Department of Health & Social Care

National Maternity and Neonatal Taskforce: meeting note

15 September, 3.30pm to 5pm, 39 Victoria Street, London

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Overview

The Secretary of State for Health and Social Care, the Rt Hon Yvette Cooper MP, chaired the fourth meeting of the National Maternity and Neonatal Taskforce. The purpose of this meeting was to discuss the strategic approach to developing the national action plan following expert reference group discussions over the summer. This included the proposed approach to the workstream on racism, discrimination and inequalities and the workstream on investigations and reviews.

Members also reflected on the Thirlwall Inquiry Report published earlier that day, and the need to ensure that patient safety and neonatal care are included in the action plan. The Secretary of State made some membership announcements, including Frankie Swords, NHS England and DHSC National Medical Director and Louisa Hendrickson, Director and

Founder of Zion's Lighthouse, joining the Taskforce, and the establishment of a new system leadership, delivery and implementation expert reference group.

Opening discussion

The Secretary of State reflected on the publication of the Thirlwall Inquiry report earlier that day and her concern that some of it reflected the downgrading of a priority on maternity and neonatal care within hospitals. She spoke of the need to ensure patient safety and safeguarding are a core part of care, and emphasised that maternity and neonatal care is a priority for her.

Taskforce members introduced themselves and their top priorities for the Taskforce, as well as sharing their personal experiences and why they are involved in this work. These included ensuring that families' voices are heard, decisions are evidence-based, the importance of clear priorities for the system and safe staffing, and strengthening accountability across maternity and neonatal services. Members also highlighted the need to rebuild trust with families, reduce unwarranted variation in outcomes and experiences, and deliver lasting, meaningful change through the Taskforce's reforms.

The Secretary of State announced recent changes to the membership of the Taskforce. Louisa Hendrickson, Director and Founder, Zion's Lighthouse, had been appointed as co-chair of the charity and third sector expert reference group and would therefore be joining the Taskforce. Lauren Caulfield, family representative, had been appointed as co-chair of the health equity expert reference group. Professor Frankie Swords, NHS England and DHSC National Medical Director, had also been appointed to the Taskforce.

The Secretary of State announced the establishment of a new system leadership, delivery and implementation expert reference group to ensure Taskforce discussions reflect delivery feasibility.

Forward look and approach to action plan development

Anna Sanders, Director in the Department of Health and Social Care, outlined the proposed strategic approach and methodology to developing the action plan. She provided a high level forward look for the Taskforce and expert reference groups. She acknowledged the tension between taking urgent, immediate actions while also ensuring taking time to think through the shifts needed to deliver real, systemic change.

Anna outlined the key workstreams going forward, which were based on the recommendations from Baroness Amos's National Maternity and Neonatal Investigation,

Donna Ockenden's review into Nottingham University Hospitals NHS Trust and additional work areas previously agreed by the Taskforce. She highlighted that the action plan will be a milestone but that development of these reforms to maternity and neonatal care would continue beyond that. Given interdependencies across the workstreams we need to maintain an overview of the whole package.

Racism, discrimination and inequalities

Taskforce members were invited to share their views on the proposed problem statement, objectives, analysis of the recommendations and next steps for the racism, discrimination and inequalities workstream.

Taskforce members were supportive of the objectives and strategic approach proposed to tackling racism, discrimination and inequalities in maternity and neonatal care, and the proposed next steps. They emphasised the need to include deprivation, and Anna noted the need to pin down specifically what areas of diversity the Taskforce wants to cover. It was noted that a cross-government approach may be needed. A "test and learn" approach might be needed to evaluate interventions given lack of evidence.

Members felt that continuity of care for those affected by inequalities was particularly important, including the wider multidisciplinary team where appropriate. It was flagged that some people experience inequalities due to harm in maternity and neonatal services, such as disabilities (including secondary victims, who can experience mental health issues).

The proposed actions relating to the Nursing and Midwifery Council (NMC) and General Medical Council (GMC) monitoring referrals through an inequalities lens were noted, but it was felt wider action relating to staff experience was also needed. Members also emphasised the importance of clear priorities and expectations for providers to support delivery, given the range of existing commitments.

The need to collect and evaluate data consistently is important, including comparison with international data. Some things could be done at a national level, such as training and guidance on data use, with trusts adapting for their local population. The importance of ensuring that family voices continue to inform implementation was highlighted, alongside the need for leaders to remain accountable for delivery and responsive to feedback on impact and emerging priorities.

The Secretary of State reiterated the need to ensure that Trusts respond to their local communities, underpinned by a strong national evidence base.

Investigation and review landscape

Taskforce members were invited to share their views on the proposed problem statement, objectives, analysis of the recommendations and next steps for the workstream on maternity and neonatal investigations and reviews.

Taskforce members discussed the need to understand current barriers stopping families from accessing the honest answers they need. It should not be up to the family to prompt investigations and reviews as trusts should be proactively considering what went wrong themselves. Members also spoke about the need for independence within investigations from the start rather than an option at the end. They raised the need for clinicians and Trusts to be transparent and open with families about what happened and concern that the legal framework undermines this. The legal process (for clinical negligence) can be extremely distressing for families and is protracted, nor does it cover 'secondary victims'. There was recognition that these issues need to be considered with relevant partners, such as the Ministry of Justice.

Members emphasised that a culture of openness and transparency is key, with leaders exemplifying it themselves. Open communication and support when things go wrong would help to rebuild trust in the system, for both families and staff. Taskforce members discussed the need for timeliness in the investigation process, but not at the cost of quality. They emphasised the need for visible, transparent learning to show families that what happened to them is leading to tangible change. They also spoke about the need for trusts to share good practice and learning with each other. International examples could help, for example a new system for prevention and investigation has been implemented in Norway that could be learned from. Members also spoke about accountability and whether CQC fines as an accountability approach are a sufficient mechanism to hold trusts to account.

There were brief remarks about the Taskforce's process for developing the action plan and addressing recommendations from key reports. The Secretary of State confirmed this would be discussed in upcoming meetings.

Members agreed that to improve the investigatory and review landscape, there is a need to consider actions in addition to those recommended in key reports and a full-scale review of the investigatory landscape is required.

Closing remarks and any other business

The importance of the Maternity and Neonatal Commissioner role was discussed. It was confirmed that there will be flexibility to iterate further once the legislation has gone through Parliament.

Members reflected on the need to ensure neonatal care is included in the action plan considering the Thirlwall Inquiry report; and perinatal mental health. The Secretary of State noted the importance of perinatal mental health in the mental health strategy as well.

The Secretary of State outlined next steps for the Taskforce and its expert reference groups, including the Taskforce and expert reference group event on 21 September, which would focus on listening to women and families. She spoke of her keenness to meet with families; before thanking the Taskforce members for their time and insight.