The Government's response to the Health and Social Care Committee report

Safety of Maternity services in England

September 2021

CP 513

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Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

September 2021

CP 513

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CORRECTION SLIP

Title: The Government’s response to the Health and Social Care Committee report: Safety of Maternity services in England

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Correction:
Page 12 Paragraph 49 Bullet 5

Text currently reads:

> The CQC undertakes strengthened assessment of Trusts' learning from deaths and their engagement with bereaved families and carers as part of the regulator’s annual inspections of Trusts.

Text should read:

> The CQC undertakes strengthened assessment of Trusts' learning from deaths and their engagement with bereaved families and carers as part of the regulator’s inspections of Trusts.

Date of correction: 6 October 2021

Contents

Introduction

1. This is the Government's formal response to the recommendations made by the Health and Social Care Committee in its report, 'The Safety of Maternity Services in England'.
2. The Government welcomes this report. Maternity safety is a priority for this Government, and the Government remains committed to making the NHS one of the best places in the world to have a baby.
3. The Committee's inquiry examined evidence relating to the safety of maternity services. It builds upon current investigations following incidents at East Kent Hospitals University Trust and Shrewsbury and Telford Hospitals NHS Trust, as well as the inquiry into the University Hospitals of Morecambe Bay NHS Trust. The inquiry also considered whether the clinical negligence and litigation processes need to be changed to improve the safety of maternity services and explored the impact of blame culture on learning from incidents.
4. The Committee's report set out its conclusions and recommendations in three parts:
    - **Chapter 1** addressed staffing numbers, funding, leadership and training.
    - **Chapter 2** focused on learning from patient safety incidents. It considered the role of the Healthcare Safety Investigation Branch (HSIB) and examined the current clinical negligence system.
    - **Chapter 3** explored women's experiences of care. This included tackling disparities in outcomes; specific interventions to improve outcomes, including Continuity of Carer and screening; and supporting informed choices and personalised care.
5. The report makes 15 recommendations. The structure of this Command Paper directly corresponds to these recommendations.

The Committee's Expert Panel Evaluation of Maternity Government Commitments

6. In 2020, the Committee commissioned an Independent Panel of Experts to assess the Government's progress in meeting its own targets in key areas of healthcare policy.
7. The Expert Panel evaluated the following four Government commitments on maternity services:
    - **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 black, Asian and Minority Ethnic 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 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 harm.
8. The Panel rated the Government's overall progress to achieve key commitments in maternity services as 'requires improvement'.
9. The Department has formally responded to the Expert Panel's evaluation separately.

Summary of Government Response to the recommendations

10. England is a safe place to give birth as evidenced by improving safety outcomes and women's reported experiences of care. The Committee noted that the vast majority of NHS births in England are safe and at its best NHS care offers some of the safest maternal and neonatal outcomes in the world.
11. Good progress has been made in meeting the National Maternity Safety Ambition. The Office for National Statistics (ONS) reports that since 2010, there has been a 25% reduction in the stillbirth rate, and a 29% reduction in the neonatal mortality rate for babies born over the 24-week gestational age of viability.
12. Through the NHS England and NHS Improvement (NHSEI) led Maternity Transformation Programme (MTP), there has been improved partnership working between the Department of Health and Social Care (DHSC), its Arms-Length Bodies (ALBs), NHS maternity and neonatal providers, Royal Colleges and academics. There is also a significantly better understanding of the causal factors relating to mortality and morbidity in pregnant women and neonates which the system continuously seeks to address.
13. Overall, while the outcome data shows that maternity and neonatal services are making real progress, there is no room for complacency, and the Department knows that unacceptable variations in the quality of care and outcomes remain. The Department has worked with its system partners to put in place specific, focused support for challenged areas, and is working to further improve oversight and escalation processes to identify concerns about the quality of care.
14. The Department acknowledges that key areas that require continuous development include organisational leadership and addressing poor culture.
15. Poor workplace culture is completely unacceptable in all areas of the NHS, and the Government remains committed to tacking this issue. The Government launched the Maternity Leadership Training Fund in early 2021 and has established strong leadership across the system through the appointment of named regional and local Maternity Safety Champions led by two national Maternity Safety Champions.
16. The Committee's report highlighted that appropriate staffing levels are a prerequisite for safe care, and a robust and credible tool to establish safe staffing levels for obstetricians is needed.
17. As the committee notes, NHSEI are investing £95.6m to target the three overarching themes identified in the first Ockenden Report: workforce numbers, training and development programmes to support culture and leadership, and strengthening board assurance and surveillance to identify issues earlier.
18. The Department has funded the Royal College of Obstetricians and Gynaecologists (RCOG) to develop a tool, which will calculate the number of obstetricians at all grades required locally and nationally to provide a safe, personalised maternity service within the context of the wider workforce.
19. The Department remains committed to improving maternity safety and will take the recommendations made by the Committee and its Panel in relation to funding for staffing into consideration. As part of this, we will need to consider an assessment of midwifery and obstetric workforce levels. This assessment would also need to take into consideration time for healthcare professionals to partake in annual multi-disciplinary training and provide personalised care.
20. The Committee's report also highlighted the importance of training for delivering safe care. NHSEI's Core Competency Framework has been developed to address known variation in training and competency assessment and ensure that training to address significant areas of harm are included as minimum core requirements for every maternity and neonatal service.

