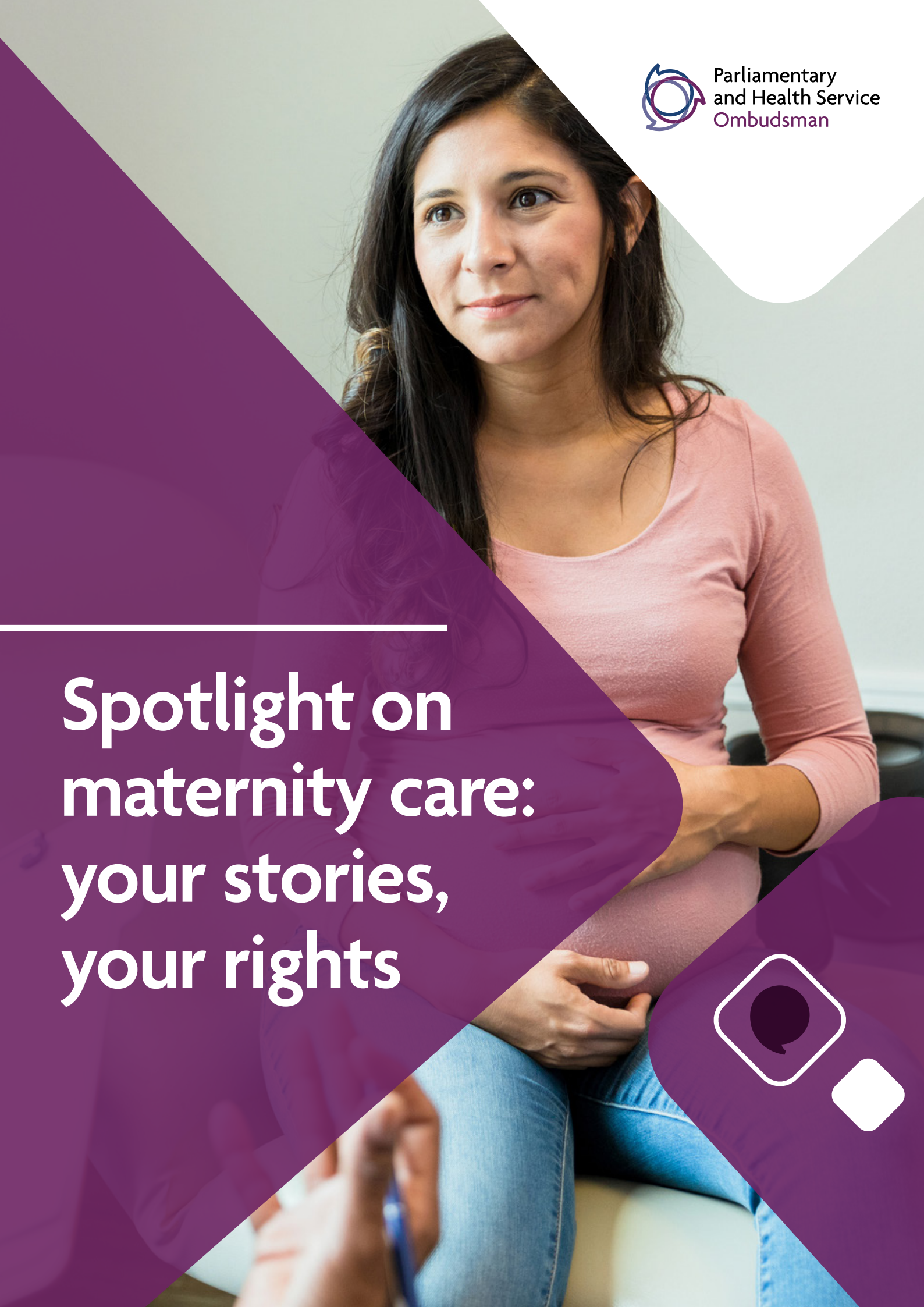


Parliamentary and Health Service Ombudsman

Spotlight on maternity care: your stories, your rights

Contents

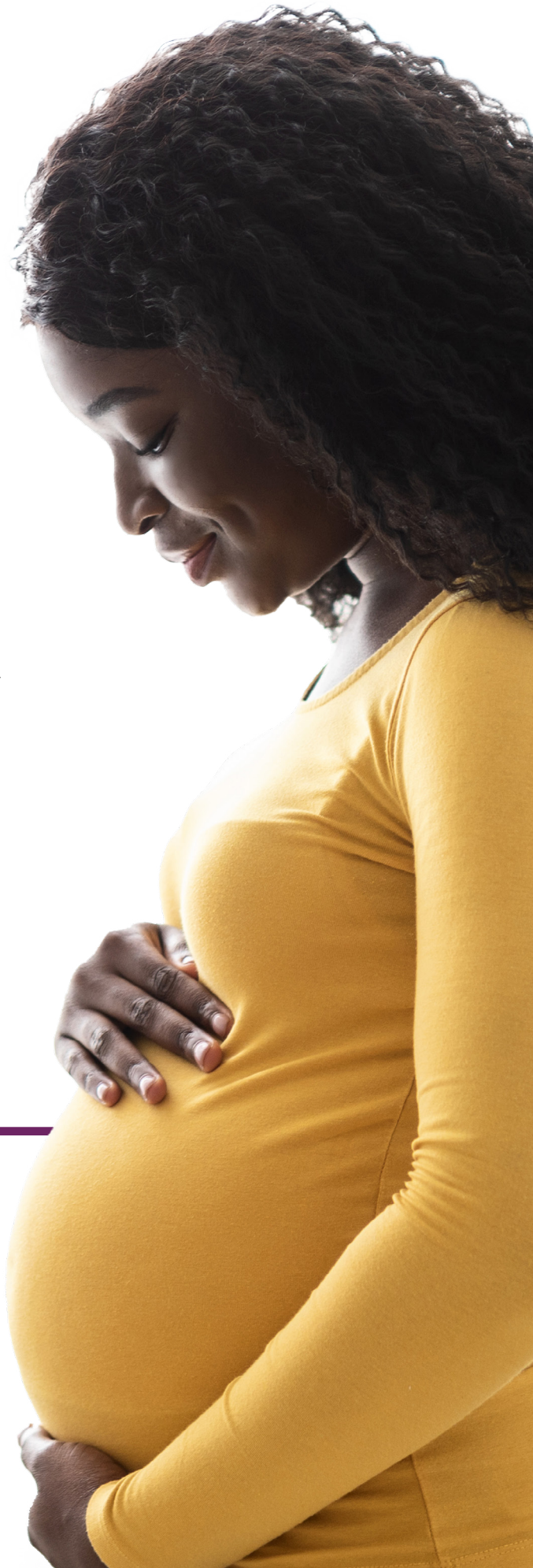
Introduction

Women should be able to have confidence that they will receive safe, effective, compassionate maternity care that focuses on their individual needs.

That is the experience of many people. But too many families still face care that puts the safety and wellbeing of women and babies at risk.

In this report, we look at themes from maternity complaints families have brought to us, to shine a light on their experiences and encourage others to let their voices be heard.

We share case summaries and guidance to help families complain and help NHS organisations understand the issues.



Maternity care issues

Maternity services are in the spotlight. In 2015, the Morecambe Bay investigation found serious failings in maternity care and neonatal (newborn) services, after one mother and 11 babies died.

Since then, maternity services have had more policy recommendations than any other health area. But there have still been major service failures in Shrewsbury and Telford Hospital NHS Trust (the Ockenden review) and East Kent Hospitals University NHS Trust (the 'Reading the signals' report). A further inquiry into maternity care at Nottingham University Hospitals NHS Trust began last year.

If we do not start tackling these issues differently, there will be more tragedies. The repeated failings have led to the Healthcare Safety Investigation Branch's (HSIB) maternity investigation programme, which aims to work with families and Trusts to bring about lasting changes to maternity care.

The latest national maternity survey shows a decline in people's positive experiences of using maternity services. The areas that need improvement include staff availability, confidence and trust, and communications and interactions with patients.

Another recent survey showed that 4 in 5 (84%) women have felt healthcare professionals were not listening to them. Women are not being listened to when they raise concerns about their pregnancies, babies, or their own health. This risk is even higher for women who are Asian, Black or Mixed ethnicity. UK studies, including a recent Birthrights report, have shown these women often had worse maternity outcomes and experiences. They also expressed more worries about labour, birth and possible medical interventions.

