We support all maternity service users to navigate the system as it exists, and campaign for a system which truly meets the needs of all

Submission from AIMS to the Health and Social Care Committee Inquiry: Safety of maternity services in England

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 lay people, doulas, antenatal educators, midwives, health visitors and obstetricians. Collectively, our volunteers have decades of experience researching, advocating 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 is pleased to see the Select Committee focusing on the important issue of maternity safety. We are mindful of the NHS Patient Safety Strategy's definition that "Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare" (NHS England and Improvement, July 2019). From listening to current maternity experiences via our UK-wide helpline, AIMS continues to hear regular accounts of care which fail to meet the safety needs of maternity service users, in either of these ways.

3. We encourage this inquiry to take a holistic view of the meaning of safety in this context and to focus on a broad set of safety indicators. By this we mean in addition to focusing on reducing the risk of short-term physical - and on occasion fatal - harm to mothers and babies, it is also important to focus on reducing damage to the long-term well-being of mothers, babies and the wider family, including their mental health.

4. We believe it is particularly important to ensure that effective care is provided from the start of a woman's maternity journey, to minimise the chances of things going wrong and an emergency arising. This is likely to be more effective in promoting safety than focussing only on putting in place - often more resource intensive - processes or technology to "fix" problems when things have gone wrong, often in the context of an emergency.

5. For AIMS, safe maternity care requires:

    - Maternity services that are **properly resourced**, with access to fit-for-purpose facilities and an adequate number of skilled and experienced staff in place, **working effectively together** as a multidisciplinary team. This includes having processes in place to ensure effective communication and collaboration between all those involved in a woman's and her baby's care, and to escalate any problems swiftly to the appropriate level for support as required.

    - An **effective regulatory system** which promotes a **culture of accountability** and encourages providers, managers and staff to take action that addresses issues identified, rather than seeking to avoid blame. There should also be a culture of continuous improvement, being proactive to ensure safe maternity outcomes as well as learning lessons from previous incidents.

    - A specific focus across the maternity services on identifying the **underlying reasons, structural and cultural, for disparities in maternity outcomes**, such as the significantly higher maternal mortality rates currently seen amongst Black, Asian and Minority Ethnic women, and taking effective action to address these.

    - Care that is rooted in an excellent understanding - on the part of all maternity service staff - of the **physiological process of birth**, and how to support this, coupled with an excellent **understanding of when to act** and what care is appropriate when problems arise. This will be care that is neither 'too much too soon' nor 'too little too late'. This understanding includes how the birth environment works to protect or disrupt physiological birth and therefore its impact on safety.

    - **Respectful, personalised care** which has the flexibility to meet every woman's individual needs - including medical, emotional, psychological and cultural - as well supporting their decisions about their care in pregnancy, birth and postnatally. This means having the resources to give every woman the level of support she needs.

    - The provision of **clear, objective, evidence-based information about all the options** to enable women to make the choices that they believe are right for them and their babies, in the light of all their personal needs - psychological as well as physical. This includes, for example, the evidence on safety of different birth places, the risks and benefits of medical interventions such as induction and planned caesarean birth in different circumstances.

    - Ensuring that staff are aware of their responsibilities to provide all the information that a woman needs, without bias, and to **respect her legal right to make decisions** even if they disagree with them. AIMS hears from many women who have been traumatised by coercive behaviour on the part of doctors and midwives, who have attempted to bully them into accepting a treatment, to the possible detriment of their emotional and psychological well-being.

    - **Relationship-based care (continuity of carer) for all women**, that has been shown to lead to better safety and psychological outcomes. AIMS regularly hears from women that continuity in the person caring for them improved the quality of maternity care, and there is also evidence that it saves babies lives, reduces the risk of premature birth and increases the chances of mothers having a spontaneous vaginal birth.

In this context, AIMS is keen to remind members of the Select Committee of the Better Births report (NHS England, 2016). This report underpins the current Maternity Transformation Programme, and offers a vision of the maternity services (see below) that encompasses each of these components of safe maternity care. This is because the MTP seeks to implement a holistic strategy which seeks to improve safety across the maternity service, by focussing on improvements in a wide-range of areas. As the initial 5-year implementation programme comes to an end in February 2021, AIMS believes that it is important to understand what specific progress has been made relating to each of the report's 28 recommendations and what mechanisms are being put in place to ensure that the report's recommendations will be implemented. We call on the Committee to request such a progress report from The Department of Health and Social Care, as a key contribution to this current review.

The Better Births Vision

> "Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

AIMS believes that fully implementing the recommendations of the Better Births report, in particular those relating to continuity of carer and choice of birth place - both of which have been shown to lead to better outcomes for mothers and babies - would go far to meet the requirements we have identified for safer maternity care. We also believe that the development of community hubs, as recommended in Better Births, will be a key element of a safer maternity service, bringing services closer to the communities they serve, with local maternity service provision integrated well with other local safety-focussed services.

AIMS looks forward to reading the Committee's response to these points in their report.

AIMS, 27th August 2020

References

NHS England (2016) National Maternity Review: Better Births – Improving outcomes of maternity services in England – A Five Year Forward View for maternity care. www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

NHS England and Improvement (2019) The NHS Patient Safety Strategy Safer culture, safer systems, safer patients July 2019 Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf