefore be necessary to reach the 2025 target. The Department has stated that it is on track to meet

³⁹³ Obstetric Anaesthetists' Association ([EPE0008](#))

³⁹⁴ Department of Health and Social Care ([EPE0026](#))

³⁹⁵ Campaign for Safer Births ([EPE0009](#))

³⁹⁶ Department of Health and Social Care ([EPE0026](#)), paras 6-8. Data sourced from the Office for National Statistics' (ONS) annual 'Births in England and Wales' database.

³⁹⁷ Department of Health and Social Care ([EPE0026](#)), para 6

³⁹⁸ Department of Health and Social Care ([EPE0026](#)), paras 6-8

³⁹⁹ [The Office for National Statistics' \(ONS\) live births, stillbirths and neonatal deaths by gestational age in England, 2010 to 2019 \(live births and stillbirths\)](#)

this target⁴⁰⁰ but provided no further information about what plans there are to support the anticipated increase in efforts needed to accelerate progress.

Several written submissions corroborate the assessment that the target to halve stillbirths by 2025 is on track, or to be commended.⁴⁰¹ However, written submissions also emphasise that a further increase in efforts is needed to achieve the 2025 target.⁴⁰² For example, the charity Caesarean Birth⁴⁰³ have challenged the Department's assertion that this commitment is on track.⁴⁰⁴ The charity references the words of Vice President Professor Tim Draycott on the Each Baby Counts report (March 15, 2021), which state:

*"I think it is clear from the data that while progress has been made in certain areas, there are still too many avoidable stillbirths, baby deaths and brain injuries occurring during term labour in the UK. [...] It is disappointing that over the five years of the programme, we have not seen the reductions in avoidable stillbirths, baby deaths and brain injuries related to term labour that we had hoped for."*⁴⁰⁵

Neonatal deaths:

ONS data shows that the target for reduction in neonatal deaths is not on track to be met.⁴⁰⁶

This target of the 2015 commitment aimed to reduce neonatal deaths from a rate of 2.9 per 1,000 live births in 2010 to 1.4 per 1,000 live births by 2025, with an intermediate target of 2.3 deaths per 1,000 live births in 2020. Data shows that, although the neonatal death rate initially fell to 2.5 per 1,000 live births in 2014, the rate then increased to 2.8 deaths per 1,000 live births in 2017, subsequently reducing to 2.7 neonatal deaths per 1,000 live births in 2019. The rate in 2019 represents a 7% decrease in neonatal deaths since 2010.⁴⁰⁷ If the rate of decrease of neonatal deaths from 2010-2019 continues at the same rate (0.02 deaths per 1,000 live births per year) then there would be an expected 2.57 neonatal deaths per 1,000 live births in 2025. This would mean the target of 1.4 neonatal deaths per 1,000 live births would have been missed by the deadline of 2025.

A change in the measure of progress against the National Maternity Ambition on neonatal deaths was introduced by the Department,⁴⁰⁸ following a change in care practice for the perinatal management of extreme preterm birth (<27 weeks of gestation).⁴⁰⁹ This change and concerns over its validity are described in greater detail in Chapter 1.

⁴⁰⁰ Department of Health and Social Care ([EPE0026](#)), para 7

⁴⁰¹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Dr Bill Kirkup ([EPE0005](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Birthrights ([EPE0019](#))

⁴⁰² Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Campaign for Safer Births ([EPE0009](#)); Caesarean Birth ([EPE0023](#))

⁴⁰³ Caesarean Birth ([EPE0023](#))

⁴⁰⁴ Department of Health and Social Care ([EPE0026](#)), para 7

⁴⁰⁵ [Reflections on the Each Baby Counts programme \(rcog.org.uk\)](#)

⁴⁰⁶ Department of Health and Social Care ([EPE0026](#)), para 9-10. Data sourced from the ONS 'Child and Infant Mortality in England and Wales' database.

⁴⁰⁷ Department of Health and Social Care ([EPE0026](#)), paras 9-10

⁴⁰⁸ Department of Health and Social Care ([EPE0026](#)), paras 12-13

⁴⁰⁹ <https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019>

By this revised measure, data show that the rate of neonatal death in 2010 was 2.0 per 1,000 live births, while the rate in 2019 was 1.4 deaths per 1,000 live births. The rate in 2019 represents a decrease of 29%, surpassing the 2020 target of a 20% reduction in neonatal deaths.⁴¹⁰ Thus, the reduction in neonatal deaths, when only including babies born at greater than or equal to 24 weeks gestation, is on track to be met. If the overall rate of decrease of neonatal deaths from 2010-2019 continues (0.07 deaths per 1,000 live births per year) then we would expect 1.0 neonatal deaths to occur per 1,000 live births in 2025, representing a 50% reduction in the rate of neonatal death since 2010.

In its written submission, the maternity charity Campaign for Safer Births (CSB) stated that high perinatal death rates have persisted in multiple pregnancies. CSB are aware of maternity units not adhering to the National Institute for Health and Care Excellence guidance and lacking specialist multiple clinics. The charity suggest that this has limited the reduction of avoidable deaths in multiple pregnancies and thus limited progress towards the target to halve 2010 neonatal death rates by 2025.⁴¹¹

Brain injuries occurring during or soon after birth:

Data provided by the Department show that the target for reduction of brain injuries occurring during or soon after birth is not on track to be met.⁴¹²

Although the original target set in 2015 intended to use the rate of brain injuries from 2010 as the baseline, the Department state that population coverage for 2010-2011 through the National Neonatal Research Database was incomplete.⁴¹³ Therefore, the earliest reliable data provided by the Department is for 2012; 4.2 brain injuries per 1,000 live births. It is not clear how the lack of data for 2010 affects the numerical targets of this element of the commitment.⁴¹⁴

If the 2012 rate of 4.2 brain injuries per 1,000 live births is taken as the baseline, the commitment would aim to reduce brain injuries to 2.1 per 1,000 by 2025, with an interim target of 3.4 brain injuries per 1,000 live births in 2020 (20% reduction). The data do not indicate progress against this target. Between 2012 and 2014 (prior to the commitment being set in 2015), the brain injury rate rose from 4.2 to 4.7 per 1,000 live births. The rate of brain injury has since fallen to 4.2 per 1,000 live births in 2019. We have not seen evidence supporting an increase in the rate of reduction of brain injury over the period of 2019-2025. Therefore, it is not clear if progress will be made towards achieving this commitment within the commitment window.⁴¹⁵

While the data shows no overall reduction in the rate of brain injuries between 2012 and 2019, it does indicate a reduction since the National Ambition was set in 2015. In addition, the Department states that the rate of infants with hypoxic ischaemic encephalopathy (HIE) has

⁴¹⁰ Department of Health and Social Care ([EPE0026](#)), paras 12-13

⁴¹¹ Campaign for Safer Births ([EPE0009](#))

⁴¹² Department of Health and Social Care ([EPE0026](#)), paras 16-19. Data sourced from data commissioned by DHSC from the Neonatal Data Analysis Unit (NDAU) and derived from the National Neonatal Research Database (NNRD)

⁴¹³ Department of Health and Social Care ([EPE0026](#)), para 17

⁴¹⁴ *Ibid.*

⁴¹⁵ Department of Health and Social Care ([EPE0026](#)), paras 16-19

fallen by 15% between 2014 and 2019, although they do not provide the data underlying this stated reduction. The Department have explained:

*"although good care can reduce the risk of hypoxic brain injury, (hypoxic ischaemic encephalopathy or HIE), the national brain injury definition also incorporates other causes, including preterm related brain injury."*⁴¹⁶

The Department's statement implies that pre-term injury cannot be improved by good care, without clarifying whether this limitation was considered when the National Ambition was set in 2015, or when the bespoke definition was agreed in 2017.⁴¹⁷

The lack of progress on this commitment and has been raised by numerous stakeholders. In addition, Dr Bill Kirkup argues in his written submission that data on brain injury rate is a more sensitive marker of unit performance than total stillbirth or total neonatal death rates.⁴¹⁸

Maternal deaths:

The data provided by the Department show that the target for reduction in maternal deaths is not on track to be met.⁴¹⁹

This target aimed to reduce the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 (20% reduction) and 5.3 in 2025 (50% reduction). Due to the relatively small numbers of maternal deaths each year, maternal mortality rates are presented triennially rather than annually. The Department describe a volatile trend with 9.7 maternal deaths per 100,000 maternities in the years 2016-2018, representing an overall reduction of 9% between 2009-2011 and 2016-18.⁴²⁰ The more recent data for 2017-2019 is not yet available therefore any recent changes cannot be accounted for.

If the 2010-2017 rate of decrease were to continue (9% over 7 years), we would expect a 19% reduction from the 2010 baseline by 2025. This would not meet the commitment of a 50% reduction. Furthermore, the wide confidence intervals on historic data mean that the projected trend is unlikely to show any statistically significant change by 2024/26 (see Figure 14). Wide confidence intervals are also present in the data for deaths due to both direct (Figure 15) and indirect causes (Figure 16). This suggest that no significant progress has been made on the target to reduce 2010 maternal death rates by 50%. The Department acknowledge that further concerted efforts, enhanced through existing and incoming initiatives, are critical if the 2025 ambition is to be met.⁴²¹

⁴¹⁶ Department of Health and Social Care ([EPE0026](#)), para 19

⁴¹⁷ Imperial College London. Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health, 2017.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662974/Report_on_brain_injury_occurring_during_or_soon_after_birth.pdf

⁴¹⁸ Dr Bill Kirkup ([EPE0005](#))

⁴¹⁹ Department of Health and Social Care ([EPE0026](#)), paras 22-24. Data sourced from the annual MBRRACE-UK confidential enquiries in maternal death and morbidity reports.

⁴²⁰ *Ibid.*

⁴²¹ Department of Health and Social Care ([EPE0026](#)), para 24

Many written submissions corroborate the observation that this commitment is not on track to be met.⁴²² The written submission from the charity Obstetric Anaesthetist Association (OAA) observes that this rate has remained largely unchanged since 1985, when the maternal death rate was 9.83 per 100,000 maternities.⁴²³ However, the OAA also observe that between 1985 and 2017 the proportion of maternal deaths attributed to indirect causes (deaths resulting from existing disease, or disease that developed during pregnancy and not due to direct obstetric causes) has increased.⁴²⁴ Consequently, we believe that, in order for further progress towards achieving the target of reducing maternal deaths to 50% of the 2010 rate by 2025, initiatives to support women must be put in place in the pre-conception window alongside increased efforts to support management of co-existing disease and mental health difficulties in the maternal population, as discussed in Chapter 1.

Additional graphs relating to maternal deaths:

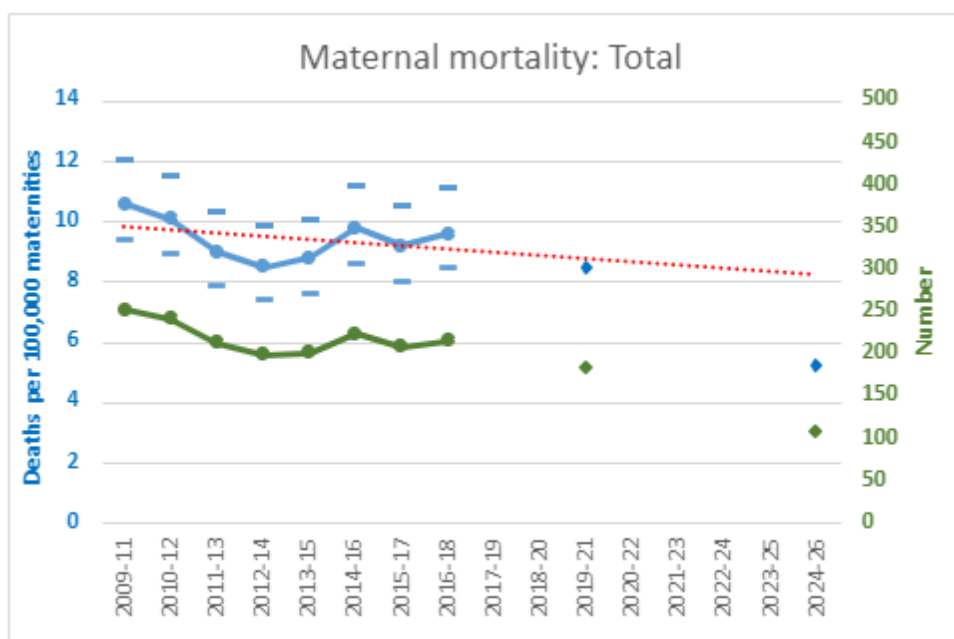


Figure 14. Annual number and rate of maternal deaths per 100,000 maternities (all causes). Due to the low numbers of deaths per year data is represented triennially. The blue line and data points represent all maternal deaths per 100,000 maternities; blue bars indicate confident intervals for each data point; green lines and data points indicate total maternal deaths per year. The red dashed lines indicate projected trends. Given the wide confidence intervals on historic data, the projected trend is unlikely to show any statistically significant change by 2024/26. The points at 2019-2021 and 2024-2026 indicate the target rates of maternal deaths. Source: the MBRRACE-UK Maternal Report Dec 2020 v10.⁴²⁵

⁴²² Obstetric Anaesthetists' Association ([EPE0008](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Baby Lifeline ([EPE0021](#))

⁴²³ Obstetric Anaesthetists' Association ([EPE0008](#))

⁴²⁴ *Ibid.*

⁴²⁵ [MBRRACE-UK Maternal Report Dec 2020 v10 ONLINE VERSION 1404.pdf \(ox.ac.uk\)](#)