In a survey by Five X More, 43% reported feeling discriminated against in their maternity care, with the most common reasons being race and ethnicity. CQC's most recent State of Care report says Black women are four times more likely to die in pregnancy and childbirth than White women. For Asian women it is two times more.

Complaints and failings

The Parliamentary and Health Service Ombudsman shares common themes from complaints we investigate to help NHS organisations improve their services.

We upheld or partly upheld 27 maternity complaints between 2020 and 2022. More than half (65%) of these involved communication issues. We also found failings relating to diagnosis, aftercare and mental health support.

These failings have led to injustices that have serious and long-lasting effects on families' lives.

Investment and change

Many of the issues are well known, and there has been a significant investment of time, energy and money to improve maternity care.

We welcome the £127 million funding boost the Government announced on 24 March 2022 for maternity services across England. We also appreciate the hard work of healthcare staff to improve them, especially when the NHS is under such significant pressure.

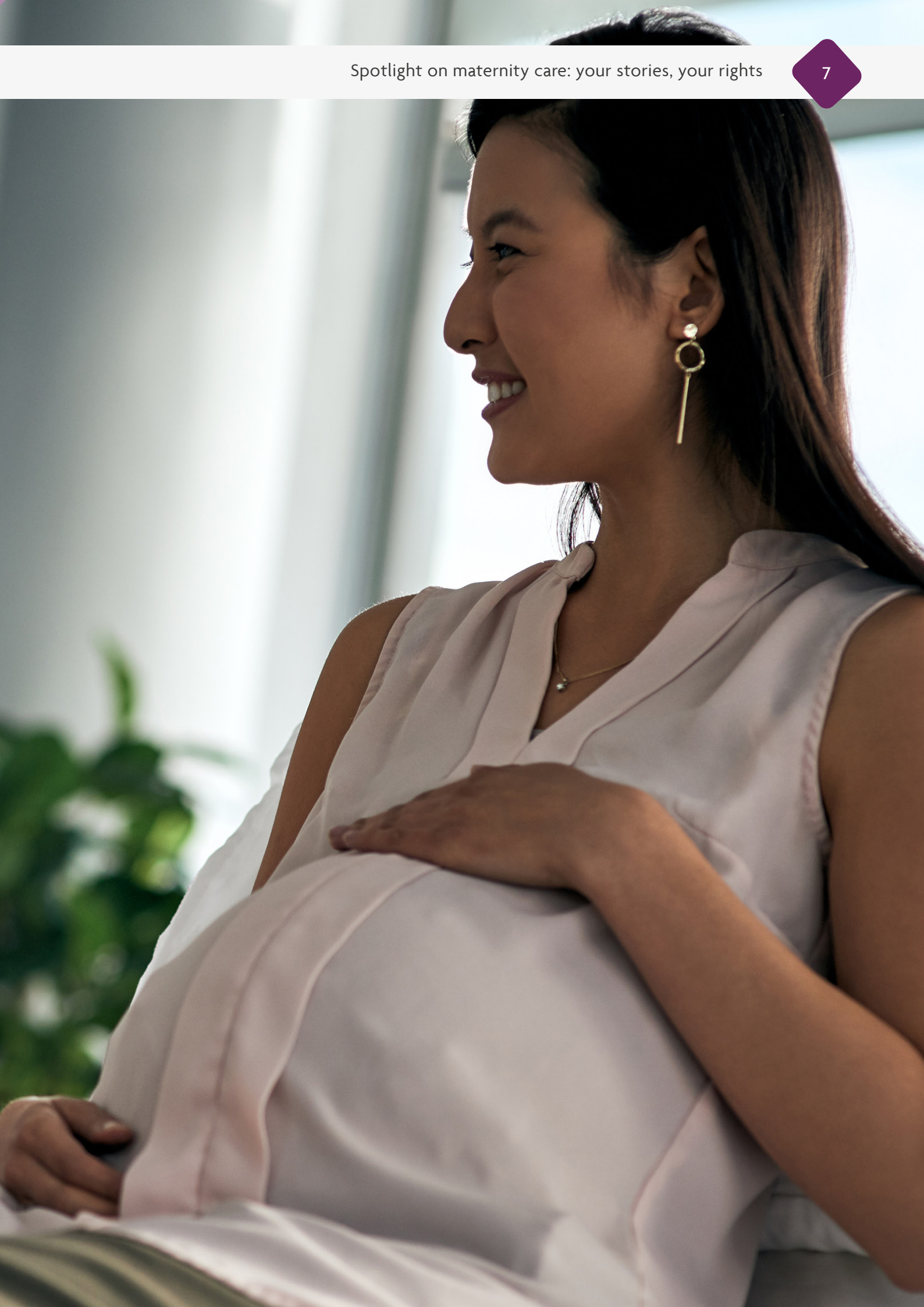
We recognise that people working in maternity services want to provide high-quality care. Culture, systems and processes can get in the way of achieving that goal.