21. Through the Avoiding Brain Injury programme, the MTP will work closely with the Royal Colleges and Care Quality Commission (CQC) to standardise the approach to fetal monitoring and to develop support tools as part of training.

22. The Government acknowledges that there are disparities in maternal and neonatal outcomes and is committed to addressing these disparities. The Committee rightly states, the underlying causes of health disparities relate to a range of issues beyond the remit of the Department. The root causes of disparities in health are a complex interaction between personal, social, economic and environmental factors. NHSEI have taken the approach of first setting metrics which have sufficient sensitivity (statistical power) to track changes in clinical outcomes for the groups most at risk, and second – through the equity and equality guidance - to identify priorities, design evidence-based interventions to address those priorities and promote an approach of continuous quality improvement.

23. The Department thanks the Committee for its work and has considered the recommendations made in its report. A detailed response to each of the recommendations made by the Committee is set out in this response.

Supporting Maternity Services and Staff to Deliver Safe Maternity Care

Recommendation 1 – Funding for Staffing

Recommendation 1 - We recommend that the budget for maternity services be increased by £200–350m per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as Trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.

Response

24. The Government is considering this recommendation.
25. The inquiry's report welcomed the recent investment of £95.6m by NHSEI to target the three overarching themes identified in the first Ockenden Report: workforce numbers, training and development programmes to support culture and leadership, and strengthening board assurance and surveillance to identify issues earlier. A significant proportion of this sum will support the recruitment of 1,200 additional midwives and 100 consultant obstetricians.
26. As the committee notes, the Department has commissioned the RCOG, to develop a new workforce planning tool to improve how maternity units calculate their medical staffing requirements.
27. The tool will calculate the number of obstetricians at all grades required locally and nationally to provide a safe, personalised maternity service within the context of the wider workforce.
28. The Department remains committed to improving maternity safety and will take the recommendations made by the Committee and its Panel in relation to funding for staffing into consideration. As part of this, we will need to consider an assessment of midwifery and obstetric workforce levels. This assessment would also need to take into consideration time for healthcare professionals to partake in annual multi-disciplinary training and provide personalised care.

Recommendation 2 – Obstetric Staffing

Recommendation 2 - We further recommend that the Department work with the Royal College of Obstetricians & Gynaecologists and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts to enable trusts to deliver safe obstetric staffing over the years to come. This work should also consider the anaesthetic workforce.

Response

29. We accept this recommendation.
30. The Department and Health Education England (HEE) already work closely with system partners to determine the number of training places for a particular specialty, including obstetrics and gynaecology and anaesthetics.
31. An example of this collaboration is HEE's joint workforce group with the RCOG. The aim of this group is to explore and implement the deliverables for the development of the Obstetrics and Gynaecology (O&G) workforce outlined in HEE's Maternity Transformation Workforce Strategy. The work is being progressed through five Task and Finish Groups, which are led by the RCOG. These groups are focusing on a range of initiatives including multi-disciplinary working and profiling and modelling of the O&G workforce.
32. We are working with partners to ensure that the number of training posts in O&G and anaesthetics, along with all other medical specialties, is in line with national and regional workforce requirements. We will continue to monitor the effectiveness of current arrangements, including considering the need for an expansion of training places.
33. In addition, as the Committee notes, the Department recently funded the RCOG to develop a tool, which will calculate the number of obstetricians at all grades required locally and nationally to provide a safe, personalised maternity service within the context of the wider workforce.
34. Over the next year, the RCOG will collaborate with and gather data from across the health sector to determine how the tool can help NHS Trusts to understand their own medical staffing needs, and provide standardised, safe and personalised care tailored to their communities.
35. The tool will be freely available to NHS Trusts across the country next year, and will provide maternity staff with a new methodology that calculates the numbers, skill sets and grades of medical staff required within individual maternity units based on local needs. It will help Trusts tackle disparities by taking into account local factors such as birth rates, age of population, the socio-economic status of the area, and geographical factors.

Recommendation 3 – Ringfenced budgets for training in maternity units

Recommendation 3 - We recommend that a proportion of maternity budgets should be ringfenced for training in every maternity unit and that NHS Trusts should report this in public through annual Financial and Quality Accounts. It should be for the Maternity Transformation Programme board to establish what proportion that should be; but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.

Response

36. We accept this recommendation in part.
37. In collaboration with national maternity partner organisations, the MTP has led on the development of a Core Competency Framework to address known variation in training and competency assessment and ensure that training to address significant areas of harm is included as minimum core requirements for every maternity and neonatal service.
38. Funding announced at the NHSEI Board in March 2021 will be put towards maternity multi-disciplinary team training and staff backfill as part of NHSEI's response to the first Ockenden Report.
39. NHSEI will need to undertake further work to explore aligning this funding with the Core Competency Framework, and work with local systems, regions and the Royal Colleges to determine how best to monitor and assure that the additional funding is feeding through into training.
40. Safety Action 8 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) ensures there is an existing lever in place, aligned to the Core Competency Framework, to ensure training requirements are in place and incentivised. As the scheme is revised annually, training requirements are reviewed regularly, informed through learning from reports, audits and enquiries. In addition, as new learning emerges, NHSEI is working with HEE to make it a requirement for more specialist training to be developed.