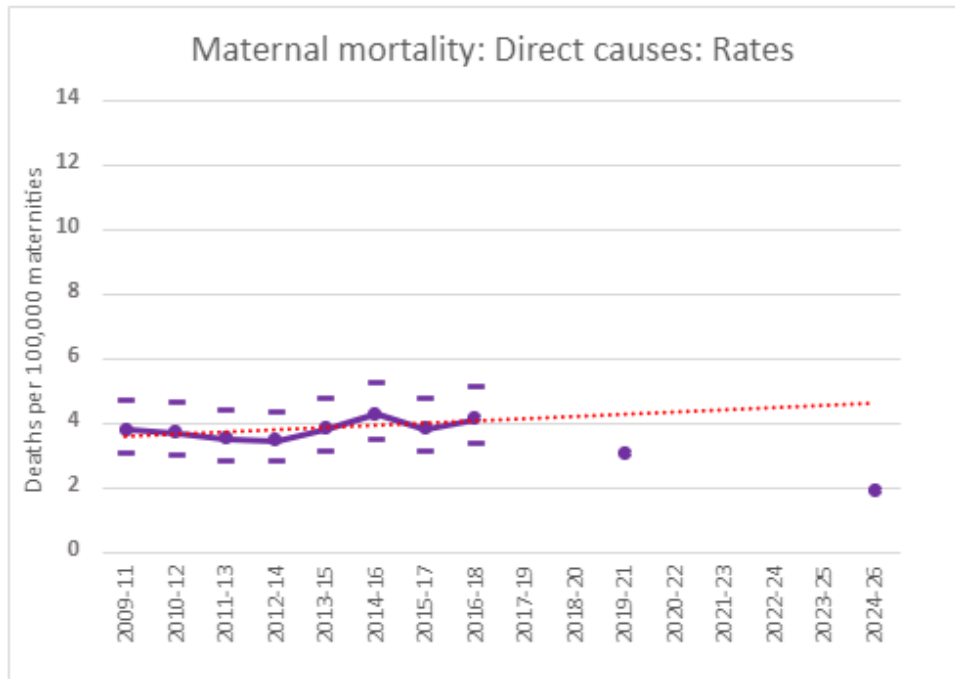


Figure 15. Annual rate of maternal deaths due to direct causes per 100,000 maternities. Due to the low numbers of deaths per year data is represented triennially. Data indicates maternal deaths due to direct obstetric; bars indicate confident intervals for each data point; the red dashed lines indicate projected trends. Given the wide confidence intervals on historic data, the projected trend is unlikely to show any statistically significant change by 2024/26. The points at 2019-2021 and 2024-2026 indicate the target rates of maternal deaths. Source: the MBRRACE-UK Maternal Report Dec 2020 v10.⁴²⁶

⁴²⁶ [MBRRACE-UK Maternal Report Dec 2020 v10 ONLINE VERSION 1404.pdf \(ox.ac.uk\)](https://www.ox.ac.uk/mbrrace-uk/maternal-report-dec-2020-v10-online-version-1404.pdf)

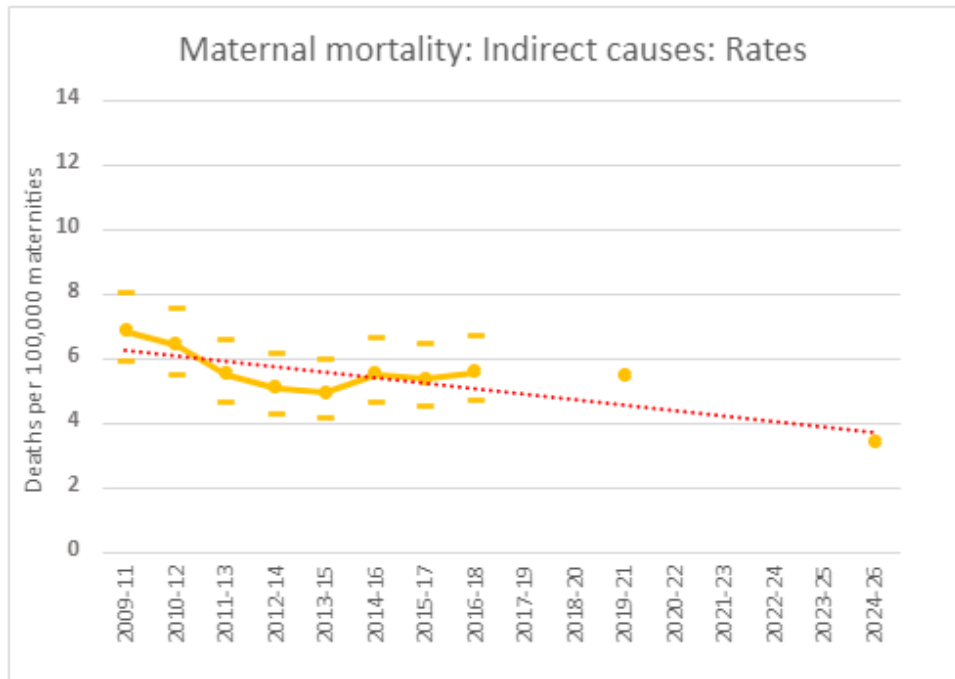


Figure 16. Annual rate of maternal deaths due to indirect causes per 100,000 maternities. Due to the low numbers of deaths per year data is represented triennially. The data indicates maternal deaths due to indirect causes, such as existing disease or disease acquired during pregnancy rather than direct obstetric causes; bars indicate confident intervals for each data point; the red dashed lines indicate projected trends. Given the wide confidence intervals on historic data, the projected trend is unlikely to show any statistically significant change by 2024/26. The points at 2019-2021 and 2024-2026 indicate the target rates of maternal deaths. Source: the MBRRACE-UK Maternal Report Dec 2020 v10.⁴²⁷

Pre-term births:

The ONS data provided by the Department show that the target for reduction in pre-term births is not on track to be met.⁴²⁸

This commitment, which was added to the existing ambition in 2017, aimed to reduce the pre-term rate by 25% from a baseline of 8% in 2015 to 6% in 2025. The data indicates that the pre-term birth rate reduced to 7.9% in 2019. This represents a 1.25% decrease from the 2010 pre-term birth rate of 8% used as a baseline for the target.⁴²⁹ If the 2015-2019 rate of decrease were to continue, we would expect a pre-term birth rate of 7.75% by 2025. This would result in the target to reduced pre-term birth rates to 6% being missed. The Department have stated that evidence-based initiatives to reduce pre-term births are currently being implemented, such as the establishment of pre-term birth clinics and the roll-out of the Continuity of Carer model of maternity care (see Chapter 2), suggesting they foresee greater reductions in pre-term birth rates in the coming years than the current rate of decrease would imply.⁴³⁰

⁴²⁷ [MBRRACE-UK Maternal Report Dec 2020 v10 ONLINE VERSION 1404.pdf \(ox.ac.uk\)](#)

⁴²⁸ Department of Health and Social Care ([EPE0026](#)), paras 14-15. Data sourced from the ONS.

⁴²⁹ *Ibid.*

⁴³⁰ *Ibid.*

The women's health research charity Wellbeing of Women suggest that the reduction from 2018 to 2019 may be an early sign of positive impact, resulting from the addition of this commitment to the National Ambition in 2017.⁴³¹ However, the charity acknowledges that, due to the later date that this commitment was established, there may not have been sufficient time for the resulting initiatives, such as the addition of pre-term birth prevention to Saving Babies Lives Care Bundle version 2 (published March 2019) to have had an effect. It is too soon to determine whether the slight trend towards reduced pre-term birth rates can be attributed to the commitment.

4) To what extent (if at all) has the NHS's Covid-19 response affected progress in achieving the targets?

The Department state that due to the COVID-19 response some improvement initiatives were suspended during the pandemic and that timescales have been revised.⁴³² It is not clear in the Department's written response on how numerical outcomes for the year 2020 were affected by COVID.

Many written submissions confirm that COVID is likely to have had an impact on achievement towards the targets of Maternity Safety.⁴³³ For example, the Care Quality Commission (CQC) paused inspections⁴³⁴ and many maternity services cancelled antenatal appointments⁴³⁵ and smoking cessation interventions.⁴³⁶ The charity Birth Trauma Association, which supports women who have experienced traumatic birth, report increased contact with their organisation. This increase suggests that the birth experiences of service users have been negatively impacted by COVID-19.⁴³⁷

The disruption to service caused by the COVID-19 pandemic will hinder progress on this commitment. However, it is currently difficult to assess the extent of these disruptions as the full impact of the pandemic on maternity safety outcomes is only beginning to emerge.⁴³⁸

A recent study reported that contracting COVID-19 during pregnancy led to increased rates of stillbirth and pre-term birth,⁴³⁹ which may impact the progress against these two targets in the data for 2020 and 2021. Moreover, in their joint written submission, the RCM and RCOG note that there were 19 maternal deaths between March 2020 and May 2020 and postulate that service disruption and delays in treatments may have been a contributing factor to this spike in maternal deaths.⁴⁴⁰ COVID-19 has also highlighted health inequalities for people from

⁴³¹ Wellbeing of Women ([EPE0017](#))

⁴³² Department of Health and Social Care ([EPE0026](#)), paras 26-27

⁴³³ British Maternal & Fetal Medicine Society ([EPE0006](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); Sands ([EPE0012](#)); Birth Trauma Association ([EPE0013](#)); Wellbeing of Women ([EPE0017](#)); Bliss ([EPE0020](#))

⁴³⁴ Care Quality Commission (CQC) ([EPE0011](#))

⁴³⁵ Sands ([EPE0012](#))

⁴³⁶ Bliss ([EPE0020](#))

⁴³⁷ Birth Trauma Association ([EPE0013](#))

⁴³⁸ Wellbeing of Women ([EPE0017](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Bliss ([EPE0020](#))

⁴³⁹ Gurol-Urganci, Ipek; Jardine, Jennifer E; Carroll, Fran; Draycott, Tim; Dunn, George; Fremeaux, Alissa; Harris, Tina; Hawdon, Jane; Morris, Edward; Muller, Patrick; Waite, Lara; Webster, Kirstin; VAN DER Meulen, Jan; Khalil, Asma; (2021) Maternal and perinatal outcomes of pregnant women with SARS-CoV-2 infection at the time of birth in England: national cohort study. American journal of obstetrics and gynecology. ISSN 0002-9378 DOI: <https://doi.org/10.1016/j.ajog.2021.05.016> (In Press)

⁴⁴⁰ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

minority ethnic backgrounds and this is predicted to be reflected in the 2020 outcome data for the maternity sector as well.⁴⁴¹

⁴⁴¹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

B: Was the commitment effectively funded or resourced?

Sub-questions:

1) Were specific funding and/or resourcing arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and how were they made? If extra funding or resourcing was provided, did it go to directly to maternity units or elsewhere, for example, to NHS Trusts?

The Department states that it has provided a range of funds to improve maternity safety.⁴⁴²This information has been included in Chapter 1.

It is not clear how the listed funding arrangements will directly support achieving the targets contained in the commitment to maternity safety. As a result, it is difficult to assess whether budgets are appropriate from the current information. The Department has provided some examples of allocation of funds to Trusts, some cases where funds were allocated directly to maternity units or LMSs, while others remain unclear.⁴⁴³ For example, in its follow up correspondence, the Department notes that the £90.05m was provided directly to LMSs.⁴⁴⁴ It notes that these funds were given with a set of objectives but not ringfenced to deliver specific initiatives, giving LMS the autonomy to meet local needs.

Regarding the £8.1 million provided to fund new Maternity Safety Training, the written submission from the charity Baby Lifeline describes clear and concerning misuse of this fund, with 50% of the money not being used for its intended purpose.⁴⁴⁵

2) If funding and/or resourcing was provided, was this taken from a "new" resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this?

It is not clear from the Department's written response if this funding is new or reallocated from pre-existing resources.⁴⁴⁶ However, following a request from the Panel for this information, the Department state in follow-up correspondence that the above funds are distinct from each other and not reallocations of pre-existing resource.⁴⁴⁷

3) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment?

⁴⁴² Department of Health and Social Care ([EPE0026](#)), para 28; [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁴⁴³ Department of Health and Social Care ([EPE0026](#)), para 28

⁴⁴⁴ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁴⁴⁵ Baby Lifeline ([EPE0021](#))

⁴⁴⁶ Department of Health and Social Care ([EPE0026](#)), para 28

⁴⁴⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

The Department do not provide information on factors that were considered nor on the evidence used to determine the level of funding or resources.⁴⁴⁸ However, following a request from the Panel for this information, the Department state in follow-up correspondence that:

*"Funding is not allocated on a commitment-by-commitment basis" and that "it is not possible to set out how all funding arrangements were assessed and determined before being allocated for each commitment individually."*⁴⁴⁹

4) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining such arrangements?

The Department signpost 'Safer Maternity - Next steps towards the national maternity ambition (2016)⁴⁵⁰, and 'Safer Maternity Care - Progress and Next Steps (2017)⁴⁵¹ in setting out the strategy and funding.⁴⁵² In its written response and follow up correspondence, the Department provide further detail on who arranged provision of certain funds, such as the £8.1m maternity safety training fund and the SBLCBv2 training fund arranged by Health Education England (HEE).⁴⁵³ However, information is not available on who was responsible for arrangements for all funds listed.

5) Do healthcare stakeholders view the funding and/or resourcing as sufficient?

Most stakeholders that submitted written evidence do not consider the funding or resourcing sufficient to achieve this commitment.⁴⁵⁴ These submissions stated that areas requiring additional funds include funds for increasing staff and resources; training of regional medical examiners and coroners; further financial incentives to implement change; specific funds to tackle brain injury; funding for Perinatal Mortality Review Tool reviews; and pre-term birth prevention training and widened implementation.

During roundtable events we held with clinicians, several participants raised the point that insufficient funds to increase staffing levels in the maternity service has a direct negative impact on training capacity and service safety, as discussed in the main body of the report.⁴⁵⁵

⁴⁴⁸ Department of Health and Social Care ([EPE0026](#))

⁴⁴⁹ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

⁴⁵⁰ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

⁴⁵¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

⁴⁵² Department of Health and Social Care ([EPE0026](#)), para 28

⁴⁵³ Department of Health and Social Care ([EPE0026](#)), para 28; [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁴⁵⁴ Baroness Cumberlege and SirCyril Chantler ([EPE0001](#)); The Royal College of Pathologists ([EPE0004](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Wellbeing of Women ([EPE0017](#)); Baby Lifeline ([EPE0021](#)); British Association of Perinatal Medicine (BAPM) ([EPE0022](#))

⁴⁵⁵ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#)); Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

Section C: Did the commitment achieve a positive impact for women?

Sub-questions:

1) What was the direct and indirect impact of the commitment on different groups (including women from Black, Asian and minority ethnic backgrounds; disabled women; and women from lower socio-economic backgrounds)? Were there equitable outcomes for different groups?