But improvements are not happening quickly enough, and we have not seen sustainable change. We must do more to make maternity services safer for everyone.

Listening to families

Families have explained that they want what happened to them to matter. They want to make sure voices like theirs are listened to and heard. They want NHS organisations to make meaningful and sustained changes so that what happened to them will not happen to others in future.

We hope the stories and guidance in this report will empower more people to share their experiences of maternity care and understand their right to complain. Complaints can make a real difference by showing how the issues are affecting people's lives. They can help organisations to learn from mistakes and improve services for everyone.



Case summaries: sharing families' stories

These case summaries show some of the common themes and missed opportunities we found in maternity complaints.

In cases where we found failings, we looked at how these affected the women and their families, and what the organisation needed to do to address them.

Progressing labour safely

Case 1: Failure to offer to try to start labour sooner

The complaint

Miss C's daughter sadly died ten days after she was born in 2018. Miss C complained about the maternity care and treatment St George's University Hospitals NHS Foundation Trust gave her.

This included her 40-week appointment, her 41-week appointment and when she went into the labour ward to give birth.

She also complained about how the Trust communicated with her and investigated what happened.

She wanted the Trust to apologise, acknowledge its failings and stop them happening again. She also wanted compensation.

What we found

The Trust did not offer Miss C a membrane sweep (also known as a cervical sweep) at her 40-week appointment. This is where the midwife or doctor sweeps their finger around the cervix in an internal examination to bring on labour. This did not happen because the Trust's policy was not clear and was not in line with National Institute for Health and Care Excellence guidance.

It was a missed opportunity because the results could have sent Miss C into labour sooner. She believed going into labour sooner may have given her baby a better chance of survival.

We also found failings in how the Trust investigated what happened. The detailed investigation started almost four months after Miss C's baby died.

The Trust should have reported the death as a serious incident within two days and completed the investigation within 60 days. This uncertainty around the investigation made Miss C's distress worse.

Putting things right

We said the Trust should acknowledge the issues with its policy and explain how it will offer sweeps in line with national guidance.

We also said the Trust should explain how it will carry out serious incident investigations in line with national guidance and tell parents about the investigation.

We recommended the Trust pay Miss C compensation for how its failings affected her.

Treatment and guidance

Case 2: Failure to provide support and appropriate care

The complaint

Mrs C complained that Portsmouth Hospitals NHS Trust did not give her proper care in 2021.

When she was just under five months pregnant, she went to the Trust's emergency department because she was having cramps. Staff told her a gynaecologist (a doctor who looks at reproductive health, including early pregnancy problems) would come to see her. She waited hours but nobody saw her or moved her to a bed or room. She then had a miscarriage in the toilet.

She said that this affected her employment, personal relationships and housing.

What we found

The Trust did not give Mrs C a gynaecology review when she arrived at the emergency department. If it had done this on time, staff would have identified a possible miscarriage and could have prepared Mrs C and supported her.

Because Mrs C was not examined or told what was happening, it left a question in her mind about whether the miscarriage could have been avoided. The Trust missed an opportunity to fully prepare Mrs C for the death of her baby.

The Trust could not have stopped the miscarriage and it did not happen because of a failing in its care. But the experience had a long-term, negative effect on Mrs C.

Putting things right

We could see the Trust took Mrs C's complaint seriously and recognised it made mistakes in the service it provided. But we did not think it had done enough to put right how its mistakes had affected Mrs C.

We said the Trust should pay Mrs C compensation for how its failings affected her.

Aftercare

Case 3: Failure to offer support and follow-up appointments after miscarriage

The complaint

Ms U complained about the care and treatment Cambridge University Hospitals NHS Foundation Trust gave her in 2019. She said it had a negative effect on her mental health.

She said she phoned the Early Pregnancy Unit and told them she was suffering pain and bleeding and thought she was having a miscarriage. A few days later she told them she had miscarried.

She said the healthcare support worker she spoke to did not show compassion, offer advice, arrange follow-up care, or cancel letters about pregnancy.

She also complained about how the Trust handled her complaint.

She wanted the Trust to improve its service to avoid making the effects of miscarriage worse for other women. She also wanted compensation.

What we found

Guidance says healthcare professionals must treat people with early pregnancy complications with dignity and respect. It says they must give information and support in a sensitive way and should have training on how to do this.

The Trust did not discuss pregnancy complications and miscarriage sensitively with Ms U during either phone call.

The healthcare support worker who spoke to Ms U was new. They apologised and said they would learn from the experience, but that was not enough to put things right.

Guidance says the Trust should arrange physical and mental health assessments after miscarriage and offer counselling if needed. It did not offer follow-up appointments after Ms U miscarried.

Because of this, the Trust missed more than one opportunity to assess and treat Ms U's mental health. This added to her distress.

The Trust investigated what happened, but it delayed sending its final response to Ms U and did not update her when it said it would. It apologised for this.

Putting things right

We said the Trust should look at its training and monitoring for new Early Pregnancy Unit staff, to see if it gives them knowledge and skills to discuss problems sensitively with patients.

We also said the Trust should make an action plan explaining why it failed and how it will make sure no other patient has the same experience.

We recommended the Trust pay Ms U compensation for how its failings affected her.

Communication

Case 4: Failure to communicate treatment options, what to expect and funeral information after miscarriage

The complaint

Miss O complained about the care and treatment Barts Health NHS Trust gave her in 2020.

After going to a labour ward in hospital, she sadly miscarried her daughter.

She said staff did not discuss pain relief with her, did not explain what to expect, left her alone for a long time and did not respond when she asked for help.

She also said the hospital's mortuary did not tell her about her daughter's funeral and where she was buried.

She wanted the Trust to improve its service to stop this happening again. She also wanted compensation to recognise the serious distress the experience caused.

What we found

Healthcare professionals did not discuss pain relief options with Miss O or explain what medication they were giving her.

There was poor communication about what to expect when experiencing a miscarriage in the second trimester (the middle three months of pregnancy, from around week 13 to week 27). This caused Miss O a lot of distress because she did not know what was happening or if her daughter would survive.

There was also a lack of support and observation from staff during her miscarriage. Miss O miscarried her daughter alone, onto the floor, and her partner had to get help.

After Miss O left the hospital, the mortuary service poorly communicated the date for her daughter's funeral, buried her without the family there, and gave incorrect information about where she was buried.

These failings led to Miss O experiencing pain longer than necessary. They made a traumatic experience worse, affected her mental wellbeing, and made her anxious about going to hospital when she became pregnant again. The mortuary's errors added to her distress and affected her ability to grieve.

Putting things right

We said the Trust should improve its service to women experiencing second-trimester miscarriages. This included improving its processes so all women in labour can get one-to-one care.

We also said it should improve the mortuary service's communication about funeral arrangements. This included speaking to family members over the phone where possible.

We said the Trust should make an action plan explaining how it will make these improvements, when it will do this by, and who will do it.

We recommended the Trust apologise to Miss O and pay her compensation for how its failings affected her.

Communication

Case 5: Failure to communicate and follow national guidance

The complaint

Miss A complained about some of the care Barts Health NHS Trust gave her in 2020 during her pregnancy and labour, and after her baby was born.

She complained staff did not investigate her bleeding during her pregnancy and did not give her proper care after her baby was born.

She said staff did not explain her delivery options or give her proper information about the haematoma (a bruise caused by a small pool of blood under the skin) on her son's head.

She said the experience made her feel low and caused her anxiety about whether she will be able to have children in future.

Miss A wanted the Trust to improve its service to make sure this does not happen to anyone else. She also wanted compensation.

What we found

Staff did not do ultrasound scans to investigate Miss A's bleeding during her pregnancy between 3 and 4 January 2020. They should have done. This caused anxiety for Miss A.