Recommendation 4 – Safety Training Targets

Recommendation 4 - We recommend that a single set of stretching safety training targets should be established by the Maternity Transformation Programme board, working in conjunction with the Royal Colleges and the Care Quality Commission. Those targets should be enforced by NHSEI's Maternity Transformation Programme, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Care Quality Commission through a regular collaborative inspection programme.

Response

41. We accept this recommendation.
42. In collaboration with national maternity partner organisations including the Royal Colleges, HSIB, NHS Resolution and the CQC, the MTP's Recommendation's Group has undertaken a review of training recommendations from maternity reports. These insights have been used to inform a Core Competency Framework to address known variation in training and competency assessment and ensure that training to address significant areas of harm are included as minimum core requirements for every maternity and neonatal service.
43. This work has been included as a requirement for meeting Immediate and Essential Actions from the first Ockenden report. The Core Competency Framework provides an evidence-based set of essential training targets upon which stretch targets can be built, incentivised through Safety Action 8 of the CNST MIS. Stretch targets will be considered as part of the next iteration of the framework.
44. In addition, a national Registry of Recommendations is being produced which will help determine newly identify training needs going forwards.
45. Through the Avoiding Brain Injury programme, the MTP will work closely with the Royal Colleges and CQC to standardise the approach to fetal monitoring and to develop support tools as part of training. NHSEI's MTP are not regulators and so are unable to enforce these targets. However, the MTP will open discussions with the relevant Royal Colleges and the CQC to share information around specific training targets in order to collaborate and support CQC's inspection programmes.

Learning from Patient Safety Incidents

47. The Government is clear that patient safety and reducing levels of avoidable harm must remain a top priority for the NHS in England.

48. A cross-system National Patient Safety Programme Board was established this year to provide new coordination and monitoring of improvements in patient safety and response to harm across the NHS. The Board's work is currently underpinned by the development of a national action plan to deliver targeted, measurable improvement and will be reviewed annually.

49. The Government is committed to the development of a safety and learning culture and transparency across the NHS so that treatment and care is always provided to the safest possible standard. Examples of initiatives include:

    - The establishing of the HSIB - including a specific programme to conduct maternity investigations. HSIB examine the most serious patient safety incidents with the sole purpose of promoting system-wide learning and improvement by finding answers, giving safety recommendations and embedding new practices across the NHS. The Government intends to legislate for HSIB to become a fully independent investigations body.
    - A statutory duty of candour - regulated by the CQC - which means that Trusts must be honest with themselves and tell patients if their safety has been compromised and apologise, vital to learning from mistakes.
    - Protections for whistle blowers when they raise concerns and Freedom to Speak Up Guardians across all Trusts supported by a National Guardian.
    - Implementing medical examiners across the NHS, a critical reform to ensure that patterns in non-coronial deaths are acted upon by Trusts and much needed support is provided to bereaved families, thereby increasing transparency.
    - The CQC undertakes strengthened assessment of Trusts' learning from deaths and their engagement with bereaved families and carers as part of the regulator's annual inspections of Trusts.
    - Quality accounts published each year by every NHS provider provide transparency to regulators and the public about the quality of services by reporting on patient safety, the effectiveness of care and patient feedback.
    - The first ever NHS Patient Safety Strategy[1] published in 2019 builds upon these reforms and will deliver substantial programmes that are planned and underway to create a safety and learning culture in the NHS.

50. The Government has this year also established in law a Patient Safety Commissioner who, when appointed, will become a champion for patients in relation to medicines and medical devices with the power to make reports and recommendations to providers and foster policies that are more conducive to an inclusive Just Culture.

[1] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/#patient-safety-strategy

Recommendation 5 – HSIB Investigations – Engagement with Trusts

Recommendation 5 - We recommend that the Health and Safety Investigation Branch (HSIB) investigations continue, but that HSIB reviews how it engages with trusts to ensure that the investigation process works in a timely and collaborative manner which optimally supports local learning and development. That review should include processes to ensure that healthcare professionals at all levels and across multidisciplinary team are able to engage with HSIB investigations. We further recommend that HSIB actively consults trainee doctors and midwives in that review.

Response

51. We accept this recommendation in part**.**
52. HSIB will continue with its existing programme of maternity investigations under the conditions set in the HSIB Maternity Directions 2018. The Health and Care Bill contains provisions which allow for NHS England or any other public body to carry out maternity investigations in the future.
53. The Government will decide which option is the most appropriate in due course and seek the views of the NHS, families and other interested parties.
54. HSIB recognises that timely production of its investigation reports is essential to support trusts and their staff with learning, to ensure that families are given the clarity they need about what happened during their care, and what actions can be taken by the Trust to reduce the risk of recurrence. In the last 12 months, HSIB has made changes to improve the timeliness of its reports, strengthened its collaboration with Trusts and multidisciplinary engagement with perinatal teams to ensure that learning is spread as widely as possible from its investigations.
55. Substantial adjustments to a range of processes along the investigation pathway has also enabled HSIB to clear the backlog of investigations that extended beyond six months, and to ensure that the average turnaround time for sharing the draft investigation report is four months and the final investigation report with Trusts is now completed within six months in over 90 percent of cases.
56. There is an established process in place to have open discussions around any concerns that are identified during the investigation. This enables immediate safety actions to be taken by the Trust. Where cases are exceeding the six-month timescale, this will generally be due to additional time needed by the family or the Trust to review the report.
57. HSIB investigations can sometimes be delayed by factors beyond HSIB's control, such as access to medical records or access to specialist medical advice. In addition, parallel investigations being conducted by professional regulatory bodies, coroners or the police, can require HSIB to pause an investigation until those processes have been completed. However, HSIB recognises that the proportion of investigations which are affected by these processes is very small and the average duration of an investigation continues to improve.
58. HSIB has a formalised and standardised process for factual accuracy checking with families and Trusts on draft maternity investigation reports. This process requires Trusts to formally advise whether they have accepted HSIB's recommendations. HSIB asks Trusts to ensure that any staff involved in the HSIB investigation are given the opportunity to contribute to the factual accuracy review. HSIB also ensures that the Trust board's Maternity Safety Champion is informed about recommendations that the Trust has not accepted.

59. All families and Trusts are offered the opportunity to hold a tripartite meeting with HSIB at the conclusion of an investigation. Doing this enables HSIB to discuss the findings and allows the Trust an opportunity to share their planned actions with the family. This also helps to provides a clear point of conclusion for the HSIB investigation and facilitates a more constructive relationship between the trust and the family going forward.

60. HSIB is continuously improving the accessibility of local learning from their investigations to support improvement. They hold Quarterly Review Meetings (QRMs) with all Trusts which are open to multidisciplinary attendance and are also attended by senior trust leaders. The QRMs provide an opportunity to share national, regional and local Trust data on numbers of investigations, criteria breakdown and frequently recurring themes at each level. HSIB is developing mechanisms for more effective engagement with doctors in training and midwives, and they encourage Trusts to facilitate trainees' and midwives' attendance and participation at the Trusts' QRMs. HSIB also attends, when invited, Trust perinatal and governance meetings and meetings with wider clinical teams to share their investigation findings. They continue to work closely with the Royal Colleges and HEE to build awareness of HSIB through healthcare training. They have also created a staff engagement video which explains the importance of staff involvement in HSIB investigations, which has been shared with all Trusts and is also publicly available.

61. HSIB's collaborative approach also involves using Trust feedback to shape the programme. HSIB has recently commenced a survey of all Trusts participating in the maternity programme, building on learning and improvements that they obtained from conducting the survey in early 2020, the results of which were shared with Trusts. This has helped to build the confidence of Trusts and staff that HSIB is collaborative and willing to learn from their experience to continuously improve the programme.

62. HSIB is also developing a learning and development pathway for patient safety investigation, which was piloted in Newcastle recently with a view to rolling out more widely for NHS organisations during 2021-22. As part of this HSIB is exploring the feasibility of an HSIB investigator and a local Trust investigator working together throughout an investigation to help Trusts learn directly from HSIB's approach, whilst ensuring that HSIB's role as an independent investigation body is maintained. HSIB is also developing a standard definitions document, a clinical reference document and an investigation template with plans to make this available on their website for use by local investigation teams.

Recommendation 6 – HSIB Investigations – Sharing Learning

Recommendation 6 - In addition, we recommend that HSIB shares the learning from its maternity reports in a more systematic and accessible manner. A top level summary of individual cases together with the key learnings derived from them should be shared rapidly across the NHS.

Response

64. We accept this recommendation in part.
65. HSIB recognises the importance of sharing learning from their investigations. HSIB has generated substantial data about safety risks in maternity services after having completed over 1700 investigations by July 2021. However, there are large volumes of safety information already generated by Trusts through reporting for maternity services, and it is important that the national bodies work together to ensure all safety data on NHS maternity services is shared across the maternity system in a way that most effectively supports safety improvement.
66. Therefore, HSIB is working closely with academic partners to develop meaningful intelligence and useful data on safety risks in maternity services that can be shared publicly and across the system. HSIB has piloted the use of a quality matrix in their engagement with Trusts to aid their understanding of safety risks in their maternity services. They have produced a newsletter for all Trusts to spread the learning about actions that have been taken across the country in response to HSIB maternity investigations – this was welcomed by Trusts and they intend the newsletter to become a regular output.
67. HSIB now attend regional perinatal quality meetings which provides opportunity to share learning with NHS England Regional Chief Midwives, Clinical Commissioning Groups and local Integrated Care System representatives, Local Maternity System (LMS) partners, Maternity Voices Partnership representatives and CQC local representatives.
68. HSIB National Learning Reports have shared themed learning and made national recommendations drawn from recurrent safety risks identified in maternity investigations, and with academic partners they are developing a taxonomy of safety risks that will help inform future maternity themed reports.
69. Interactive learning opportunities with HSIB's investigators have been welcomed by stakeholders – HSIB have held a maternity focused webinar for the ambulance sector and plan to hold more interactive learning opportunities on maternity topics going forward.

Recommendation 7 – Streamlining the data collection process

Recommendation 7 - NHSEI must streamline the data collection process to reduce the burden for trusts. The Department must ensure that insights collected by all bodies are collated in a coordinated manner and shared across organisations in a timely manner. As part of this process, the Department must assess current data gaps and develop a plan to address these. Particular focus should be given to using data to understand the causes of and reduce the variation between maternity units. National measures are driving improvements overall but there are some units being left behind. We need to know why.

Response

70. We accept this recommendation in part.

71. We agree that data collection should be streamlined, and that insights collected should be collated in a coordinated way and shared across organisations in a timely manner. The MTP will be commissioning the build of a single notification portal in 2021/22, as part of the Learn from Patient Safety Events (LFPSE)[2] service which is replacing the National Reporting and Learning System (NRLS). This single notification portal will reduce the burden reporting requirements for maternity services and enable sharing of data on incidents with multiple organisations.

72. Currently Trusts are required to notify various organisations of incidents within their services, and often a large amount of duplicate information is being reported to more than one organisation. The development and implementation of a single notification portal across Trusts in England will enable Trusts to submit a core dataset to multiple organisations at the same time. This will result in a clear and strong benefit to the frontline in having one place to report detailed information, avoiding duplication of work and consequently NHS resource. There will also be certainty for the organisations being reported to: NHS Resolution (Early Notification Scheme), HSIB, the National Perinatal Epidemiology Unit at the University of Oxford (MBRRACE-UK) and the University of Bristol (National Child Mortality Database), that they have all been made aware of the same incidents.

73. We believe that the current data gaps in maternity services are known and there is already a robust response in train to deal with these. The Maternity Services Dataset (MSDS) is a national, patient-level, secondary uses data set which captures key information at each stage of the maternity care pathway. Under the MTP, the MSDS was significantly updated in April 2019 in order to make sure that the right data is collected from maternity services. However, compliance with the updated dataset is heavily reliant on the maturity of Trusts' Maternity Information Systems, which is variable across the country.

74. Consequently, data quality is currently variable, with many Trusts' submissions containing incomplete data. This impacts the programme's ability to report information in key areas such as provision of Continuity of Carer, which uses complex metrics that are reliant on the submission of multiple data items.

75. We anticipate the £52 million joint support package between NHSX and NHSEI announced earlier this year to accelerate the roll out of digitally mature Maternity Information Systems and women's Digital Maternity Records in line with the Long Term Plan, should help improve data collected by the MSDS, although a mechanism for ensuring that the capture of clinical information in line with any updates to best practice will need to be considered. The funding package will ensure the delivery of three outcomes:

[2] NHS England » Learn from patient safety events (LFPSE) service

76. To empower women through a digital Personalised Care and Support Plan, incorporating access to curated healthcare information and their clinical data, in order to make informed decisions.
77. Improved Patient Safety - Clinicians and other practitioners have access to relevant and timely information at any point of care that allows them to ensure the best health and care outcomes for pregnant women.
78. Digital Maturity - Improving the user experience for clinicians and women including the reduction in burden of data entry, on reducing duplicate data entry and driving towards a paperless environment.
79. Safety Action 2 of the CNST MIS will also target improving MSDS data in key areas, as it has done successfully in previous years.
80. A publicly available Maternity Services Dashboard also presents Trusts' clinical data drawn from MSDS and national maternity indicators from other sources such as MBRRACE-UK and the CQC to enable comparison between organisations and identification of areas for local quality improvement. The dashboard also provides an indication of where gaps in MSDS data lie.

Recommendation 8 – Implementing the Rapid Redress and Resolution Scheme

Recommendation 8 - While the review of the negligence system is underway, we recommend the Department must implement the Rapid Redress and Resolution Scheme in full. We also recommend the Department provides the Committee with the scope and timetable for its review of clinical negligence by September 2021.

Response

81. We reject this recommendation. The Government does not intend to put in place a Rapid Redress and Resolution Scheme, as explained in the Department's evidence to the Committee in February 2021.
82. The Department consulted on the Rapid Resolution and Redress scheme in 2017. The consultation proposed to offer a voluntary administrative alternative to tort-based redress for birth injuries, along with strengthened early support for families, and maternity investigations.
83. Following consultation, the Department decided against the introduction of the Rapid Resolution and Redress scheme, as several of the benefits it may have delivered had been achieved through other parallel initiatives, including NHS Resolution's Early Notification scheme and HSIB's independent maternity safety investigations.
84. The scheme also did not address the high and rising cost of clinical negligence cases.

Recommendation 9 – Litigation Reforms

Recommendation 9 - We recommend that following that review, the Department brings forward proposals for litigation reforms that award compensation for maternity cases based on whether an incident was avoidable rather than a requirement to prove clinical negligence. That approach would allow families to access compensation without the need for the courts in the vast majority of cases and establish a substantially less adversarial process.

Response

85. In order to continue to improve patient safety and address the rising costs of clinical negligence, the Government announced in Spending Review 2020 that it will publish a consultation on these issues. Decisions on next steps will be taken following the consultation.

Recommendation 10 – Standardisation of Compensation

Recommendation 10 - In addition, we recommend that the Department and NHS Resolution remove the need to compensate on the basis of private healthcare provision where appropriate NHS care is available; and that compensation is standardised against the national average wage to prevent unjust variability in compensation payouts.

Response

86. The Government plans to consult on next steps to address the rising costs of clinical negligence. Decisions on next steps will be taken following the consultation.

Recommendation 11 – The role of the professional regulators in helping to end the blame culture

Recommendation 11 - Finally, given their recognition of the role the professional regulators have in ending the blame culture, we recommend that the General Medical Council and the Nursing and Midwifery Council review what changes are required to their remits or working practices to reduce the fear clinicians have of their regulators and allow them to open up more about mistakes that are made.