This information is included in the main body of the report in Chapter 5.

A letter from Nadine Dorries on 15 April 2021 acknowledges the disparities in outcomes for service users from ethnic and socio-economically deprived backgrounds, and states that the Department launched a new £7.6million Health and Wellbeing Fund. However, the date that this fund was launched is not stated in the letter and the Fund is not mentioned in the Department's written response.⁴⁵⁶

The Department's initial written response gave only nationwide data of progress against the targets contained with this commitment to maternity safety, with no sub-group analysis. In further correspondence, the Department provided data broken down by ethnicity and socio-economic deprivation for stillbirths, neonatal deaths, and maternal deaths. Information on outcomes for disabled women and data broken down by background for brain injuries and pre-term births has not been made available.⁴⁵⁷

A further limitation of the data provided by the Department in its initial written response is the lack of breakdown by Trust to allow the full range of safety outcomes relating to Maternity Safety to be assessed rather than national rates. The Better Births report states that national averages can mask regional variation in metrics such as stillbirths and neonatal deaths.⁴⁵⁸ Dr Bill Kirkup further corroborates the importance of monitoring the safety outcomes at individual Trusts, as national averages that can lead to underperforming Trusts being overlooked.⁴⁵⁹

2) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

It is unclear if improvements seen in stillbirths and neonatal deaths are attributable to the commitment or reflect a continuation in an existing trend towards reduced stillbirth rates. During discussions at the meeting on 29 April 2021, NHSE/I and Department officials suggested that attributing improvements to specific interventions would not be possible.⁴⁶⁰

⁴⁵⁶ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Cheryl Mackrory MP, regarding baby loss prevention and data reporting \[15 April 2021\]](#); Department of Health and Social Care (EPE0026)

⁴⁵⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#); and [Annex A \[7 June 2021\]](#)

⁴⁵⁸ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#) pages 21-28

⁴⁵⁹ Dr Bill Kirkup ([EPE0005](#))

⁴⁶⁰ An informal meeting was held between members of the Expert Panel and officials from the Department of Health and Social Care and NHSE/I regarding Government commitments in the area of maternity services [29 April 2021]

3) Has (or will) there been (or be) a meaningful improvement in process measures reasonably attributable to the policy?

The Department explain multiple changes in process measures such as the PIER framework (prevention, identification, escalation and response), the implementation of local maternity systems (LSMs), refreshing MatNeoSIP⁴⁶¹, and Implementing Maternal Medicine Networks and Maternity outreach clinics⁴⁶² but no roll-out dates are provided. Therefore, it is not clear if these changes in process measures are due to the commitment, nor is their implementation is responsible for the progress seen on stillbirth and neonatal death rates.

Further changes in process measures reported by the Department include:

- the establishment of the Maternity Transformation Programme Board in 2016 which determines a consistent set of expectations for all LMSs on safer and more personalised care;
- the implementation of NHS Resolution Early Notification scheme, which requires Clinical Negligence Scheme for Trusts members to notify NHSR of maternity incidents that have the potential to become high value claims. The EN scheme helps improve the experience for the family and affected staff, share learning rapidly with the individual trust and wider system, and improve the process for obtaining compensation for families, meeting needs in real time where possible.
- the introduction of the Maternity Incentive Scheme in Jan 2018, which incentivises the delivery of safer maternity care through the achievement of ten safety actions.⁴⁶³

There is little detail on whether these changes to processes contribute to the outcomes, nor if they can be attributed to Maternity Safety.

Several written submissions have also corroborated the process measures described in the Department's written response. Submissions also identify additional changes to process measures, such as the implementation of national guidance from the Saving babies lives care bundles version 1 and 2, Each Baby Counts programme, and the Nursing and Midwifery Council Future Midwives Standards. Written submissions also commend the establishment tools and processes to investigate safety incidents in maternity services, such as introducing the Healthcare Safety Investigation Branch's Maternity Investigation Team and developing the Perinatal Mortality Review Tool.⁴⁶⁴

The Department's written response does not describe any changes in process measures aimed at reducing the disparity of risk to women from minority backgrounds in its written response.⁴⁶⁵ However, the joint submission from the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives mentions specific initiatives to target racial inequalities.⁴⁶⁶

⁴⁶¹ Department of Health and Social Care ([EPE0026](#)), para 2

⁴⁶² Department of Health and Social Care ([EPE0026](#)), para 25

⁴⁶³ Department of Health and Social Care ([EPE0026](#)), para 41

⁴⁶⁴ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); Birth Trauma Association ([EPE0013](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); Wellbeing of Women ([EPE0017](#)); Birthrights ([EPE0019](#)); Bliss ([EPE0020](#))

⁴⁶⁵ Department of Health and Social Care ([EPE0026](#))

⁴⁶⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

4) Have service users been hindered by the commitment and its implementation? If so, how as this been monitored and evaluated?

The only concern raised in the written submissions from the charities National Childbirth Trust (NCT) and Association for Improvements in the Maternity Services (AIMS) is that an unintended consequence of this commitment is an increase in interventions and induction rates that could result in poorer birthing experiences for women.⁴⁶⁷ However, this concern was not borne out in the SPiRE analysis of SBLCB.⁴⁶⁸

5) By focusing on the target(s) contained in the commitment, have other aspects of care been reprioritised or removed?

A concern raised in the written submissions is that that Continuity of Carer (CoC) is being viewed as the 'fix all' for the disparity in outcomes for minority groups, which are discussed in Chapter 5.⁴⁶⁹ While there is strong evidence that CoC is likely to be central to improving the outcomes and experiences of women from minority ethnic backgrounds,⁴⁷⁰ this approach needs to be supplemented with additional targeted initiatives to address examples of structural racism and ensure the concerns of women from minority ethnic backgrounds are heard and addressed.⁴⁷¹

⁴⁶⁷ NCT (National Childbirth Trust) ([EPE0014](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁴⁶⁸ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0250150>

⁴⁶⁹ British Maternal & Fetal Medicine Society ([EPE0006](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Donna Ockenden ([EPE0025](#))

⁴⁷⁰ https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

⁴⁷¹ Birth Trauma Association ([EPE0013](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Birthrights ([EPE0019](#)); Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

Section D: Was it an appropriate commitment?

Sub-questions:

1) Was (or is) the commitment likely to achieve meaningful improvement for service users, maternity staff and/or the maternity services as a whole?

Meeting the Maternity Safety commitment would achieve meaningful improvements for women and babies, as the Department state that UK was underperforming on various safety measures by international standards, prior to this commitment being set.⁴⁷²

However, as described previously in the main report, clinicians at our roundtable events raised concerns over the burden that this commitment placed on maternity staff.

2) Is the commitment wide enough in scope? Is the commitment specific enough?

It is not clear whether the various targets contained within commitment 1 are wide enough in scope. The targets set are sufficiently specific with fixed numerical goals and deadlines.⁴⁷³

Several written submissions raised various ways in which the scope of this commitment could have been improved, such as:

- monitoring other safety metrics, for example induction rates or maternal morbidity;⁴⁷⁴
- expanding the jurisdiction of medical examiners to include stillbirths;⁴⁷⁵
- monitoring and addressing the systematic failures in poorly performing services to reduce variation across Trusts;⁴⁷⁶
- delineating between unavoidable and avoidable deaths;⁴⁷⁷
- a greater focus on tackling the indirect factors causing maternal deaths;⁴⁷⁸
- a lack of target on reducing preventable miscarriage;⁴⁷⁹
- and a lack of a specific target to reduce the disparity of outcomes for disadvantaged women.⁴⁸⁰

The limitation of the Department not including a specific target on reducing the disparity in outcomes amongst minority ethnic and socio-economically deprived service users has been discussed in Chapter 5. The other potential expansions in the scope of commitment 1 that we believe warrant further discussion are described in further detail in Chapter 1.

3) Has the commitment had any unintended consequences (either positive or negative)?

The charities the National Childbirth Trust and the Association for Improvements in the Maternity Services both raise concerns that an unintended negative consequence of this commitment includes an increase in interventions and induction rates that could result in

⁴⁷² Department of Health and Social Care ([EPE0026](#)), para 61

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

⁴⁷³ Department of Health and Social Care ([EPE0026](#)), para 1

⁴⁷⁴ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); Birth Trauma Association ([EPE0013](#))

⁴⁷⁵ The Royal College of Pathologists ([EPE0004](#)); Dr Bill Kirkup ([EPE0005](#))

⁴⁷⁶ Dr Bill Kirkup ([EPE0005](#))

⁴⁷⁷ Dr Bill Kirkup ([EPE0005](#)); Campaign for Safer Births ([EPE0009](#))

⁴⁷⁸ Obstetric Anaesthetists' Association ([EPE0008](#)); NCT (National Childbirth Trust) ([EPE0014](#))

⁴⁷⁹ Sands ([EPE0012](#))

⁴⁸⁰ Sands ([EPE0012](#)); Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

poorer birthing experiences for women.⁴⁸¹ However, as stated previously, this was not borne out in the SPIRE analysis of SBLCB.⁴⁸²

Wellbeing of Women report that a positive unintended consequence of establishing pre-term birth clinics to reduce pre-term birth rates is that increased contact with clinicians allows women to raise and have their concerns addressed. This has led to a positive psychological impact beyond their treatment to reduce their risk of pre-term birth.⁴⁸³

Written submissions indicate that caesarean rates are likely to increase as a result of the commitment. However, there are disagreements in the written submissions as to whether this is a positive or a negative consequence. Whether caesarean rates are a useful metric of Trust performance is also contentious, as many Trusts aim to reduce caesareans rates and yet they are highly influenced by case mix and maternal choice.⁴⁸⁴

4) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment's appropriateness been reviewed since its creation?

This information is included in the main report in Chapter 1.

⁴⁸¹ NCT (National Childbirth Trust) ([EPE0014](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁴⁸² <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0250150>

⁴⁸³ Wellbeing of Women ([EPE0017](#))

⁴⁸⁴ Birth Trauma Association ([EPE0013](#)); Caesarean Birth ([EPE0023](#))

Annex B: Continuity of Carer

This section contains additional information based on the sub-questions from the planning grid.

A: Was the commitment met overall? Or is the commitment on track to be met?

Sub-questions:

1) Were continuity of carer commitments met in 2019 and 2021? If not, why?

This information is included in the main report in Chapter 2.

2) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met? How significant are these? Was appropriate action taken to account for any mitigating factors?

The Department cite staff shortages, sickness, redeployment, and self-isolation as major limiting factors hindering CoC roll-out during COVID-19 pandemic restrictions.⁴⁸⁵ We asked the Department for information on what action was taken to account for any mitigating factors. However, we have not received information relating to actions taken, or intended to be taken, to account for these limiting factors.⁴⁸⁶

Both the written submission from Donna Ockenden and the joint submission from RCM/RCOG corroborate the Department's statement that short staffing has been a major mitigating factor leading to lack of progress on the commitment to provide CoC.⁴⁸⁷ However, RCOG/RCM also cite delays in funding, implementation guidance, lack of adequate progress data collection and difficulty in recruiting staff into continuity teams as other mitigating factors.⁴⁸⁸ Baroness Cumberlege and Sir Cyril Chantler, authors of Better Births, also indicate staff shortages hindered progress, as well as variable success in changing work-place processes.⁴⁸⁹ In addition to these limitations, the charity Birthrights points out that Trusts had different starting points and staffing challenges from the outset, with some Trusts starting with no established infrastructure while other Trusts have been running CoC maternity teams for years.⁴⁹⁰

These mitigating factors raised by stakeholders represent significant barriers to CoC implementation that were not adequately appreciated and accounted for by the Department when funding and resourcing this commitment.

⁴⁸⁵ Department of Health and Social Care ([EPE0026](#)), para 66

⁴⁸⁶ [Letter from Rt Hon Jeremy Hunt, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Committee's Expert Panel, to Rt Hon Matt Hancock MP, Secretary of State, regarding Government commitments in the area of maternity services \[16 March 2021\]](#); Department of Health and Social Care ([EPE0026](#))

⁴⁸⁷ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

⁴⁸⁸ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁴⁸⁹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁴⁹⁰ Birthrights ([EPE0019](#))

3) What guidance was provided to support NHS staff in implementing the commitment?

The Department list national and local guidance on implementing Continuity of Carer spanning 2017-2020.⁴⁹¹ However, they do not provide any further information on reach, dissemination and target dates for roll-out. The Department states that a phased roll-out of Continuity of Carer was implemented but does not provide further detail on justification for a phased roll-out nor associated timeframes of phases.⁴⁹² Therefore, a question regarding the roll-out of CoC was put to the Department in writing on 17 May 2021, (Q8 and 16). In follow up correspondence the Department stated that:

"In December 2016, seven Early Adopter sites were selected and funded to implement Local Maternity System objectives faster. Of these, six developed and tested models of continuity of carer.

In March 2017, Implementing Better Births: A Resource Pack for Local Maternity Systems first set out the ask for all Local Maternity Systems to ensure that most women receive continuity of carer by March 2021. More detailed guidance on implementing continuity of carer was published in December 2017.

*NHS Planning Guidance for 2018/19 set out the first interim universal deliverable, for Local Maternity Systems to place 20% of women in a continuity of carer pathway by March 2019."*⁴⁹³

The Department also stated that:

*"The level of implementation has been phased to allow Local Maternity Systems flexibility to develop models –in line with national standards and principles of best practice –that meet local opportunities, needs and challenges." and "phased implementation has given maternity services opportunity to test continuity of carer on a smaller scale and assess benefits to clinical outcomes, experience for women, and staff experience. It has also provided an important opportunity for midwives to familiarise themselves with continuity of carer teams operating in their trusts."*⁴⁹⁴

In its written submission, Birthrights suggested that guidance was deliberately flexible when issued in 2017 to account for the differing starting points and staffing challenges across Trusts.⁴⁹⁵ The need for flexibility is reinforced by the comment from a roundtable participant that:

*"...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."*⁴⁹⁶

This reported lack of guidance on implementation of CoC communicated to both clinicians and Trust executives is corroborated by the written submission from Donna Ockenden. Donna

⁴⁹¹ Department of Health and Social Care ([EPE0026](#)), para 72

⁴⁹² Department of Health and Social Care ([EPE0026](#)), para 4

⁴⁹³ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

⁴⁹⁴ *Ibid.*

⁴⁹⁵ Birthrights ([EPE0019](#))

⁴⁹⁶ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

Ockenden's written submission states that lack of centralised guidance led to competing and confusing messages from Trust boards and regional CoC leads, particularly surrounding the costs of transitioning to a CoC model of care.⁴⁹⁷

Initial lack of implementation guidance at the outset of the commitment led to confusion and variable interpretations and implementation of CoC across England. The resulting national variation in CoC provision has hindered progress on this commitment.

