Submission from AIMS to the Health and Social Care Committee Inquiry: Delivering Core NHS and Care Services during the Pandemic and Beyond

7th May 2020

1. Since 1960, AIMS has been a leading advocate for improvements in UK maternity care. We have national and international links and a membership of midwives, health visitors, obstetricians and lay people. Collectively, our volunteers have decades of experience researching, advocating on and campaigning for improvements in UK maternity care. Importantly, we also support women directly to navigate the maternity system. We use our knowledge, influence and experience to instigate policy change at local and national level. We run an email and telephone helpline which provided support to more than 400 women during 2018/19. We also have a large network via our volunteers and members, who engage with mothers, health care providers and others on social media and at meetings. We provide information on our website and in a series of books. This information is produced to help women to make informed decisions about their care, and to challenge misinformation.

2. AIMS has been highly impressed at the speed with which the professional bodies, in particular the Royal College of Obstetricians (RCOG) and the Royal College of Midwives (RCM), started work on producing guidance for NHS staff and service users as the coronavirus pandemic first established itself in the UK. Their guidance has been regularly updated, in a way which has demonstrated a willingness to listen to a wide range of stakeholders.

3. On the other hand, we feel that there was an unfortunate delay in the production of guidance to Trusts from NHS-England: their guidance was published on April 9th 2020, by which time the guidance from the professional bodies was up to version 7. We also note that the NHS-England guidance has not so far been updated to take on board stakeholder comments. AIMS commented on the NHS-England guidance, and our comments can be found at www.aims.org.uk/campaigning/item/response-clinical-guidance-coronovirus.

4. We feel that earlier guidance to NHS Trusts might have avoided some of the unnecessary disruption to services that service users have experienced. That said, we look forward to seeing the impact of this guidance, which we hope will encourage local decision-makers to make robust and transparent decisions around maternity service provision in the current

period. We also hope it will introduce a joined-up approach to the sharing of good practice and information across the UK. We have yet to see evidence of the benefits of the governance framework set out in the guidance, however, and look forward to a robust evaluation of how well the proposed framework, including a formal role for the newly appointed regional Chief Midwives, has worked.

5. Overall, AIMS has been concerned about the ability of the maternity services to maintain a consistent service to women and families across the country during the early stages of the pandemic. We also feel that individualised care for women and recognition of the needs especially of disadvantaged groups, and those with emotional or mental health concerns, has often been lacking.

6. In particular, we have seen a marked difference between the ongoing Trust responses to the crisis. We note that this is reflective of how Trusts have been responding to Maternity Transformation Programme more generally since the launch of Better Births in February 2016. This has resulted in the maternity services on offer across the country being a postcode lottery. We have seen some Trusts adopting innovative solutions to maintain midwife-led birth options and other services. Meanwhile, others have immediately suspended support for all home births and/or closed their midwife-led units without any attempt to explore other options as suggested in the NHS-E and RCM/RCOG guidance.

7. AIMS is hearing from many women being caused significant anxiety over being told (often late in pregnancy) that support for a home birth or access to a freestanding MLU will not be available. For many, this is a key safety issue, having a detrimental effect on their mental health, especially those suffering birth trauma as a result of previous experiences in hospital. Many of these women as a consequence feel forced to decide between leaving their home to birth in hospital or having to birth without the support of a midwife (unattended birth).

8. Similarly, we feel that too many Trusts made upfront announcements to say that they were cancelling services such as elective caesareans, without any transparency around the basis for such a decision.

9. Many of these restrictions in services raise a human rights issue. We understand that, from a legal perspective, Trusts can limit a woman's right under Article 8 of the Human Rights Act to choose the circumstances of her birth if the restriction is lawful, has a legitimate aim (such as protecting the health of others) and if the action taken is proportionate. But in order for a restriction to be proportionate, the Trust Board must show that it has explored all reasonable options to address any hurdles faced, and to review decisions as soon as circumstances change. We would question whether this is happening in most cases.

10. We feel strongly that the divergence in local approaches reflects, at least in part, differences in capacity at the local level for making strategic decisions about the organisation of maternity services, as well as differing levels of commitment to the Maternity Transformation Programme, including its focus on individualised services. AIMS believes that the following examples point to a lack of understanding of how blanket policies work to undermine the safety of individual women, in a way which is likely to impact disproportionately members of disadvantaged groups.

