Response to the Health and Social Care Select Committee call for evidence re Delivering Core NHS and Care Services during the Pandemic and Beyond

About National Maternity Voices:

An NHS Maternity Voices Partnership (MVP) is a multidisciplinary NHS working group chaired by a service user representative; a team of women and families, commissioners and maternity service staff, collaborate to review and develop local maternity care. National Maternity Voices is an association of MVP chairs which connects and represents MVPs in England. We promote effective ways of involving service users in developing maternity services. Our purpose and values can be found here.

Reflections on the delivery of maternity services in England March-April 2020

MVP lay chairs have been valuable as links into the community of expectant and new parents and independent critical friends of maternity services reviewing service changes and communications. They have been most effective where a modest investment had been made in resourcing the MVP and good working relationships had been established.

1. The classification of pregnant women as a 'vulnerable' group on 16th March exacerbated anxiety in pregnant women and midwives were bombarded with questions which they were initially ill prepared to answer. Many women failed to get through to midwives at all and looked to social media for answers. Maternal stress is known to have physical and mental effects on unborn babies e.g. increase the risk of preterm birth. The rapid development of guidance by the joint effort of the Royal Colleges and consistent signposting to the RCOG site helped considerably, though questions relating to local practice remained. There are many good examples of MVPs co-producing information for local families about Covid 19 and service changes e.g.Manchester LMS Covid Q+ A. There remains concern in some areas that key messages such as the 'essential' nature of most antenatal appointments is not well understood by families. This is particularly the case for disadvantaged people e.g. those whose first language is not English. It would have been helpful if coproduced plain English/video/translated versions of information were prioritised earlier.
2. As the pandemic took hold in April, staff sickness together with lack of availability of ambulances led to changes in the services offered. These decisions were taken rapidly and sometimes communicated in ways that increased service users concerns. In some areas MVP Chairs were informed of the proposed changes and given a chance to comment. in some places women had to choose between obstetric unit birth (with attendant risks of intervention and worries about infection) or unattended birth at home. (For women at low risk of complications, NICE recommends that birth in a midwife led unit or at home because the outcomes for babies are no different while intervention rates are lower suggesting unneeded intervention is more prevalent in obstetric units). It is important that women have access to the care that is most suitable for them, recognising it is each woman's own decision about where she would feel safest. Service user representatives have queried and positively influenced both national guidance and local service changes. We welcome NHS England coronavirus specialty guidance issued in April which clearly states the MVP chairs should be involved in review of service changes. Later in April pressure on the NHS eased

somewhat and some services were reinstated e.g. home birth is once more supported in many areas of London. The information about service changes remains patchy and not all providers have up to date information on their websites.

3. Restrictions on visiting hospitals have meant women are asked to go alone to scans. Despite repeated requests in many places there is no flexibility or option for a phone call e.g. for those who are very anxious due to past history such as the death of a baby before birth.
4. There is also concern about the restrictions on parent's involvement with the care for their babies on neonatal units where long-term harm can arise from separation of (particularly) mothers and babies. Visiting restrictions vary and some providers are being creative in the use of digital technology to bring parents and babies together.
5. Antenatal classes have been suspended and post-natal care has been slimmed down. Third sector organisations are helping to fill the gaps especially with telephone/online breastfeeding support, but this relies on parents hearing about these options. In some places the NHS is signposting to these services. Concern remains about the impact on breastfeeding, particularly that areas where rates are low will suffer most from the reduction of support.
6. Where NHS Maternity Voices Partnerships are well established, maternity services have been able to co-produce service changes and communications at speed. The result has been more woman centred services, a reduction in anxiety of the local expectant parents, and less pressure on the front-line staff. Where links with service user representatives are weak and/or MVPs non-existent, service users may be left anxious and disempowered despite the good intentions of NHS staff. The service user representative network has also enabled good practice to be spread rapidly around the country e.g. the use of dedicated Covid query telephone lines. Inconsistencies between providers continue to be challenged. It is vital that MVPs are properly resourced in all parts of England so that the independent service user voices can be heard at local strategic meetings as services normalise. It is also important that provider trusts understand the remit and role of MVP service user chairs at this time.

Questions for the committee to consider

National Maternity Voices would like the select committee to explore how decisions affecting the local provision of maternity care are being made. We would also expect the impact on health inequalities particularly BAME families to be of particular interest.

1. What plans were in place prior to the pandemic to ensure the health of expectant mothers and babies was prioritised in a disaster situation?
2. To what extent is the mental and physical health of mothers and babies being compromised by measures to reduce the spread of infection? Is the potential harm of requiring healthy women to birth in obstetric units understood by Maternity Safety Champions?
3. How are the needs of the BAME population, marginalised and vulnerable groups being met, particularly around communication in different languages and plain English?

4. How can kind, personalised and safe maternity services, which maintain women's human rights in childbirth, be maintained with a reduced and stressed workforce?
5. How will the effects of the pandemic/service changes on premature birth, perinatal mortality, breastfeeding rates and the experience of maternity service users be measured?
6. How are the providers being held to account for service changes being proportionate, given that many commissioners (and indeed CQC and NHSE) are depleted by staff sickness and redeployment?
7. How can the NHS with its multiple organisations more effectively disseminate good practice and also be responsive to local circumstances?
8. What is the NHS doing to ensure the value and practice of coproduction with service users, even when time is short, is more widely understood within its own management, including within maternity teams in trusts.

This submission has been prepared by the committee of National Maternity Voices based on our working knowledge of discussions in the national network in the last few weeks. We would like an opportunity to submit further evidence based on consultation by us with all service user NHS Maternity Voices Partnership chairs in the network.

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