4) Does the submitted count include those placed on a continuity of carer pathway or in receipt of continuity of care? If not, what is the rate of achievement based on the full commitment?

The commitment sets targets for women to 'receive' CoC. However, the Department's response reports on NHS Trusts' capacity to roll-out this model of care; not on the number of women who currently access the model.⁴⁹⁸ Therefore, with survey data on the number of women receiving CoC only expected to be obtained in 'summer' 2021,⁴⁹⁹ the relevant data to show progress against this commitment is not available. The Department cite their intention to record the number of women in receipt of CoC routinely through MSDSv2 but acknowledge that NHS Trusts' capacity to evidence continuity of care is an issue.⁵⁰⁰ The charities SANDS and AIMS also highlight the confusion caused by the collection of data on capacity to provide, rather than receipt.⁵⁰¹ No further data or explanation was provided in the Department's response on how to improve data collection on continuity of carer.

We understand that the MSDSv2 only records monthly placement as a "yes" or "no". The tool does not record the number of women in receipt of CoC as a percentage. Therefore, it is not possible to track increased receipt of CoC nor monitor the effects of the pandemic on receipt. In addition, not all Trusts are compliant with this data collection requirement thus even when MSDSv2 is fully operational, comprehensive data on CoC receipt will still be lacking.

There has been a lack of progress on establishing appropriate systems to collect relevant data on CoC receipt, which would allow accurate assessment of progress against this target and support roll-out of this model of care.

5) Does the commitment have a clear and fixed deadline for implementation? Has the numerical target contained in the commitment been achieved or is it on track to be achieved?

This Commitment has a clear and fixed deadline for implementation. However, the phrasing of the commitment is vague using terms such as 'majority' and 'similar percentage' which reduces clarity and introduces ambiguity. The initial ambition aims for a 'majority' of women to be in receipt of continuity of care by 2021, while the Department's states the "NHSE/I remains committed to delivering continuity of carer to most women, so that it becomes the default model of care for women in maternity services across England by March 2023".⁵⁰² The Department also refer to an "ambition for 35% of women to be placed on Continuity of Carer pathways by March 2021", without clarifying when the time scales were revised and 35% was announced as a new intermediate target for 2021.⁵⁰³ The charity SANDS signposted the Safer

⁴⁹⁷ Donna Ockenden ([EPE0025](#))

⁴⁹⁸ Department of Health and Social Care ([EPE0026](#)), para 67

⁴⁹⁹ Department of Health and Social Care ([EPE0026](#)), para 68

⁵⁰⁰ Department of Health and Social Care ([EPE0026](#)), para 74

⁵⁰¹ Sands ([EPE0012](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁵⁰² Department of Health and Social Care ([EPE0026](#)), para 65

⁵⁰³ Department of Health and Social Care ([EPE0026](#)), para 69

Maternity Care Progress Report 2021⁵⁰⁴, which notes that targets have been delayed by a year. However, SANDs report that that the actual targets contained within this report suggest that delivery has been delayed by more than a year.⁵⁰⁵

It is unclear whether data eventually collected on numbers of service users in receipt of CoC will demonstrate that necessary progress against this commitment has been made. The Department is currently only reporting on NHS Trust's capacity to provide rather than actual provision.⁵⁰⁶ Regardless, it is clear that the percentage targets in the commitment are not on track to be achieved (see Chapter 2).

6) What is meant by "similar percentage of women"? How has this been defined? Has this or will this be achieved by 2024?

The Department has not clarified the definition of "similar percentage of women", nor does it provide adequate data to show achievement on their commitment to provide CoC to 75% of women from BAME and socio-economically deprived backgrounds by 2024.⁵⁰⁷ The Department do provide information on the percentage of existing CoC teams in areas of deprivation (~60%) or areas with high proportions of black, Asian and mixed ethnicity women (~50%).⁵⁰⁸ However, this data does not give any indication of CoC provision or uptake by women of these backgrounds within these areas. It is unclear from the Department's response how women from "from BAME communities" and "most deprived groups" will be identified and accounted for in the MSDSv2 dataset, once fully established.

7) Does data show achievement against the target (where applicable)?

This information is included in Chapter 2 of the main report.

8) To what extent has the NHS's response to Covid19 affected progress on policy goals/targets?

The Department state that many Trusts have paused implementation of CoC teams and suspended existing provision due to staff shortages.⁵⁰⁹ The Department has not elaborated on the factors underlying the decision to postpone roll-out, nor established whether an impact assessment was carried out of the effect of this suspension.

During the meeting 29 April 2021, NHSE/I officials stated that feedback from front line staff highlighted difficulty in implementing the assessment of CoC receipt in 2020 due to the pandemic. NHSE/I instead asked Trusts for information on 'building blocks' for CoC provision that had been put in place (e.g., undertaking a BirthRate Plus assessment, sufficient numbers of midwives), and to put an emphasis on increasing the number of and women from minority ethnic and low socio-economic backgrounds receiving CoC.⁵¹⁰

⁵⁰⁴ <https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-9.4-safer-maternity-care-progress-report-2021-amended.pdf>

⁵⁰⁵ Sands ([EPE0012](#))

⁵⁰⁶ Department of Health and Social Care ([EPE0026](#)), para 67

⁵⁰⁷ Department of Health and Social Care ([EPE0026](#)), para 65

⁵⁰⁸ Department of Health and Social Care ([EPE0026](#)), para 67

⁵⁰⁹ Department of Health and Social Care ([EPE0026](#)), para 66

⁵¹⁰ An informal meeting was held between members of the Expert Panel and officials from the Department of Health and Social Care and NHSE/I regarding Government commitments in the area of maternity services [29 April 2021]

Written submissions from Baroness Cumberlege and Sir Cyril Chantler, British Maternal and Fetal Medicine society, RCM/RCOG, SANDs, Association for Improvements in the Maternity Services (AIMS), Birthrights and Donna Ockenden all acknowledge that COVID-19 will have delayed implementation of CoC.⁵¹¹ In a joint submission, the RCM/RCOG highlight that the physical and mental toll the pandemic has placed on staff, stating that the resulting depletion of staffing numbers will have impacted provision of CoC.⁵¹²

The charity AIMS suggests the impact of COVID-19 will vary between regions,⁵¹³ while Birthrights reports that Trusts with a more advanced implementation of CoC when the pandemic began suffered less of an impact on services during the pandemic.⁵¹⁴

The COVID-19 pandemic has inevitably slowed progress on this commitment. However, it is not the main reason that the target has been missed and should not prevent the urgent resumption of implementation of CoC across the country.

⁵¹¹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); Birthrights ([EPE0019](#)); Donna Ockenden ([EPE0025](#))

⁵¹² Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁵¹³ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁵¹⁴ Birthrights ([EPE0019](#))

B. Was the commitment effectively funded (or resourced)?

Sub-questions:

1) Were specific funding and/or resourcing arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and how were they made? If extra funding or resourcing was provided, did it go directly to maternity units or elsewhere, for example, to NHS Trusts?

This information is included in Chapter 2 of the main report.

2) If funding and/or resourcing was provided, was this taken from a "new" resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this?

It is not clear if the Health Education England (HEE) fund or the £90.05 NHSE/I package represents new or reallocated funds. The Service Development Fund (SDF) money is described by the Department as for "this and the fulfilment of other objectives as part of the MTP (Maternity Transformation Programme)" suggesting the funds for transitioning to CoC may come at the expense of funding other aspects of the MTP, but no further details are given.⁵¹⁵

In follow-up correspondence on 7 June 2021, the Department state that all the funds described which includes the HEE fund and the £90.05 NHSE/I package are taken from new resource streams.⁵¹⁶

3) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment? Did the system have relevant support to deliver the change set out in the commitment?

The Department's written response lacks detail in the factors considered when determining funding and resources for CoC. The Department has stated that it has modelled the CoC system not to be more expensive once implemented.⁵¹⁷ The Department explain that this has been confirmed by some NHS Trusts following of implementation CoC.⁵¹⁸

The Department recognised transitional costs in changing the default care model, and therefore provided funds, such as the SDF and HEE mentioned previously. However, it does not clarify the expected costs of this transition in its response.⁵¹⁹

The Department state the Maternity and Women's Health Policy Team at NHSE/I were responsible for determining the amount of funding allocated to each LMS, based on weighted populations.⁵²⁰ The evidential basis for HEE funding allocations is not described in the Department's written response. Following a request from the Panel for this information, the Department state in follow-up correspondence that:

⁵¹⁵ Department of Health and Social Care ([EPE0026](#)), para 76

⁵¹⁶ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁵¹⁷ Department of Health and Social Care ([EPE0026](#)), para 76

⁵¹⁸ *Ibid.*

⁵¹⁹ *Ibid.*

⁵²⁰ Department of Health and Social Care ([EPE0026](#)), para 77

*“Funding is not allocated on a commitment-by-commitment basis” and that “it is not possible to set out how all funding arrangements were assessed and determined before being allocated for each commitment individually.”*⁵²¹

Several written submissions⁵²² and discussions with clinicians at the roundtable events⁵²³ suggest that there are existing understaffing issues and embedded working styles within the maternity system. These barriers meant that greater support was needed to deliver the organisational changes required to achieve this commitment than was originally appreciated.

4) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining such arrangements?

The Department’s written response explains that both HEE and NHSE/I were involved in determining funding.⁵²⁴ NHSE/I was involved in determining the size of the SDF within the £90.05 package and determining allocation to LMSs through its Maternity and Women’s Health Policy Team.⁵²⁵ However, detail on who was ultimately responsible in calculating the size of the HEE fund or the proportion of the SDF needed and the amount eventually allocated for delivering the CoC commitment is not clear.

5) Do healthcare stakeholders view the funding and/or resourcing as sufficient?

Written submissions from Baroness Cumberlege and Sir Cyril Chantler, British Maternal and Fetal Medicine society, Campaign for safer births, RCM/RCOG, SANDs, and Donna Ockenden all emphasise that ringfenced funding is required to support adequate staffing and training of CoC teams.⁵²⁶

Several written submissions, including Donna Ockenden and RCM/RCOG, also suggest that the funding arrangements for the implementation of CoC were insufficient. Moreover, the charity National Maternity Voices states that further resources are needed to ensure CoC reaches and is taken up by marginalised women.⁵²⁷

This suggests that inadequate funding and resources contributed to the underestimated challenges of reorganising staff structures and processes to accommodate CoC.

⁵²¹ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

⁵²² British Maternal & Fetal Medicine Society ([EPE0006](#)); NHS Providers ([EPE0007](#)); Campaign for Safer Births ([EPE0009](#)); Birthrights ([EPE0019](#)); Donna Ockenden ([EPE0025](#))

⁵²³ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#)); Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

⁵²⁴ Department of Health and Social Care ([EPE0026](#)), paras 76-77

⁵²⁵ *Ibid.*

⁵²⁶ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Donna Ockenden ([EPE0025](#))

⁵²⁷ National Maternity Voices ([EPE0018](#))

C. Did the commitment achieve a positive impact for service users?

Sub-questions:

1) What was the direct and indirect impact of the commitment on different groups (including women from Black, Asian and minority ethnic backgrounds; disabled women; and women from lower socio-economic backgrounds)? Were there equitable outcomes for different groups?

The Department cite evidence that the Continuity of Carer model “has also been shown to improve outcomes for women from ethnic minorities and those living in deprived areas (Rayment-Jones et al 2015; Homer et al 2017)⁵²⁸”, but do not provide evidence of this improvement in relation to specific interventions or outcomes resulting from the commitment itself.⁵²⁹

Data are not currently available to assess CoC placement or receipt by minority ethnic or socio-economically deprived backgrounds, and therefore it is not possible to assess whether outcomes are equitable across groups. Several written submissions commented on the impact of the CoC pathway on women from black and ethnic minority, or economically disadvantaged backgrounds.⁵³⁰ The joint submission from Baroness Cumberlege and Sir Cyril Chantler described roll-out as “urgent” for these groups of women,⁵³¹ while submissions from Campaign for Safer Births, RCM/RCOG, the Nursing and Midwifery Council, AIMS, and National Voices agreed that the model is likely to reduce persistent health inequalities for marginalised women.⁵³² The Nursing and Midwifery Council described improvements associated with CoC as significant, explaining that:

“Continuity of carer can significantly improve outcomes for black and ethnic minority women as well as for those living in deprived areas.”⁵³³

However, written submissions from Donna Ockenden and The Birth Trauma Association cautioned against the temptation to view the model as a “panacea”⁵³⁴, advising that Continuity

⁵²⁸ H. Rayment-Jones, T. Murrells, J. Sandall. An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data—a retrospective, observational study. *Midwifery*, 31 (4) (2015), pp. 409-417

C.S. Homer, N. Leap, N. Edwards, J. Sandall. Midwifery continuity of carer in an area of high socio-economic disadvantage in London: a retrospective analysis of albanian midwifery practice outcomes using routine data (1997–2009). *Midwifery*, 48 (2017), pp. 1-10.