11. Some Trusts appear to have made hasty decisions about accompanying birth supporters during the pandemic that do not seem to be properly considered nor to take account of the individualised impact of this blanket policy. Trusts have refused to allow any birth supporters in some scenarios, neglecting the needs of women for support, including in early labour and during inpatient induction. A blanket policy of only one supporter fails to take account of the needs of women who might require two supporters, for example where English is not the first language or where women with disabilities require additional support.

12. Most Trusts are only admitting birth supporters once mothers are in 'active labour'. It is common for midwives and doctors to only accept that women are in active labour if a vaginal examination has demonstrated 4cm dilation. Thus many women are being forced to have a vaginal examination in order to have their birth supporter admitted, when they otherwise might have declined it. This raises concerns about coercion.

13. The issue of birth supporters accompanying women to ultrasound scan appointments during pregnancy has also become contentious, with some Trusts issuing blanket bans. As well as undermining the clear requirement for decisions about service provision to be proportionate, this demonstrates a highly limited understanding of the vital role that birth supporters play, especially for mothers who have additional needs for support, such as those who have had a previous loss or have mental health issues. It is not simply an opportunity for birth supporters to see the baby, but rather a vital support for the mother, especially if a scan reveals unexpected news about the baby's wellbeing.

14. AIMS would also like to draw the Committee's attention to the potential for changes to services and clinical practice to impact upon maternity outcomes for women and babies. We look forward in due course to seeing a careful review of the outcomes associated with these changes. In making such an evaluation, however, a good understanding of the changes that have been put into place will be vital.

15. One area of confusion relates to the recommended practice with respect to the induction of labour, where we have noted a discrepancy in the RCM/RCOG guidance. On the one hand, it is suggested that induction of labour should be reduced for indications that are not strictly necessary (www.rcog.org.uk/globalassets/documents/guidelines/2020-04-17-coronavirus-covid-19-infection-in-pregnancy.pdf). Yet other RCM/RCOG guidance suggests that the 41 week appointment should include an offer of either outpatient or inpatient induction of labour to avoid a further appointment (www.rcog.org.uk/globalassets/documents/guidelines/2020-04-24-guidance-for-antenatal-and-postnatal-services.pdf). We struggle to see how this makes sense. Any routine scheduling of interventions makes it more likely that women will undergo them, so in this case is likely to lead to more women having inductions that are "not strictly necessary". As a consequence, many women will be exposed to the risks of several extra days in hospital, or of having to go to hospital when planning to birth elsewhere. Any additional time in hospital is known to increase the risk of infection, and this is likely to apply to coronavirus too.

16. AIMS is also concerned about mixed messages being received by women, which has led to much confusion. On the one hand, pregnant women are hearing messages to stay at home and self-isolate, whilst on the other hand they are being urged to attend appointments in places which might strike them as particularly risky. To some extent, this confusion - or

cognitive dissonance - might be understood as inevitable. Evidence seems to be emerging, however, that those Trusts who had done most to meet the vision of the Maternity Transformation Programme before the pandemic, for example by developing a more personalised and decentralised community-based approach to service delivery, including a continuity of carer model of care, are communicating more effectively.

17. The effective delivery of maternity services requires that women have access to good information to enable them to make informed decisions. AIMS is concerned about the accessibility of information for service users, both at the local and national level. Nationally, we believe that professional bodies could do more to make their information accessible to maternity service users, for example those with differing levels of literacy. Locally, we have noted that some Trusts are only putting information about service changes on Facebook: this is not accessible to all, and we would argue that such information should be located on their websites. In some cases, we know that Trusts have been relying on local Maternity Voice Partnerships to share information. This uneven provision of information has left many women confused about what services are and are not on offer and what they can expect from the maternity services: this is a further cause of unnecessary anxiety for women, many of whom are already feeling extremely vulnerable. This highlights a longstanding lack of a robust process by which Trusts communicate with service users. We are also concerned that IT issues suggest a lack of agility on the part of Trusts to update key information on their websites as necessary.

18. Finally, AIMS is concerned - despite the guidance from NHS-E and the professional bodies - that there is in many cases a lack of transparency around local decisions to change the organisation of maternity services, including how these decisions are made, the criteria used, and the frequency with which decisions are reviewed. This works to undermine trust and the opportunity for public scrutiny. AIMS believes that the guidance being provided by NHS-E could go further in supporting Trusts to recognise the importance of this issue, by encouraging a robust governance framework and allowing national maternity leaders to critically review local decisions and promote the sharing of best practice. In maternity as elsewhere, there is an important balance to be struck between national policy and local decision-making: our sense is that an increased level of national leadership is necessary, to ensure that a good level of service is received by all families, wherever in the country they live.