Response

87. We welcome the Committee's recommendation that the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) have a role to play in helping to end the blame culture that currently exists in the health sector. DHSC is working with the GMC, NMC and other partners to ensure regulated healthcare professionals feel supported to speak out when mistakes are made. This will help to create environments that enable learning.

Steps taken by the GMC and NMC

88. The GMC and the NMC both recognise that more needs to be done to address the blame culture and both have undertaken work to support the development of just cultures. This includes the NMC's guidance for employers on referrals, a new resource to support employers to resolve concerns locally, and guidance for professionals on speaking up, as well as its animation titled 'Caring with Confidence'. The GMC's outreach teams have delivered over 400 sessions on raising and acting on concerns about patient safety. These sessions encourage doctors to actively engage with and participate in patient safety improvements and embrace a just culture.

89. The NMC has also prioritised making improvements to its Fitness to Practise (FtP) procedures. It introduced a more systematic approach towards understanding the context in which incidents occur, rather than focussing on the actions of an individual and apportioning blame. The NMC has also recently improved its guidance and support for those involved in FtP procedures. The NMC has plans to publicise and embed these changes and to understand the impact this has on professionals.

90. In 2019, the NMC published its new Future Midwife Standards[3], based on the best global evidence of what is needed to deliver effective and safe care. The NMC is committed to working with partners to embed these important standards across midwifery practice.

91. The GMC recognised that to build trust and confidence as a regulator, it must address any perception of fear that registrants may have. The GMC has reported that the number of cases relating to clinical error brought before Tribunals is very small and their evidence suggests a consistent trend towards fewer cases. The GMC has developed guidance and resources to support both doctors and employers in raising and acting on concerns and to better understand the effect of human factors when things go wrong.

92. In 2018, the GMC commissioned three independent reports[4] aimed at supporting a profession under pressure and improving the GMC's relationship with doctors. The GMC has taken many steps to address the recommendations outlined in the reports and although the scope of this programme is wide, there is commonality across all three reports in respect of emphasising the need to move from a blame to a learning culture.

[3] NMC publishes new future midwife standards - The Nursing and Midwifery Council

[4] Independent review of medical manslaughter and culpable homicide - GMC (gmc-uk.org), Fair to refer - GMC (gmc-uk.org), UK-wide review of doctors and medical students wellbeing - GMC (gmc-uk.org)

Reform

93. DHSC has consulted on extensive changes to the legislation of all the healthcare professional regulators including the GMC and NMC. Proposed changes will include; providing greater discretion to determine which FtP complaints should be investigated; greater scope for resolving complaints through a process of agreed outcomes without the need for formal FtP Panel/Tribunal hearings; and removing the GMC's power to appeal decisions of the Medical Practitioners Tribunal.

94. DHSC is working to introduce legislation for these reforms in the course of 2022. These changes will support the GMC and NMC in putting in place FtP procedures which are less adversarial.

Next steps

95. A key strategic theme in the GMC's 2021-25 corporate strategy[5] is 'enabling professionals to provide safe care'. The GMC is scoping how it can take this forward. Examples relevant to recommendation 11 include; collaborating with the NMC on a virtual version of Professional Behaviours and Patient Safety (PBPS) programme, with a plan to pilot with a focus on maternity services; and piloting an updated Responsible Officer referral form as part of its work on Fairer Employer Referrals.

96. The NMC corporate strategy 2020-2025[6] sets out its commitment to learning the lessons from inquiries into major failings of care. The NMC has committed to a new and more dynamic approach to developing professional standards, to reviewing its Code and to evaluating the initial impact of its new FtP initiatives. To further improve patient safety and system-wider learning, the NMC is piloting work with the GMC and the CQC to share data and support safe cultures; and working together with the HSIB to collaborate on information sharing.

97. The NMC has recently commissioned research to understand how its registrants, the public, employers and its partners understand and engage with it as a regulator. As part of this research, the NMC will explore maternity services, patient safety, and blame culture. The NMC will use this information to develop its communication and engagement approaches.

[5] corporate_strategy_document_final_en_04122020.pdf (gmc-uk.org)
[6] Our strategy - The Nursing and Midwifery Council (nmc.org.uk)

Providing Safe and Personalised Care for All Mothers and Babies

98. The Government welcomes the Panel's acknowledgement of the importance of personalised care for women and the need to fully embed the principle of informed consent into service delivery.

99. The Government is committed to delivering safe and personalised care for all women and their babies.

100. Our vision is that our staff of all professions and disciplines will work together with women and families to deliver co-produced personalised and safe care.

101. Current programmes are focusing on multi-disciplinary training and team working, addressing barriers to escalation, ensuring organisations are more responsive to women and family concerns, that models of Continuity of Carer all have a linked obstetrician and that each woman has personalised care informed by shared decision tools that include current evidence about short and long term risks and benefits; using best principles of risk communication.

Recommendation 12 – Continuity of Carer

Recommendation 12 - Having the right skill set, as noted above, is crucial for the successful implementation of continuity of carer. We therefore recommend that those involved in delivering this model have received appropriate training and that all professionals are competent and trained in all areas that they work in, particularly in relation to black mothers where the disparities are the greatest.