⁵²⁹ Department of Health and Social Care ([EPE0026](#)), para 83

⁵³⁰ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#)); British Maternal & Fetal Medicine Society ([EPE0006](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Sands ([EPE0012](#)); Birth Trauma Association ([EPE0013](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); National Maternity Voices ([EPE0018](#)); Birthrights ([EPE0019](#)); Caesarean Birth ([EPE0023](#)); Donna Ockenden ([EPE0025](#))

⁵³¹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁵³² Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); National Maternity Voices ([EPE0018](#))

⁵³³ Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#))

⁵³⁴ Birth Trauma Association ([EPE0013](#)); Donna Ockenden ([EPE0025](#))

of Carer needs to be embedded within wider structural change⁵³⁵ supported by cultural awareness, and anti-racism training.⁵³⁶ The Birth Trauma Association noted that persistent disparities in outcomes experienced by affluent black women suggest that reasons for ongoing health inequalities are more complex than socio-economic disadvantage.⁵³⁷ The National Childbirth Trust (NCT) state that for CoC to meet its aims to reduce health inequalities for marginalised groups, it needs to be part of a wider programme of change within maternity services. NCT have stated that:

*"We acknowledge the accelerated commitment to providing a continuity-of-carer model of practice for these and other women – and their babies - who are at greater risk of mortality and serious morbidity. However, this move is unlikely to be successful unless it is embedded in a wider culture change across the NHS and other statutory agencies, as well as within the voluntary and community sector where support to parents is offered."*⁵³⁸

The British Maternal and Medicine Fetal Society highlighted a need to develop specific strategies to support roll-out to women from minority ethnic backgrounds.⁵³⁹ While The Birth Trauma Association warned against treating women from minority ethnic backgrounds as a homogeneous group, recommending a more specific focus on the needs and challenges facing distinct ethnic groups.⁵⁴⁰

Submissions from RCM/RCOG and Caesarean Birth highlighted the lack of outcome data relating to identified groups of women as an important limitation of current CoC roll-out⁵⁴¹ while SANDS called for clarity relating to the 75% target for black and ethnic minority women.⁵⁴²

We agree that there is a justifiable focus on women from minority ethnic backgrounds following the MBRRACE-UK report showing that black women are four times more likely to die as a result of complications in their pregnancy than white women and that Asian women are twice as likely to die or suffer injury.⁵⁴³ However, there are currently no data available to assess the needs of other vulnerable service users such as women with disabilities, migrant women, or LGBT service users. There is a risk that the current focus on women from minority ethnic backgrounds may have the unintended consequence of obscuring inequitable outcomes for other groups. The focus of Continuity of Carer needs to be on personalised and safe care for all marginalised women.

A report from Hidden Voices of Maternity suggests that women with learning disabilities may benefit from CoC.⁵⁴⁴ The report states that some women with learning disabilities may avoid maternity care due to negative staff attitudes, lack of clear explanations of what is going on, or fear of the involvement of social services. Parents with learning disabilities highlighted that having a single trusted point of contact throughout their pregnancy would improve their

⁵³⁵ NCT (National Childbirth Trust) ([EPE0014](#)); Birthrights ([EPE0019](#))

⁵³⁶ Birthrights ([EPE0019](#))

⁵³⁷ Birth Trauma Association ([EPE0013](#))

⁵³⁸ NCT (National Childbirth Trust) ([EPE0014](#))

⁵³⁹ British Maternal & Fetal Medicine Society ([EPE0006](#))

⁵⁴⁰ Birth Trauma Association ([EPE0013](#))

⁵⁴¹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Caesarean Birth ([EPE0023](#))

⁵⁴² Sands ([EPE0012](#))

⁵⁴³ [MBRRACE-UK Maternal Report Dec 2020 v10 ONLINE VERSION 1404.pdf \(ox.ac.uk\)](#)

⁵⁴⁴ [Hidden-Voices-of-Maternity-Report-FINAL-260815-2.pdf \(patientexperiencenetwork.org\)](#)

experience and outcomes. PEN, a not-for-profit organisation, and CHANGE, a national human rights organisation, propose continuity as one of their key recommendations, as this model has been shown to work well with other vulnerable groups such as teenage mothers.⁵⁴⁵

There is evidence that some maternity units have responded quickly to meet the additional needs of women who do not speak English. For example, during our roundtable events, one midwife described the development of a specialist non-English speaking team. The midwife explained:

*"We've got a non-English speaking team at the one of our providers as part of the CoC 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."*⁵⁴⁶

2) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

Evidence provided in written submissions cast doubt on the claim that improved outcomes can necessarily be attributed to CoC.⁵⁴⁷ The submission from Donna Ockenden and her team raised a concern about the lack of data relating to how outcomes relate to particular aspects of the CoC pathway. Ockenden wrote:

*"It is unclear to the Maternity review team what components of CoC can be attributed to the improved outcomes found within the research."*⁵⁴⁸

Caesarean Birth and RCM/RCOG raised a similar concern, citing lack of data relating to outcomes following continuity pathway compared with more traditional modes of care.⁵⁴⁹

*"There is as yet little published data on whether there have been meaningful improvements in outcomes that can be reasonably attributable to the current policy commitment, in a real life rather than experimental research setting."*⁵⁵⁰

Evidence from the Cochrane reviews support the value of Continuity of Carer in improving outcomes but there is a paucity of data currently available to track outcomes.

3) Has (or will) there been (or be) a meaningful improvement in process measures (i.e., are women able to access the service; quality of feedback when things go wrong etc) reasonably attributable to the policy?

A written submission from SANDS, a stillbirth and neonatal death charity, describes the relational benefits of CoC, with midwives and women able to develop more positive, trusting relationships.⁵⁵¹ While this is likely to be particularly important for women with more complex

⁵⁴⁵ [Hidden-Voices-of-Maternity-Report-FINAL-260815-2.pdf \(patientexperiencenetwork.org\)](#), <https://www.bestbeginnings.org.uk/parents-with-learning-disabilities>

⁵⁴⁶ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

⁵⁴⁷ Caesarean Birth ([EPE0023](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

⁵⁴⁸ Donna Ockenden ([EPE0025](#))

⁵⁴⁹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Caesarean Birth ([EPE0023](#))

⁵⁵⁰ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁵⁵¹ Sands ([EPE0012](#))

needs, SANDS highlights that additional time is likely to be needed for midwives to establish mutual trust with these women.

However, Birthrights, a charity promoting human rights in pregnancy and childbirth, highlight significant variability between Trusts as a likely cause of inequitable experiences of CoC, with some women able to develop a relationship with one midwife, while others based in small continuity teams may not have the same opportunities to relate to a named midwife and instead may see up to six midwives throughout pregnancy.⁵⁵²

There were also concerns raised about the potential negative impact on midwifery staff and the wider profession, with senior leaders described as unwilling to acknowledge or respond appropriately to staff feedback about concerns about CoC. Donna Ockenden's written submission indicates that when senior midwives in Trusts across England have tried to escalate their concerns about CoC roll-out to the Regional Chief Midwives and LMS leads, they have been labelled as obstructive of the National Maternity vision, suggesting that staff may have been discouraged from raising concerns about CoC. In particular, the written submission explains:

*"When poorly implemented CoC has been raised as a safety concern by those responsible for leading maternity services, they have been described as being obstructive to change."*⁵⁵³

4) Have service users been hindered by the commitment and its implementation? If so, how as this been monitored and evaluated?

During roundtable events, clinicians raised concerns that the prioritisation of roll-out for minority ethnic and socio-economically disadvantaged women may reduce overall roll-out due to practical, geographical constraints. One midwife said:

*"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... 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."*⁵⁵⁴

Clinicians also reported that changing targets have meant redirecting services away from women who had previously been eligible for the pathway:

*"In a in a Trust where you had the case loading teams operating for 20 years' we are experiencing 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."*⁵⁵⁵

Written submissions from RCM/RCOG and Donna Ockenden raised concerns about the implementation of CoC and its impact on women receiving more traditional models of

⁵⁵² Birthrights ([EPE0019](#))

⁵⁵³ Donna Ockenden ([EPE0025](#))

⁵⁵⁴ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

⁵⁵⁵ *Ibid.*

maternity care.⁵⁵⁶ The submission from Donna Ockenden refers to a 'two-tiered'⁵⁵⁷ system with women on Continuity pathways prioritised even when women not receiving CoC are in greater clinical need. She wrote:

*"Many Trusts set up 'pilots' for CoC which excluded swathes of women, resulting in 2-tiered services: women in CoC teams and those receiving more traditional care. Those in CoC teams are prioritised on the Labour Ward meaning their midwife who may have been working elsewhere, is moved from the area she is working in to look after the woman in labour but she is not replaced, leaving the area she was working in short-staffed."*⁵⁵⁸

Both RCM/RCOG and Donna Ockenden recommend that safe staffing is an essential prerequisite for Continuity of Carer and that Trusts should not be pressured to roll-out the model at a pace that outstrips the capacity of units to manage the transition safely.⁵⁵⁹

The implementation of Continuity of Carer is an important and well-evidenced model of care. Successful implementation will rely on clear and flexible guidelines and funding to meet the needs of individual Trusts, and which support staff through the transition.

5) By focusing on the target(s) contained in the commitment, have other aspects of care been reprioritised or removed?

Donna Ockenden and The Birth Trauma Association raised concerns about the risk of Continuity of Carer being viewed as a "panacea" which may detract from work to effect more meaningful systemic changes within maternity services.⁵⁶⁰ The British Fetal and Maternal Medicine Society and The Birth Trauma Association commented that the focus on continuity of carer should be supplemented by an additional focus on competency and quality of care.⁵⁶¹

⁵⁵⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

⁵⁵⁷ Donna Ockenden ([EPE0025](#))

⁵⁵⁸ *Ibid.*

⁵⁵⁹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Donna Ockenden ([EPE0025](#))

⁵⁶⁰ Birth Trauma Association ([EPE0013](#)); Donna Ockenden ([EPE0025](#))

⁵⁶¹ British Maternal & Fetal Medicine Society ([EPE0006](#)); Birth Trauma Association ([EPE0013](#))

D. Was it an appropriate commitment?

Sub-questions:

1) How was "continuity of carer" defined by the Government when creating the related commitment(s)? Was this definition informed by evidence of what is meant by continuity of carer? Was this definition and the commitment effectively communicated to NHS Trusts and staff at different levels? If so, how? If not, why?

From the Continuity of Carer Workforce Modelling Tool,⁵⁶² in practice, Continuity of Carer means that:

- A woman's maternity care is provided by midwives organised into teams of eight or fewer (headcount). Each midwife will aim to provide all antenatal, intrapartum and postnatal care for up to 36 women per year, but at agreed times is supported by the team, such as for unsocial hours or out of hours care.
- All staff in the Maternity Service contribute to achieving Continuity of Carer, including CoC team midwives, core midwives and others in the MDT working in the acute setting, such as obstetricians and sonographers.
- Based on the best evidence available, Continuity of Carer supports the delivery of safer and more personalised care. The 2016 Cochrane review concluded that continuity of carer models save babies' lives, reduce interventions and improve clinical outcomes.

In a meeting on 29 April 2021, the Department confirmed that the definition of "default model of care", refers to the majority of women and that it is anticipated that the CoC pathway will be offered to every woman unless she opts out.⁵⁶³

However, in a written submission, Donna Ockenden commented that there is a lack of consistent understanding relating to Continuity of Carer stating that:

"differing interpretations as to what is actually meant by CoC. Some interpretations mean a midwife just saying "hello" to a woman in an antenatal clinic to count as continuity".⁵⁶⁴

There was also some confusion about whether CoC should always include the entire pregnancy pathway. SANDS states that:

"it is essential that Continuity of Carer ensures continuity in the team that provides care before, during and after labour, as defined in the NHS Long Term plan. This is the model that is associated with the research-based evidence, and suggestions that continuity of antenatal and postnatal care only will be sufficient, are not based on any evidence."⁵⁶⁵

The Association for Improvements in the Maternity Services (AIMS) also took the view that the target should include the full pathway citing evidence of regional variation in this regard, "it appears that the 'continuity' model is understood as allowing care (especially in labour) to be provided by any one of a team of up eight midwives. Whilst this may well represent, in many areas, an improvement over the current standard model of care, AIMS does not believe

⁵⁶² [Continuity of Carer Workforce Modelling Tool \(continuityofcarer-tools.nhs.uk\)](https://continuityofcarer-tools.nhs.uk)

⁵⁶³ An informal meeting was held between members of the Expert Panel and officials from the Department of Health and Social Care and NHSE/I regarding Government commitments in the area of maternity services [29 April 2021]

⁵⁶⁴ Donna Ockenden ([EPE0025](#))

⁵⁶⁵ Sands ([EPE0012](#))

that this approach will deliver the expected policy benefits".⁵⁶⁶ However, RCM/RCOG question the practicality of this ambition and advocate for local services "to develop a variety of approaches, for example, focusing on improving antenatal and postnatal continuity in areas where factors such as midwife shortages or a lack of midwife volunteers to work in continuity teams was slowing implementation."⁵⁶⁷

2) Is the commitment wide enough in scope? Is the commitment specific enough?

Further detail on the rationale and anticipated benefits when setting the commitment is needed, particularly for disadvantaged groups. The commitment and Department's response do not provide clarification on the start and end dates of the CoC pathway, which would have aided commitment specificity.⁵⁶⁸ Particularly in relation to the postnatal period, given the prevalence of maternal suicide.⁵⁶⁹

In response to a follow up question put to the Department on the end date of the CoC pathway, the Department stated that:

"Women are expected to be on a continuity of carer pathway for as long as they are under midwifery/obstetric care. This can be up to 28 days postpartum according to midwives' statutory duties, but is normally around 10 days postpartum, when most women are discharged from maternity services and transferred to the care of the health visitor.

*Midwives are also responsible for ensuring the correct referrals are made to the appropriate healthcare professionals depending on the needs of women and should liaise with health visitors who provide place-based care to help support this."*⁵⁷⁰

Given the importance of CoC in the management of parents with learning disabilities,⁵⁷¹ it is evident that the commitment is not wide or clear enough in scope. We suggest that women with disabilities should be included in the priority women for roll-out of CoC, yet the commitment is limited to BAME and socio-economically deprived backgrounds, which do not explicitly include women with disabilities.

3) Has the commitment had any unintended consequences (either positive or negative)?

Campaign for Safer Births and the British Maternal and Fetal Medicine Society comment that high-risk women, who are not from the backgrounds currently being prioritised, are less likely to be able to access CoC and may be excluded from the benefits of this pathway.⁵⁷² Caesarean Birth note that other aspects of care may be side-lined by the increased focus on CoC stating that "there has been a disproportionate focus on this single aspect of maternity care while downplaying the importance of others".⁵⁷³

⁵⁶⁶ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁵⁶⁷ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁵⁶⁸ Department of Health and Social Care ([EPE0026](#))

⁵⁶⁹ Better Births: Improving Outcomes of Maternity Services in England (2016) [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

⁵⁷⁰ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#)

⁵⁷¹ [Hidden-Voices-of-Maternity-Report-FINAL-260815-2.pdf \(patientexperiencenetwork.org\)](#)

⁵⁷² Campaign for Safer Births ([EPE0009](#)); British Maternal & Fetal Medicine Society ([EPE0006](#))

⁵⁷³ Caesarean Birth ([EPE0023](#))

4) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment's appropriateness been reviewed since its creation?