When Miss A went back into hospital, staff did not properly explain her delivery options or the induction of labour process (where labour is started artificially). Staff should have explained this clearly.

After Miss A had her baby, her placenta did not deliver naturally as it should. This is called a retained placenta. Staff removed Miss A's placenta manually but did not do it in an operating theatre under anaesthetic, which meant they did not remove a large part of it. This did not follow the Trust's policy. It also meant Miss A experienced pain and needed two more operations months later to remove the rest of the placenta.

Staff did not properly explain the haematoma on Miss A's baby's head to her before she left the hospital.

Putting things right

We said the Trust should make sure its communication is in line with the Nursing and Midwifery Council and General Medical Council standards.

We said it should keep full records of any discussions about scanning women who are bleeding. It should follow National Institute for Health and Care Excellence guidance when it is having these discussions.

We said it should make sure staff know about its policy for manual removal of retained placenta, where this should happen and under what conditions.

We said it should share an action plan with Miss A to explain how it will make these changes to help stop the failings happening again.

We recommended the Trust pay Miss A compensation for how its failings affected her.

Making a complaint to the NHS in England

If you are not happy with the maternity care you have received, you have the right to make a complaint.

Hearing from patients when things go wrong is so important. Sharing your experience can improve services for everyone and help stop mistakes happening again.

This guide tells you how to complain to the NHS in England and what to expect.
You can also read our top tips on how to make a complaint.

How to make a complaint

1. Speak to a member of staff

Before you make a complaint, you could share your views and experiences with a member of staff. Many problems can be sorted out quickly by telling staff about your concerns at the place where you received care.

This could be your midwife, your doctor, or someone else. Feel confident in raising your concerns. Staff should welcome your feedback because it can help to improve services.

2. Get advice from someone not involved in your care

If you want help and advice about making a complaint, there are lots of organisations that can support you.

For example, you can speak to your local Patient Advice and Liaison Service (PALS), the Patients Association or your local Healthwatch.

3. Make a formal complaint to the NHS

If you want to make a formal complaint, you must do this within 12 months of what happened. You can complain to the NHS organisation you are not happy with (such as a hospital or GP practice). Or you can complain to the commissioner of the service, which will either be NHS England or your local integrated care board.

NHS organisations all have their own complaints process, and you can usually find this on their website, at reception, or by asking staff. If your complaint is about more than one organisation, you only need to make one complaint. The organisation that receives your complaint will work with the others to make sure you get a coordinated response.

After you have sent your complaint, the organisation should contact you within three working days to say they have received it. They should explain what will happen next, how they will handle your complaint and how long it will take.

The organisation must deal with your complaint properly and investigate it as quickly as they can. Some complaints will take longer than others. Communication is really important - they must keep you updated throughout the process so you know what is happening.

The organisation should respond to your complaint in writing. This should tell you how they carried out the investigation and what they found. If they have made mistakes, they should apologise to you. They should explain any lessons learned or changes they will make to put things right.

4. Complain to the Parliamentary and Health Service Ombudsman

If you are not happy with how the NHS handled your complaint, you can speak to us to look into it. We are an independent organisation and we do not take sides. Our service is free.

You can complain to us if:

- you have reached the end of the NHS complaints process and you still do not feel the issue has been sorted out
- the organisation has not dealt with your complaint after six months (unless it has explained why it is taking a long time and given you an expected completion date).

Find out more about how to complain to us and how we deal with complaints.

What to expect when you make a complaint

The NHS Complaint Standards explain how NHS organisations should approach complaint handling. They are based on My Expectations, which says what patients want to happen when they make a complaint.

The Complaint Standards say organisations should:

- welcome complaints in a positive way
- be thorough and fair
- give fair and accountable responses
- promote a learning culture.

When organisations meet the Complaint Standards you should feel:

- confident to speak up
- that making your complaint was simple
- listened to and understood
- that your complaint made a difference
- confident to make a complaint in the future.

Where to get more help

If you need help making a complaint, there are organisations that can support you:

- our website has more information about getting advice and support
- Birthrights has information and advice about your rights in pregnancy and childbirth
- Five X More helps Black women and birthing people make informed choices during pregnancy and after childbirth
- Maternity Action has information about maternity rights and benefits for refugees.

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