Response

102. We accept this recommendation.

103. NHSEI agrees that all professionals involved in maternity care should be competent and confident in all areas of their work, including when working in Continuity of Carer teams or with them.

104. As part of developing local delivery plans, all maternity services will be asked to complete a Training Needs Analysis. This should address updating clinical skills of midwives in Continuity of Carer teams providing care for women throughout the pregnancy journey and across a range of settings, and for midwives providing care to women from diverse ethnic backgrounds and those living in the most deprived communities. A template and best practice guidance on completing the Training Needs Analysis will be shared with maternity services.

105. HEE has provided a national training package on Continuity of Carer since 2018/9. NHSEI will work with HEE to ensure the national training offer for 2021/22 continues to support the areas set out above for newly qualified midwives, experienced midwives transferring into Continuity of Carer teams, and the wider staff involved in supporting these ways of working, such as obstetricians, midwifery leaders and managers and system leadership. The training will also align with the Core Competency Framework described in paragraph 37.

Recommendation 13 – Introducing a target to end the disparity in maternal and neonatal outcomes

Recommendation 13 - Given the underlying causes of these outcomes for women from black, Asian and minority ethnic groups relate to a range of issues beyond the remit of the Department, we recommend that the Government as a whole introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target. The Department must lead the development of a strategy to achieve this target and should include consultation with mothers from a variety of different backgrounds.

Response

106. The Government accepts this recommendation in part.

107. The NHS Mandate[7] sets out an aim of year on year reductions in the difference in the stillbirth and neonatal mortality rate per 1,000 births between that for black, Asian and Minority Ethnic women and the national average.

108. The Committee rightly states, the underlying causes of health disparities relate to a range of issues beyond the remit of the Department. The root causes of disparities in health are a complex interaction between personal, social, economic and environmental factors. The Marmot Review "FairSociety, Healthy Lives" states that to take action on health inequalities, action must be taken across all social determinants of health (PHE, 2017[8]).

109. Pregnancy lasts around 40 weeks, but a lifetime approach is needed to address issues which contribute to maternal and neonatal deaths and to help women prepare for pregnancy.

110. The life course approach to disparities in health indicates that there are opportunities for intervention at many points throughout life. Reducing health disparities through the life course requires a whole-of-society approach dealing comprehensively with all health determinants[9].

111. The health of women as they enter pregnancy remains a major challenge to maternity services, and two-thirds of maternal deaths in the UK are now in women with pre-existing medical conditions. Preconception health describes the health of women and men during their reproductive years. Good preconception health encompasses two main concepts:

- Planning a pregnancy: Enabling women and their partners to choose if and when to start or grow their families
- Fit for pregnancy: Recognising that many pre-pregnancy health behaviours and risk factors are amenable to change

112. Improving preconception health represents an opportunity to reduce maternal and infant mortality and morbidity, prevent non-communicable disease in parents and their children and improve intergenerational health.

113. In the UK, preconception health is frequently affected by excess maternal weight, dietary deficiencies, smoking, excessive alcohol consumption, mental health issues, and recreational drug use, all of which are associated with poorer pregnancy outcomes and frequently rooted in social and economic deprivation.

[7] The government's 2021 to 2022 mandate to NHS England and NHS Improvement (publishing.service.gov.uk)
[8] Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk)
[9] https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach

114. The Department and its ALBs are undertaking a range of work in relation to public health to help women, including those in the preconception period, to be as healthy as possible. This includes work on smoking cessation, promoting a healthy lifestyle and healthy eating.

115. The new Office for Health Improvement and Disparities (OHID) will be established on 1 October 2021. The OHID will target health disparities, including racial and ethnic disparities in health, focusing on research, communications and expertise to reduce health disparities across all groups. The OHID is committed to improving preconception health from a universal and targeted perspective.

116. For the past three years NHSEI have been working to address the findings of the MBRRACE-UK reports[10] about maternal and perinatal mortality, which show worse outcomes for mothers and babies from black, Asian and Mixed ethnic groups and those living in the most deprived areas.

117. Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer and Misha Moore, the National Specialty Advisor for Obstetrics - Public Health, are leading this work. The work aims to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes for mothers and their babies.

118. During 2021-22, NHSEI will launch the 'Core20PLUS5' (Most deprived 20% of our population plus other population groups as identified by local population health data e.g. ethnic minority communities) initiative to drive targeted health inequalities improvements in key areas including Continuity of Carer. Further, through the Innovation and Technology Payment (ITP) programme, NHSEI is supporting the NHS to adopt Placental growth factor (PIGF) based tests to help rule out pre-eclampsia quickly so that pregnant women receive the most appropriate care. Pre-eclampsia is more prevalent in black women.

119. The Maternity Transformation Programme is a priority programme in terms of addressing health disparities. Interventions to tackle health disparities feature in the NHS Long Term Plan, Phase 3 planning guidance and the 2021/22 planning guidance (implementation guidance) [11]which commits to the publication of equity and equality guidance and asks LMS's to coproduce Equity Action Plans by 28 February 2022.

120. Further information is set out in 'the Government's response to the Health and Social Care Committee's Expert Panel's Evaluation of the Government's progress against its policy commitments in the area of maternity services in England'.