In their formal response to the planning grid, the Department give a revised deadline of March 2023 for CoC to become the default model of care for most women.⁵⁷⁴ It does not provide any rationale or details relating to the decision-making process underpinning this revised target.

There was some concern from stakeholders about the inclusion in the target of the ambition to roll-out to 'the majority of women'. The ambition in the Better Births report was for all women to have access to CoC. SANDS and AIMS commented that the target to roll-out the model to 'the majority' of women may limit this ambition and could result in Trusts who record 51% of women on CoC as having successfully implemented the model.⁵⁷⁵

5) Were any type of approaches or attempts to "scale up" the programme more successful than others?

The Department did provide any additional information relating to scaling up.⁵⁷⁶

During the roundtable events with clinicians, questions were raised about the appropriateness of a national roll-out of CoC.

*"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."*⁵⁷⁷

6) Is the target contained in the commitment an effective measure of policy success?

The lack of reliable data on implementation of CoC makes it difficult to be used as an effective measure of policy success.

⁵⁷⁴ Department of Health and Social Care ([EPE0026](#)), para 65

⁵⁷⁵ Sands ([EPE0012](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁵⁷⁶ Department of Health and Social Care ([EPE0026](#)),

⁵⁷⁷ Transcript of Expert Panel roundtable with clinicians on 26 May 2021 ([EPE0030](#))

Annex C: Personalised Care

This section contains additional information based on the sub-questions from the planning grid.

A: Was the commitment met overall? Or is the commitment on track to be met?

Sub-questions:

1) Does the commitment have a clear and fixed deadline for implementation? Has the commitment been met? If not, why?

The original deadline for this commitment was revised due to service disruptions associated with the COVID-19 pandemic.⁵⁷⁸ Data show that the revised deadline is unlikely to be met due to limited progress to date.⁵⁷⁹ However, recent improvements in digitisation may allow roll-out of PCSPs to most women by April 2023, according to a written submission from Baroness Cumberlege and Sir Cyril Chantler, authors of Better Births.⁵⁸⁰

2) Does data show achievement against the target (if applicable)?

The Department have not set out clear steps to ensure PCSPs are available to all women across the entire pregnancy pathway by March 2022.

Access to digital maternity records is regarded as an important element of PCSPs enabling women to share information with clinicians and to access relevant healthcare information.⁵⁸¹ The target for national roll-out of Maternity Digital Care Records is March 2024, suggesting that at least some aspects of PCSPs will not be in place by the revised commitment deadline.⁵⁸²

Written submissions from RCM/RCOG and Baroness Cumberlege and Sir Cyril Chantler referred to difficulty assessing progress against this commitment due to lack of data. RCM/RCOG state that “the quality and coverage of data is a particular concern and is undoubtedly having an adverse impact on the ability of the MTP to accurately assess progress being made towards meeting the commitments around personalisation and choice.”⁵⁸³

Written submissions from The Birth Trauma Association, a charity supporting women who have experienced traumatic birth, and Caesarean Birth, an organisation supporting women and advocating for improved safety and informed choice in maternity care, both reported concerns that Caesarean Delivery on Maternal Request (CDMR) were being denied in some NHS Trusts. Caesarean Birth commented that while there is evidence of excellent personalised care in individual Trusts, it is still “a postcode lottery”⁵⁸⁴ rather than the default standard of care.

⁵⁷⁸ Department of Health and Social Care ([EPE0026](#)), para 133

⁵⁷⁹ Department of Health and Social Care ([EPE0026](#))

⁵⁸⁰ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁵⁸¹ Department of Health and Social Care ([EPE0026](#)), para 130

⁵⁸² *Ibid.*

⁵⁸³ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁵⁸⁴ Caesarean Birth ([EPE0023](#))

3) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

The original deadline was revised due to the impact of COVID-19 on maternity care.⁵⁸⁵

4) To what extent (if at all) has the NHS's Covid-19 response affected progress on targets?

The joint submission from Baroness Cumberlege and Sir Cyril Chantler⁵⁸⁶ indicated that COVID-19 slowed progress against this target. Caesarean Birth reported that during the pandemic women's choices were not prioritised and that there were increased reports of CDMR (caesarean delivery on maternal request) being refused. The charity stated that this lack of choice negatively impacted many women more than the widely reported issue of birthing partners not being allowed during delivery.⁵⁸⁷

"Throughout the pandemic, there has been considerable focus on women being able to have their birth partner present for their baby's NHS birth, but feedback from women questioned by Caesarean Birth emphasised that for the majority, access to the caesarean birth itself was even more important than having a partner present."⁵⁸⁸

⁵⁸⁵ Department of Health and Social Care ([EPE0026](#)), para 133

⁵⁸⁶ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁵⁸⁷ Caesarean Birth ([EPE0023](#))

⁵⁸⁸ *Ibid.*

B. Was the commitment effectively funded (or resourced)?

Sub-questions:

1) Were specific funding and/or resourcing arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and how were they made?

There are no specific funds allocated to PCSP implementation and delivery.⁵⁸⁹

2) Were staff adequately trained to work with parents to develop care plans?

PCSP guidance published in March 2021 states that “all health professionals should have access to training in personalised care, informed decision making, risk communication, and in choice conversations. Generic training is currently available from the Personalised Care Institute and maternity specific training expected to be ready April 2021. A trauma-informed care e-learning module is also being developed by Health Education England (HEE)”⁵⁹⁰

It is not clear if staff will be able to access protected training time, or whether there will be an audit of PCSP training. There is no specific budget reported to support staff training.

In their joint written submission, RCM/RCOG cite lack of specific resources for PCSP training as a reason for concern about quality of plans, stating that “without adequate training in the delivery of personalised care and in having informed conversations with women, there is a risk that some maternity services will provide sub-optimal standards and quality of personalised care.”⁵⁹¹

3) If funding and/or resourcing was provided, was this taken from a “new” resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this?

Funding for PCSPs is part of a larger budget (£95 million) allocated to address the seven immediate and essential actions (IEAs) outlined in the Ockenden report. These IEAs are:

- Enhanced Safety
- Listening to Women and Families
- Staff Training and Working Together
- Managing Complex Pregnancy
- Risk Assessment throughout pregnancy
- Monitoring Fetal Well-Being
- Informed Consent.

However, of the larger budget £57.3 million is ringfenced for specific workforce improvements. The remaining £37.7 million is allocated to improvements in multi-disciplinary working (£26.5 million) and funds to support continued ‘consistent, sustainable’ improvements within maternity services (£11.2 million).

It is not clear the extent to which PCSP delivery will be prioritised within this larger budget.

4) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support

⁵⁸⁹ Department of Health and Social Care ([EPE0026](#))

⁵⁹⁰ [Personalised care and support planning guidance: Guidance for local maternity systems, 5.4.](#)

⁵⁹¹ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

the delivery of the commitment? Did the system have relevant support to the deliver the change set out in the commitment?

We have no details on how funding decisions relating to this commitment were made.

5) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining funding and resourcing arrangements?

We have no details about who was consulted about funding decisions relating to this commitment.

6) Do healthcare stakeholders view the funding and/or resourcing as sufficient?

This information is included in the main report.

C: Did this commitment achieve a positive impact for women?

Sub-questions:

1) What was the direct and indirect impact of the commitment on different groups (including women from Black, Asian and minority ethnic backgrounds; disabled women; and women from lower socio-economic backgrounds)? Were there equitable outcomes for different groups?

This information is included in Chapter 5 of the main report.

2) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

The Department refer to a 2019 Care Quality Commission (CQC) survey showing “statistically significant”⁵⁹² improvements in the areas of patient satisfaction and involvement compared to previous years although no raw data is provided to assess the scale of these improvements. However, given the relatively low numbers of women currently able to access PCSP model of care, any improvements are unlikely to relate specifically to the commitment.

Written submissions raised concerns about the extent to which current PCSP guidance will improve outcomes for women.⁵⁹³ Birthrights and Better Breastfeeding, a charity campaigning for better support for women who choose to breastfeed, commented that unless resources are available to enact women’s choices PCSPs will not be meaningful. The joint submission from Baroness Cumberlege and Sir Cyril Chantler also raised the issue of plan implementation by highlighting that personalised care does not end with the formulation of a plan but involves coordinated service delivery planning to ensure care is wrapped around the mother. In reference to the personalised care envisaged in Better Births, they state that:

*“It was intended that every mother should have the opportunity to discuss with her midwife how she wanted the birth of her child to be organised. Having developed this plan, the task was to wrap the care around the mother so that this could be safely achieved wherever possible.”*⁵⁹⁴

Several written submissions stated that unless resource planning is fully embedded, PCSPs risk becoming a bureaucratic, tick-box exercise.⁵⁹⁵ Lack of clear quality assurance guidelines was also raised as an important limitation, with PCSP data reporting only quantity and not quality of plans.⁵⁹⁶ The National Childbirth Trust commented that “any care plan must avoid both the perception and the actuality of being a tick-box exercise.”⁵⁹⁷ while Campaign for Safer Births stated that “we are very concerned that at present only quantity not quality is being monitored.”⁵⁹⁸

⁵⁹² Department of Health and Social Care ([EPE0026](#)), para 140

⁵⁹³ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); Birthrights ([EPE0019](#))

⁵⁹⁴ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁵⁹⁵ British Maternal & Fetal Medicine Society ([EPE0006](#)); NCT (National Childbirth Trust) ([EPE0014](#)); Better Breastfeeding ([EPE0024](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Campaign for Safer Births ([EPE0009](#))

⁵⁹⁶ Campaign for Safer Births ([EPE0009](#))

⁵⁹⁷ NCT (National Childbirth Trust) ([EPE0014](#))

⁵⁹⁸ Campaign for Safer Births ([EPE0009](#))

Clinicians at our roundtable events shared these concerns. One obstetrician commented that a plan to digitise maternity data will not, in itself, improve the quality of information women have access to during pregnancy and digitisation should not be viewed as a reliable quality indicator:

*“There is focus on the fact that many women have this information available on their phones. That doesn’t suddenly make it more worthwhile and exacting information - it’s just on your phone. It’s not sensitive enough.”*⁵⁹⁹

A midwife also raised concerns that without plans to coordinate personalised care plans with spending priorities many women will be offered meaningful care choices:

*“Some Trusts, for example, don’t even use pools for women who have no complexities, so water birth isn’t a thing for them, it’s just not an option. So, women don’t have the same choices across the wider network. Unfortunately, they just don’t.”*⁶⁰⁰

3) Has (or will) there been (or be) a meaningful improvement in process or access measures (i.e. are women able to access the service; quality of feedback when things go wrong etc), reasonably attributable to the policy?

The Department have provided a limited interpretation of what personalised care might be. For example, the guidance published in March 2021 emphasises the importance of choice without considering that free choice depends on many factors including appropriate professional support, quality of unbiased information, and the availability of resources.⁶⁰¹ The Department has not considered issues of critical feedback when things go wrong. The framing of the commitment is not clearly defined and does not provide detail of what a good PSCP might be or how to ensure women are listened to in a meaningful way.

Campaign for Safer Births raised concerns that contingency planning is not always carried out, especially for women identified as low risk. They also identified barriers to women receiving unbiased advice, particularly when choices conflict with preferred options of midwives and Trusts. They cite examples of the practice of the “pushing of inaccurate and sometimes dangerous information by people in the maternity sphere – where causal links have NOT been proven – e.g. women being told that a c-section increases the risk of leukaemia in their baby.”⁶⁰² Their submission concludes by stating that “women need and deserve accurate, unbiased, up to date information.”⁶⁰³

For women from non-English speaking backgrounds, personalised care may be best supported by coordinated care planning with existing community support groups. During our focus groups, women described having a known point of contact to translate and support as invaluable, especially following traumatic experiences.

“Having someone with you helps you to feel like you have someone behind you. There’s someone supporting you. If you’ve been through a bad time, losing a baby is not easy, it’s

⁵⁹⁹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁶⁰⁰ *Ibid.*

⁶⁰¹ Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: Our First Report following 250 Clinical Reviews (2020). [national-maternity-review-report.pdf \(england.nhs.uk\)](#)

⁶⁰² Campaign for Safer Births ([EPE0009](#))

⁶⁰³ *Ibid.*

hard for every woman and I'm not just talking about me- I wouldn't want any women to go through what I went through. It would make a difference having her there. She speaks my language and can explain more to me. When the doctor is translating sometimes, I didn't understand. You have a question in your mind, but you can't explain it in English. If English was my native language I would speak, and I wouldn't need anyone." ⁶⁰⁴

4) Have service users been hindered by the commitment and its implementation? If so, how as this been monitored and evaluated?

Digitisation will be a key feature of personalised care from 2024 and is anticipated to increase women's decision-making autonomy and ownership of their maternity care. The joint submission from Baroness Cumberlege and Sir Cyril Chantler stated that this is likely to be the case for "the cohort of birthing mothers who are usually comfortable with the use of personal technology".⁶⁰⁵ Women without access to technology, or for whom English is an additional language, may risk exclusion from this aspect of planning. RCM/RCOG warn that "where women lack access to digital technology there is a risk that they will experience digital exclusion."⁶⁰⁶

5) By focusing on the target(s) contained in the commitment, have other policy ambitions been reprioritised or removed?

We found no evidence to support this.

⁶⁰⁴ Transcript of Expert Panel focus group with women from East African backgrounds dated 19 May 2021 ([EPE0031](#))

⁶⁰⁵ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁶⁰⁶ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

D: Was this an appropriate commitment?

Sub-questions:

1) How is "personalised care" defined? Was this definition informed by evidence of what is meant by personalised care? Was this definition appropriately communicated to NHS Trusts, staff and patients, or has it been interpreted differently by these groups? If so, how? If not, why?