121. Given that the social determinants of health are beyond the control of health services - requiring sustained and significant action across government, businesses and civil society - it would not be appropriate to set the NHS a hard target for a specific level of reduction in a particular health disparity over time. Instead, NHSEI have taken the approach of first setting metrics which have sufficient sensitivity (statistical power) to track changes in clinical outcomes for the groups most at risk, and second – through the equity and equality guidance - to identify priorities, design evidence-based interventions to address those priorities and promote an approach of continuous quality improvement.

122. For this reason, the NHS will measure progress against its equity aims for mothers and babies through metrics described in the Equity and Equality Guidance for LMS's.

[10] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | NPEU (ox.ac.uk)
[11] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

Perinatal mortality metrics

Indicator: The stillbirth and neonatal mortality rate per 1,000 births for black and Asian babies divided by the rate for white babies in the UK, expressed as a ration. Source: MBRRACE-UK		
Accountability arrangements	**Baseline (2017)**	
Long Term Plan headline metric	**1.7**	

Indicator: The modelled difference in the stillbirth and neonatal mortality rate per 1,000 births between the most deprived and the least deprived communities in England, measured using the slope index of inequality. Source: ONS		
Accountability arrangements	**Baseline (2017)**	
Long Term Plan headline metric	**4.39**	

Plans for an English Maternal Morbidity Outcome Indicator

123. Whilst even amongst women from black ethnic groups maternal deaths are rare, for every woman who dies 100 women have a severe pregnancy complication or 'near miss' - when she survives but often with long term health problems. Disparities in the numbers of women experiencing a near miss exist between different ethnic groups. Near misses are more common than maternal deaths, so we can investigate disparities at LMS or regional level to assess local variation and identify areas with best practice.

124. The Policy Research Unit in Maternal and Neonatal Health and Care has been asked by the DHSC to investigate disparities in 'near misses', through the use of the English Maternal Morbidity Outcome Indicator[12], which assesses the rates of various pregnancy complications and can, in contrast to investigation of maternal deaths, be compared across regions or LMS's.

[12] Nair M, Kurinczuk JJ, Knight M (2016) Establishing a National Maternal Morbidity Outcome Indicator in England: A Population-Based Study Using Routine Hospital Data. PLoS ONE 11(4): e0153370. DOI: https://doi.org/10.1371/journal.pone.0153370

Recommendation 14 – Choices at Birth

Recommendation 14 - We recommend that NHS England and Improvement establish a working group comprising of women and their families, organisations providing support for women throughout their pregnancy and clinicians to develop a set of actions for maternity services to consider in order to ensure no woman feels pressured to have a vaginal delivery and is always informed clearly what the safest option is for her birth. The working group's remit should also include researching and addressing the wider societal factors, including media and social media, that put pressure on women to want to have an unassisted birth.

Response

125. We accept this recommendation in part.

126. NHSEI acknowledge concerns about a focus on "normality at any costs". Our vision is that our staff of all professions and disciplines will work together with women and families to deliver co-produced personalised and safe care. Current programmes are focusing on multi-disciplinary training and team working, addressing barriers to escalation, ensuring organisations are more responsive to women and family concerns, that models of Continuity of Carer all have a linked obstetrician and that each woman has personalised care informed by shared decision tools that include current evidence about short and long term risks and benefits; using best principles of risk communication.

127. NHSEI acknowledge this work needs to be prioritised in maternity services and have established an improvement oversight group with a workstream that focusses on personalised care and support planning. A key element of this work is the development and implementation of the iDecide framework, which will be accessible to all women via a digital platform and facilitates informed consent incorporating the Montgomery standard. We are working collaboratively with the Personalised Care Institute to develop tools which provide decision support training for all Health Care Professionals.

128. Our work is informed by services user representatives who are an integral part of our programme planning – they inform and shape our programmes of work to ensure that the needs of women and their families are central. Our ambition is that through a process of shared decision making every woman has a Personalised Care and Support Plan in place by March 2022.

129. To address the issues around terminology the RCM have convened the Re:Birth Project established in June 2021 to undertake a research led structured approach to developing an agreed consensus view among members of the maternity community in the UK (the Royal Colleges, NHSEI, health professionals and service users) around some of the language used to 'name' the different types of birth. We look forward to reporting on the findings and recommendations of this important work.

Recommendation 15 – Caesarean Section Rates

Recommendation 15 - It is deeply concerning that maternity units appear to have been penalised for high Caesarean Section rates. We recommend an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently. NHS England and Improvement must write to all maternity units to ensure that they are aware of this change.

Response

130. We accept this recommendation.

131. NHSEI agrees that caesarean section rates should not be used to performance manage Trusts and supports the use of the Robson criteria to measure caesarean section rates more intelligently.

132. Robson group data is collected as part of the MSDS. The National Maternity Services Dashboard which uses data from the MSDS, has the capability to display Caesarean rates by Robson groups where trusts can compare themselves against other trusts within the same MBRRACE-UK group or nationally by quartiles, to identify areas for quality improvement.

133. LMS's and regions have already been informed of this via a national maternity bulletin. Data quality is variable, as outlined in paragraph 74, but there is a plan to address this as set out in paragraph 75. NHSEI will cascade a further communication that advises against the use of total caesarean rates as a means of performance management, and instead encourages the importance of using Robson group data on caesarean section rates intelligently for quality improvement purposes.

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