The Department have provided a loose definition of personalised care and support plans as being a plan "that reflects the woman's care needs and decisions throughout pregnancy, labour and birth and the postnatal period, and is reviewed at every contact. The plan should be underpinned by support from their midwife and include an open, but tailored conversation about the choices available."⁶⁰⁷

Guidance⁶⁰⁸ released in 2021 includes a hard-copy assessment tool but does not provide in-depth consideration of how PCSPs should be effectively incorporated into working schedules, or how to ensure delivery is not reduced to a token conversation. There is no overview of workplace stresses or pressures that may be barriers to midwives' engagement in this tool, or how to ensure doctors and other senior professionals are also bound by the same principles.

There is no information provided related to the interpretation of PCSP guidance by different groups.

The joint submission from Baroness Cumberlege and Sir Cyril Chantler asks, "what is to be regarded as an adequate plan?"⁶⁰⁹ while RCM/RCOG refer to problems with lack of clarity, poor dissemination, and the remit of plans as being 'open to interpretation'.⁶¹⁰ Consequently, several stakeholders express concerns that PCSPs risk becoming bureaucratic, tick-box activities.⁶¹¹

2) Is the commitment wide enough in scope? Is the commitment specific enough?

Guidance published in March 2021 does not provide a detailed assessment of what makes a good PCSP, or how PCSP delivery may be impacted by existing models of working. Issues of staff training and development have not been fully addressed by the Department. There is no clear start and end point for PCSPs currently: guidance indicates that "the agreed plan will cover antenatal care, birth plan and postnatal care".⁶¹² However, no detail is provided about how long after birth PCSPs will be enacted, or how midwifery and health visiting teams will be expected to coordinate support. A written submission from Birth Trauma Association highlighted the need for personalised care to extend into the post-natal period, and to

⁶⁰⁷ Department of Health and Social Care ([EPE0026](#)), para 129

⁶⁰⁸ Personalised care and support planning guidance, Guidance for local maternity systems Version 1, March 2021. [Report template - NHS website \(england.nhs.uk\)](#)

⁶⁰⁹ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁶¹⁰ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁶¹¹ British Maternal & Fetal Medicine Society ([EPE0006](#)); Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Birthrights ([EPE0019](#)); Better Breastfeeding ([EPE0024](#)); NCT (National Childbirth Trust) ([EPE0014](#))

⁶¹² Personalised care and support planning guidance, Guidance for local maternity systems Version 1, March 2021. [Report template - NHS website \(england.nhs.uk\)](#), p. 4

incorporate a meaningful way to record the views and experience of parents, especially when things go wrong.⁶¹³

3) Has the commitment had any unintended consequences (either positive or negative)?

The joint submission from RCM/RCOG expressed concern that the expectation to discuss personalised care in every ante-natal appointment may shift focus away from other aspects of care and add additional pressure to already overstretched midwifery staff. They state:

*"The requirement to demonstrate personalised care planning at every antenatal appointment, when midwives are not being given additional time to carry out the appointment, may have the unintended consequence of limiting the time that midwives have to discuss other issues with the women they are caring for."*⁶¹⁴

Caesarean Birth commented that roll-out of personalised care plan may lead to increased elective caesareans which, while not in itself necessarily an undesirable outcome, would require additional resource and planning considerations.⁶¹⁵

Clinicians in the roundtable events raised concerns that the focus on a PCSP booklet may detract from more meaningful process changes. One midwife suggested that "we should be refocusing that energy and that investment within the time that the midwife has with the woman... if we're distracted by something like the booklet that the woman may never look at again then we might just be missing a trick."⁶¹⁶

Clinicians also highlighted that requirement for staff to be supported to deliver PCSPs appropriately, especially where there are fears of litigation when things go wrong:

*"Of course, women should be supported in every single decision they make, but we also have to support teams and staff because these are tough times for people and staff are very vulnerable too and staff are worried that they're going to be sued."*⁶¹⁷

*"I think the key thing is to support the woman but support the staff who are caring for her as well. And the tendency is not to do either because it's inconvenient."*⁶¹⁸

4) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made and now (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment been reviewed since its creation?

The issue of personalised care is central to several recommendations in the Ockenden report.⁶¹⁹ It is not currently clear how the roll-out of PCSPs as described in the guidance in March 2021 will be expected to impact the challenges described in the Ockenden report.

⁶¹³ Birth Trauma Association ([EPE0013](#))

⁶¹⁴ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁶¹⁵ Caesarean Birth ([EPE0023](#))

⁶¹⁶ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁶¹⁷ *Ibid.*

⁶¹⁸ *Ibid.*

⁶¹⁹ Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust: Our First Report following 250 Clinical Reviews (2020) [OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST](#) (publishing.service.gov.uk)

5) Is the target contained in the commitment an effective measure of policy success?

The target for the roll-out of PCSPs may not meaningfully capture improvements in patient experience due to lack of clarity around the scope and remit of a 'good' PSCP.

Annex D: Safe Staffing

This section contains additional information based on the sub-questions from the planning grid.

A: Was the commitment met overall? Or is the commitment on track to be met?

Sub-questions:

1) Does the commitment have a clear and fixed deadline for implementation? If not, why? If so, how was this determined?

The commitment on Safe Staffing does not have clear and fixed deadlines for implementation. The Department have not specified measurable outcomes or timescales related to this commitment, nor has it provided clarity on what is understood by the terms “appropriate number and mix of clinical professionals”, “quality care” or “avoidable harm”.

Birthrights, a charity promoting human rights in pregnancy and childbirth, and the Association for Improvements in Maternity Services (AIMS), a maternity services improvement charity, both commented that the lack of measurable targets and deadlines undermines the urgency of the staffing problem and the energy required for it to be resolved. In its written submission, AIMS stated that ‘It is time for this issue to be subject to proper scrutiny, and for the Government to make clear its commitment on this issue.’⁶²⁰

2) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?

There is no clear consensus about optimal safe staffing across the full range of professional disciplines and individual units. While there is a midwifery staffing tool, Birthrate Plus, The British Maternal and Fetal Medicine Society raised concerns this may be too simplistic to meet the needs of an increasingly complex maternal population, does not incorporate time needed for staff training, drills, or engagement in reviews, or address issues of appropriate mix of staff.⁶²¹

Clinicians consulted during our roundtable events agreed that increasing maternal complexity needs to be considered in any estimate of safe staffing ratios. One obstetrician commented that “everyone accepts that complexity for pregnant women is definitely increasing, and complexity needs more obstetric time.”⁶²²

A lack of optimal staffing ratios for obstetric consultants prevents clear assessment of safe staffing for this group of maternity professionals. The British Maternal and Fetal Society and RCM/RCOG both refer specifically to the difficulty assessing staffing levels for obstetric staff. To address this, plans are being made to develop a new tool similar to Birthrate Plus. This tool will be developed by the Royal College of Obstetricians and Gynaecologists. On 22 April, in a letter to the Health and Social Care Select Committee, Nadine Dorries MP, Minister of State, Department of Health and Social Care, stated that she anticipates that this new tool

⁶²⁰ AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))

⁶²¹ British Maternal & Fetal Medicine Society ([EPE0006](#))

⁶²² Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

will be ready by Autumn 2021.⁶²³ Additional information received from the Department on 7 June 2021 anticipates that the tool will “calculate the number of obstetricians at all grades required nationally to provide a safe, woman-centred maternity service within the context of the wider workforce”⁶²⁴but provides a revised timescale of 12 months for the delivery of “subsidiary objectives”.

A joint submission from Baroness Cumberlege and Sir Cyril Chantler, authors of the Better Births report, acknowledges the complexity and challenges involved in defining safe staffing, describing it as multifactorial and a “wicked problem”.⁶²⁵

Lack of definitional clarity has undoubtedly contributed to slow progress in this area. However, the Panel does not accept this as a sufficient reason for the scale of ongoing staffing deficits.

3) Does data show achievement against the target?

The average Birthrate Plus assessment of optimal midwife staffing ratios is one midwife for every 24 births.⁶²⁶ This ratio is based on data collected from 55 Trusts during 2019/20. Midwife staffing data was provided by the Department at two timepoints, 2016 and 2020/1, showing staffing ratios in excess of this figure, with some improvements in 2020/1 compared with 2016. However, differences in data collection methodology at each time point make it difficult to meaningfully compare these figures.

The Department state that there was one midwife for every 30 births (1:30) in 2016 based on Health Education England (HEE) reports of Electronic Staffing Records (ESR) of active staff. This is based on the Department’s estimate of 663,157 live births for 2016. The ratio for active midwifery staff in non-managerial roles was not explicitly reported but based on the raw data provided is calculated to be 32 births (31.5) per midwife.

The Department do not report staffing ratios after 2016.

Additional information⁶²⁷ provided by the Department stated that in the year to January 2021, 2238 (8%) of midwives left the midwives staffing group, while 178 (6%) of Obstetrics and

⁶²³ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding the maternity workforce gap \[22 April 2021\]](#)

⁶²⁴ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[18 June 2021\]](#);

⁶²⁵ Baroness Cumberlege and Sir Cyril Chantler ([EPE0001](#))

⁶²⁶ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding the maternity workforce gap \[22 April 2021\]](#); Although the DHSC response to the planning grid does refer to Birthrate Plus it does not explicitly state this figure.

⁶²⁷ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee’s Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

Gynaecology doctors left the HCHS doctors' group.⁶²⁸ These figures are based on headcount and include people leaving and starting service.⁶²⁹

Baby Lifeline also describes a cyclical pattern for midwifery staffing levels with peaks following new trainee qualification in September-November followed by a steady decline until the next intake. At the end of the year, numbers of midwives are typically just above where they started the previous September, suggesting that "the NHS needs to train many more midwives than ten years ago to increase the number practicing."⁶³⁰

It is not possible to infer from data provided by the Department relating to obstetric staffing how reported changes relate to safe staffing overall.

NHS Digital data from December 2020 shows that there are currently 3402 Obstetrics/Gynaecology doctors in training, an increase of 3.5% from December 2019. However, the Department have not information is provided regarding expected retention/career trajectories of trainees, or how these trainees might be expected to improve safe staffing in maternity units.

The Department also report that there are 2,487 consultants currently working in Obstetrics and Gynaecology.⁶³¹ Of this number, it is not clear how many are active in front-facing obstetric positions nor is relevant context provided to allow consideration of how appropriate this figure might be in terms of safe staffing levels in maternity units.

There are no assessments or recommendations related to safe consultant staffing on either a regional or national basis.

During our roundtable events with clinicians one obstetrician referred to funding for 80 addition obstetric posts, stating "there are approximately 2500 obstetricians available now, 20% of that is approximately 500 and 80 have been committed in the most recent government promise, so we think we're about 420 down now."⁶³²

The Department report NHS digital data showing that there are currently 6902 Midwife Support Workers (MSW) employed in Trusts, a small increase (0.8%) from November 2019. No context is given to allow consideration of how this number may relate to overall safe staffing of maternity units or how the MSW role contributes to safer staffing objectives.

There is a lack of context and clarity about how MSW initiatives are expected to contribute to safer staffing in maternity units.

⁶²⁸ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding Government commitments in the area of maternity services in England \[7 June 2021\]](#)

⁶²⁹ *Ibid.*

⁶³⁰ Baby Lifeline ([EPE0021](#))

⁶³¹ Department of Health and Social Care ([EPE0026](#)), para 102

⁶³² Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

4) Are there national standards for safe staffing for midwifery and obstetrics? If not, why? If so, have such standards been met?

Midwifery:

Birthrate Plus is the national standard for safe staffing for midwives and recommends an average ratio of 1 midwife per 24 women. However, there were concerns raised in the written submissions that Birthrate Plus may be too simplistic: The British Maternal and Fetal Medicine Society commented it does not consider the increasing complexity of the maternal population. In addition, it was felt that changes to delivery of care models (i.e. Continuity of Carer) and regional variations were likely to require updated measures for safe midwifery staffing.⁶³³

Clinicians at the Panel's roundtable events raised concerns about the extent to which funded establishment figures reflect safe staffing levels. One obstetrician commented that "one of the problems that we've had in staffing, both for midwifery and for obstetricians, has been that the gaps are all predicated by what the establishment is, which is predicated by the budget of that unit. So, the gaps in the rota don't even address what is going to produce the safe staffing."⁶³⁴

A midwife also commented that the recent Ockenden review has highlighted discrepancies between funded establishment and Birthrate Plus recommendations:

*"Ockenden has really highlighted, and helped us to understand, that we needed to take a closer look at whether services were actually able to fulfil what their Birthrate Plus recommendations were saying."*⁶³⁵

There are no data or tools currently available to assess safe staffing for non-midwifery staff.

A tool to estimate optimal staffing ratios for obstetricians is in development and expected to be ready by Autumn 2021⁶³⁶

5) Do staffing levels vary across NHS Trusts and unit? If so, how?

There is significant regional variation across trusts in terms of complexity of patient population and quality of care.⁶³⁷ Configuration of staffing teams based on local requirements is raised as an important issue in the 2016 'Better Births' report.

The Department have not provided information relating to safer staffing on a regional basis.

Dr Bill Kirkup, Chair of the Morecambe Bay Maternity Investigation in 2013, refers to "alarming"⁶³⁸ variability between Trusts in terms of staffing levels and skill, while RCM/RCOG and NHS Providers highlight regional variation in demand, particularly between rural and urban

⁶³³ Donna Ockenden ([EPE0025](#))

⁶³⁴ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁶³⁵ *Ibid.*

⁶³⁶ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the maternity workforce gap \[22 April 2021\]](#)

⁶³⁷ NHS Providers ([EPE0007](#)); Care Quality Commission (CQC) ([EPE0011](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#))

⁶³⁸ Dr Bill Kirkup ([EPE0005](#))

units. Dr Kirkup states that improvements in maternal safety over recent years has largely been the consequence of changes in mid-performing NHS Trusts which make up the majority of maternity units. He warns that “the continuance of serious problems in some units implies that the poorly performing tail has been left largely unchanged.”⁶³⁹

Addressing the issue of safe staffing may require a regional perspective with NHS Trusts enabled to exercise autonomy and flexibility based on local need. In its written submission, NHS Providers state that:

*“It is important that trusts are able to make these determinations and agree an appropriate skills mix within teams to meet the demand for care at a local level, as they are best placed to understand the skills, competencies and availability of the workforce within their local area as well as the care needs and levels of acuity at any given time within the local population.”*⁶⁴⁰

During our roundtable events, clinicians raised the importance of services being staffed according to regional need. One obstetrician mentioned variable acuity between rural and urban units as being an important consideration, while also highlighting the fact that under-resourcing is common in both settings, particularly during out of hours care. For example, participants told us:

*“If I’m working in a town in Sussex as opposed to an inner-city London hospital, the type and skill mix of obstetricians you need to deal with that complexity is different because Town X would refer in the complexity into different hospitals so one has to bear in mind that there isn’t a simple answer to the solution. But the answer no is absolutely categorical. We do not have enough staff to deal with the complexity now, and that is heightened and worsened out of hours, that’s for sure.”*⁶⁴¹

Another consultant called for more regional flexibility, commenting that “one size doesn’t fit all.”⁶⁴²

⁶³⁹ Dr Bill Kirkup ([EPE0005](#))

⁶⁴⁰ NHS Providers ([EPE0007](#))

⁶⁴¹ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁶⁴² *Ibid.*

B. Was the commitment effectively funded (or resourced)?

Sub-questions:

1) Were specific funding and/or resourcing (including, in particular, on staffing) arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and how were they made?

The Department has committed to providing £10.6 million to “increase consultant time”. Evidence from the roundtables indicate that this will be ringfenced for 80 additional obstetric posts.⁶⁴³

2) If funding and/or resourcing was provided, was this taken from a “new” resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this?

The Department has not clear if the funding breakdown is from a new or reallocated resource stream.

3) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment?

We did not find evidence or details on how funding decisions relating to this commitment were made.

4) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining funding and/or resourcing arrangements?

We did not find details on who was involved in decision making relating to this commitment.

5) Do healthcare stakeholders view the funding and/or resourcing as sufficient? In particular, are there sufficient midwives and specialist in training to fulfil and maintain staffing levels now and in the future?

While stakeholders have welcomed the £95 million allocated for workforce improvements in their written submissions, none felt confident that this figure will be sufficient to meet identified workforce needs. Campaign for Safer Births questioned whether the £95 million will cover existing shortfalls let alone meaningfully extend staffing numbers.⁶⁴⁴ The British Maternal and Fetal Medicine Society called for a strategic workforce plan to focus investment in specific areas rather than unimaginative number boosting strategies.⁶⁴⁵

Several written submissions identified a lack of funding for continued professional development and training as a leading cause of staff attrition.⁶⁴⁶ Baby Lifeline commented that

⁶⁴³ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁶⁴⁴ Campaign for Safer Births ([EPE0009](#))

⁶⁴⁵ British Maternal & Fetal Medicine Society ([EPE0006](#))

⁶⁴⁶ Campaign for Safer Births ([EPE0009](#)); Royal College of Obstetricians and Gynaecologists, Royal College of Midwives ([EPE0010](#)); Care Quality Commission (CQC) ([EPE0011](#)); AIMS - Association for Improvements in the Maternity Services ([EPE0016](#)); Andrea Sutcliffe (Chief Executive and Registrar at Nursing and Midwifery Council) ([EPE0015](#)); Baby Lifeline ([EPE0021](#))

50% of funds allocated to staff training via the Maternity Safety Training Fund were “swallowed up by Trusts deficits”⁶⁴⁷ highlighting the need for protected funding to support staff retention. Birthrights highlighted the unfavorable discrepancy between initiatives supporting progress of safe staffing compared with safety initiatives related to commitment 1: Maternity Safety. Investment in staff retention was highlighted as more cost-effective solution than recruitment initiatives overall. Baby Lifeline commented that “it is far cheaper to retain staff rather than train new staff, and there are also benefits to be found in areas such as workforce morale and mental wellbeing.”⁶⁴⁸

⁶⁴⁷ Baby Lifeline ([EPE0021](#))

⁶⁴⁸ *Ibid.*

C: Did the commitment achieve a positive impact for women?

Sub-questions:

1) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?

Spending commitments in relation to midwifery training are not expected to have an impact on patients until 2024.⁶⁴⁹

Recruitment and retention of staff for the additional 1000 midwife posts and the 844 posts currently vacant is likely to be challenging in the context of high attrition.

The Department refer to improvements in patient experience reflected in the 2019 CQC maternity survey compared with the 2018 survey “across a greater number of questions”.⁶⁵⁰ It is not clear what specific improvements these might be or how they may relate to the overall commitment.

The Department compare NHS National Staff Survey results between 2015 and 2020 showing improvements in questions relating to staffing. The percentage of midwives endorsing the statements “I am able to meet conflicting demands” and “there are enough staff for me to do my job properly” increased from 27% to 34% and 20% to 28% respectively over this period. No information was provided regarding total number of respondents in either sample, or the wider context of responses in each survey. Despite improvements, 66% of midwives surveyed feel that they are not currently able to meet conflicting demands, and 72% of midwives do not agree that there are enough staff at their unit to allow them to perform their job properly.

There was a slight decrease between 2015 and 2020 in the percentage of midwives who endorsed the statement, “I am satisfied with the quality of care I give to patients / service users”. In 2020, 68% of midwives agreed with this statement compared with 69% in 2015. This suggests almost a third of midwives currently feel unsatisfied with the quality of care offered to women.⁶⁵¹

It is not clear how any reported changes relate to specific government initiatives relating to the commitment.

2) Has (or will) there been (or be) a meaningful improvement in process measures (i.e. staff in training / recruitment strategies etc), reasonably attributable to the policy?

The extent to which the 3650 additional midwifery training places and the funding for 1000 maternity posts results in meaningful improvements in midwifery staffing is likely to depend on simultaneous efforts to improve staff retention.

While the Department acknowledges the need for systemic change within maternity staffing⁶⁵² it does not specify in detail any initiatives to support this aim and current plans to address staff shortages is limited to new recruitment to existing staffing models. The Department does not elaborate on required workforce or team changes necessary for sustained

⁶⁴⁹ Department of Health and Social Care ([EPE0026](#))

⁶⁵⁰ Department of Health and Social Care ([EPE0026](#)), para 119

⁶⁵¹ Department of Health and Social Care ([EPE0026](#))

⁶⁵² Department of Health and Social Care ([EPE0026](#)), para 122

improvements in maternity, for example, the development of specialist and consultant midwife posts or protocols relating to locum staff.

3) By focusing on the target(s) contained in the commitment, have other aspects of care been reprioritised or removed?

The Department acknowledges that “safe care is not only about having the right numbers of staff but ensuring that there is a multidisciplinary workforce that is working and training together, that staff feel happy and empowered in their role”.⁶⁵³ However, the lack of specific targets and objectives relating to this commitment has meant that the Department has focused initiatives exclusively on staffing numbers and does not include an assessment of meaningful changes required to workplace culture or ways of working.

During our roundtable events with clinicians, participants commented that ongoing shortages inevitably mean that resources are prioritised away from meaningful changes to ante-natal and post-natal care. One obstetrician told us that “our focus is always on the crisis points”,⁶⁵⁴ while another commented:

*“We always focus on the delivery suites almost like the fire service, when in fact of much of maternity care precedes that. I think the real strain that I’ve noticed in recent years has been the drain from the community...the focus of everything is about the avoidable incidents that occur when these all go wrong in delivery suite and our maternity assessment centres. So, actually, we focus on what happens in secondary care to the detriment of what actually could be avoidable and could be pinched in the bud in in the community setting. And that’s where our real lack is I believe.”*⁶⁵⁵

⁶⁵³ Department of Health and Social Care ([EPE0026](#)), para 125

⁶⁵⁴ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

⁶⁵⁵ *Ibid.*

D: Was it an appropriate commitment?

Sub-questions:

1) How are the terms "appropriate number", "mix" and "avoidable harm" defined? Were these definitions appropriately communicated to NHS Trusts and staff? If so, how? If not, why?

The Department have not provided additional clarity on these points. Staffing ratios for midwifery staff as detailed in Birthrate Plus are the only measures to support progress against "appropriate number". There are no equivalent ratios provided for other maternity unit staff, although we acknowledge the development of a staffing tool for obstetricians.⁶⁵⁶

There is no assessment of optimal workforce configuration to address the commitment to the right "mix" of staff.

2) Is there evidence to support what a standard level of staffing commitment is for all staff groups?

Staffing ratios provided by the Department relate to midwifery staff only. A tool to assess safe staffing for obstetricians is in development and is expected to be ready by Autumn 2021.⁶⁵⁷

3) Is the commitment wide enough in scope? Is the commitment specific enough?

The commitment lacks specificity and clarity of remit. The Department refer to 2016 'Better Births' report as the basis for this commitment. This report includes recommendations related to systemic changes to maternity unit staffing and working practices including effective multidisciplinary working, strong leadership, and the development of an open and honest working culture. The commitment does not clearly set out defined initiatives to tackle these issues, nor does it set out how progress against these targets should be measured or assessed.

We conclude that the commitment is not sufficiently broad in scope and should be developed to include both workplace culture and issues of psychological safety.

Clinicians attending roundtable events called for an increased focus on efficient staff distribution and effective multi-disciplinary working, stating that "care in maternity is not just about staffing, it's about systems and structure."⁶⁵⁸ One midwife commented on the relative neglect of postnatal care compared with the labour ward:

⁶⁵⁶ [Letter from Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health, to Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Select Committee, and Professor Dame Jane Dacre, Chair, Health and Social Care Select Committee's Expert Panel, regarding the maternity workforce gap \[22 April 2021\]](#)

⁶⁵⁷ *Ibid.*

⁶⁵⁸ Transcript of Expert Panel roundtable with clinicians on 21 May 2021 ([EPE0028](#))

"It's distribution of that staffing as well. So, from the shop floor perspective there's always one to one care in labour, it's prioritised, but perhaps on the postnatal ward, that number of midwives is perhaps not as great. So those midwives are overstretched." ⁶⁵⁹

4) Has the commitment had any unintended consequences (either positive or negative)?

We found no information on unintended consequences.

A written submission from NHS Providers commented that ongoing staff shortages make it difficult for maternity services to make meaningful changes to workplace culture, learn from mistakes, or to adapt to new ways of working. ⁶⁶⁰

5) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment been reviewed since its creation?

We do not feel that the commitment is sufficiently robust to reflect the urgency of this issue, and its importance in achieving wider maternity improvements.

6) Is the target contained in the commitment an effective measure of policy success (if applicable)?

Other than Birthrate Plus midwife staffing ratios, there are no clear targets contained in the commitment against which to effectively measure policy success.

⁶⁵⁹ *Ibid*

⁶⁶⁰ NHS Providers ([EPE0007](#))

Appendix: Anchor statements for CQC-style ratings

Rating	Was the commitment met overall/Is the commitment on track to be met?	Was the commitment effectively funded?	Did the commitment achieve a positive impact for patients?	Was it an appropriate commitment?
Outstanding	The commitment was fully met/there is a high degree of confidence that the commitment will be met	The commitment was fully funded with no shortfall	Patients and stakeholders agree that the impact was positive	Evidence confirms appropriateness of the commitment
Good	The commitment was met but there were some minor gaps, or is likely to be met within a short time after the deadline date/it is likely that the commitment will be met, but some outstanding issues will need to be addressed to ensure that is the case	The commitment was effectively funded, with minor shortfalls	The majority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment was appropriate overall, with some caveats
Requires improvement	The commitment has not been met and substantive additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if substantive additional steps are taken	The commitment was ineffectively funded	A minority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment needs to be modified
Inadequate	The commitment has not been met and very significant additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if very significant additional steps are taken	Significant funding shortfalls prevented the commitment being met	Most patients and stakeholders did not agree there was a positive impact for patients	Evidence suggests the commitment was not appropriate

Published written submissions

The following written submissions were received and can be viewed on the [inquiry publications page](#) of the Committee's website.

EPE numbers are generated by the evidence processing system and so may not be complete.

- 1 AIMS - Association for Improvements in the Maternity Services ([EPE0016](#))
- 2 Baby Lifeline ([EPE0021](#))
- 3 Baroness Cumberlege; and Sir Cyril Chantler ([EPE0001](#))
- 4 Better Breastfeeding ([EPE0024](#))
- 5 Birth Trauma Association ([EPE0013](#))
- 6 Birthrights ([EPE0019](#))
- 7 Bliss ([EPE0020](#))
- 8 British Association of Perinatal Medicine (BAPM) ([EPE0022](#))
- 9 British Maternal & Fetal Medicine Society ([EPE0006](#))
- 10 Caesarean Birth ([EPE0023](#))
- 11 Campaign for Safer Births ([EPE0009](#))
- 12 Care Quality Commission (CQC) ([EPE0011](#))
- 13 Department of Health and Social Care ([EPE0026](#))
- 14 Kirkup, Dr Bill ([EPE0005](#))
- 15 NCT (National Childbirth Trust) ([EPE0014](#))
- 16 NHS Providers ([EPE0007](#))
- 17 National Maternity Voices ([EPE0018](#))
- 18 Noble, Sarah (Director of Midwifery and Lin Ward, Deputy Head of Midwifery
Warkwick Hospital, South Warwickshire NHS Foundation Trust) ([EPE0027](#))
- 19 Obstetric Anaesthetists' Association ([EPE0008](#))
- 20 Ockenden, Donna ([EPE0025](#))
- 21 Royal College of Obstetricians and Gynaecologists; and Royal College of Midwives
([EPE0010](#))
- 22 Sands ([EPE0012](#))
- 23 Sutcliffe, Andrea (Chief Executive and Registrar, Nursing and Midwifery Council)
([EPE0015](#))
- 24 The Royal College of Pathologists ([EPE0003](#))
- 25 The Royal College of Pathologists ([EPE0004](#))
- 26 Vernon, Helen (Chief Executive, NHS Resolution) ([EPE0002](#))
- 27 Wellbeing of Women ([EPE0017](#))

Transcripts

Roundtable with clinicians (1/2) ([EPE0028](#))

Roundtable with NHSE/I ([EPE0029](#))

Roundtable with clinicians (2/2) ([EPE0030](#))

Focus group with women from East African backgrounds ([EPE0031](#))