IN THE UK COVID-19 PUBLIC INQUIRY

CHAIR: BARONESS HEATHER HALLETT

On behalf of the RCM

Gill Walton Statement

First Witness Statement in Module 3

Dated: 17 November 2023

WITNESS STATEMENT OF GILL WALTON (THE RCM)

I am Gill Walton, the Chief Executive of the Royal College of Midwives ("RCM"). My office address is 10-18 Union Street, London, SE1 1SZ.

1. I make this statement on behalf of the RCM in response to a letter dated 31 July 2023 sent on behalf of the Chair of the UK Covid-19 Public Inquiry (the "Inquiry"), pursuant to Rule 9 of the Inquiry Rules 2006. This statement is made for the purposes of Module 3 of the Inquiry, which is examining the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. As requested, this statement focuses on the period of time between 1 March 2020 and 28 June 2022.

2. This statement is structured as follows:
   a) Introduction;
   b) The structure, role and aims of the RCM;
   c) Responding to the pandemic;
      Steps taken by the RCM
      Lack of guidance from central government and NHS England
   d) Continued operation of maternity services;
      Increased use of technology
      Adherence to guidance
      Visiting restrictions
      Lack of PPE
   e) Vulnerable groups;
      Classification of pregnant women
      Black, Asian and minority ethnic (BAME) women

f) Conclusions and lessons learned.
Recommendations

A. INTRODUCTION

3. The RCM is a trade union and professional association representing the vast majority of midwives and maternity support workers ("MSWs") across the UK. It was established in 1881 as the Matron's Aid or Trained Midwives Registration Society, but has existed under its present name since 1947. The union provides workplace advice and support, professional and clinical guidance and information, and learning opportunities through its range of events, conferences and online resources.

4. I joined the RCM as Chief Executive and General Secretary in September 2017. I have been a midwife since 1987. Prior to joining the RCM, I had a wide midwifery experience in the NHS and I was a Director of Midwifery in 4 trusts over 20 years.

5. I have led many transformation programmes for maternity services and been involved in several national maternity-related projects. I have also been involved in national policy and strategy development, including work with the RCM, the Nursing and Midwifery Council ("NMC") and the health departments of the UK and devolved governments.

B. STRUCTURE, ROLE AND AIMS OF THE RCM

6. The role and functions of the RCM are different to that of the medical royal colleges; this distinction is not always appreciated and has led to misunderstanding about what we are competent to do, and what falls outside our remit. For example, the RCM does not set practice standards. Standards for midwifery are set by the NMC, while clinical and other guidelines and standards are formulated by individual maternity providers using the evidence of the National Institute for Health and Care Excellence ("NICE") and NHS England. The RCM has no role, remit or authority to set standards for practice either for individuals or for services. Nor do we have any authority to hold individuals or services to account.

7. What the RCM is, is a voluntary membership organisation which provides professional and trade union services for its members and which advocates for midwives, MSWs and midwifery at local, national and international level. The RCM has offices in the devolved

nations, providing professional advice and employment relations services to RCM members in those countries. In terms of our professional offer, we produce educational updates, best practice briefings and related guidance. We do not have responsibility for services and have no power to compel individual midwives to follow any professional advice. We are a voice for our membership and ensure that a midwifery perspective is heard within policy, political and other professional forums.

8. As a trade union with recognition rights to represent our members in NHS trusts, our role is to ensure that employment and professional disciplinary processes are followed by employers and that our members receive a fair hearing; we also take collective action on behalf of our members where issues and concerns relating to employment, terms and conditions and so on, extend beyond the individual.

9. In the context of the Covid-19 pandemic, it is important to clarify our role and responsibilities, because there were occasions, as our evidence indicates, where we were drawn into actions that should have been the responsibility of the Government, the civil service or arm's length bodies, such as NHS England.

C. RESPONDING TO THE PANDEMIC

10. The Covid-19 pandemic presented particular challenges for maternity services, given the limited scope for delaying or rationing care and treatment, and the additional pressure on services due to the inclusion by the Government of pregnant women in the vulnerable group category, resulting in considerable anxiety for many pregnant women, new mothers and their families. For the RCM, the initial challenge was how to support maternity services, our members and women and families through what was a rapidly evolving and extremely stressful time. Our main aims and objectives were to:

    a) communicate to governments and other decision-makers the unique challenges faced by maternity services;
    b) reassure women and families that midwives and MSWs will continue to provide safe and high-quality care, despite the pressures and constraints that services were operating under; and
    c) ensure that midwives and MSWs' rights at work were protected and that their health and wellbeing were prioritised.

Steps taken by the RCM

11. As the majority trade union for midwives and MSWs, and the professional voice of midwifery, we were conscious of the need to provide trade union and professional leadership throughout. This required us to work in new ways and to operate at an unprecedented speed and level of intensity. We prioritised working in partnership with the Royal College of Obstetricians and Gynaecologists ("RCOG"), to ensure that we provided women and families, and maternity teams, with the best available, most consistent and up-to-date advice and support. Together, we established a guidance cell, which met daily to produce joint updates on care as well as developing more detailed guidance on specific topics, such as the provision of care in midwife-led settings or on antenatal and postnatal appointments.

12. Our Expert Clinical Advisory Group (ECAG) was established to research, develop and formulate guidance for midwives and MSWs on a range of professional and clinical issues, including the provision of antenatal, intrapartum and postnatal care both for women with Covid-19 or Covid symptoms and those who were Covid or symptom free. These briefings were reviewed and regularly updated and shared through our member networks and communication channels. Additionally, we created a Covid-specific webpage where all our briefings and guidance were freely available.

13. ECAG also developed responses to questions from women and families about a diverse range of concerns relating to service provision and care. These Q&As were posted on the dedicated Covid-19 hub on our website and were updated in line with new and emerging evidence. We also responded daily to questions that came through our helpline as well as correspondence from a range of professional and interest groups, such as Maternity Action, Birthrights and the Association for the Improvement of Maternity Services (AIMS). By way of example, see my letter to Professor Soo Downe in March 2020 regarding concerns she had raised about aspects of the service-led response [Exhibit GW/1 - INQ000280419]; our response to an AIMS query in March 2020 regarding maternity care provision in the pandemic [Exhibit GW/2 - INQ000280420]; proposed January 2021 updates to the website Q&As [Exhibit GW/3 - INQ000280421]; and July 2021 Q&As on vaccination in pregnancy and breastfeeding [Exhibit GW/4 - INQ000280422].

14. An RCM Professorial Advisory Group was also established to undertake rapid analytic reviews and inform our professional briefings on induction of labour, optimising maternity

services, birth companionship and staff psychological welfare. See for example the April 2020 rapid analytic scoping review on induction of labour in a pandemic [Exhibit GW/5 - INQ000280423].

15. As a result, the RCM produced an extensive amount of guidance, briefings and analysis related to the provision of maternity care during the pandemic. Guidance and updates were communicated to members via an information hub on the RCM website, media releases on the website, member blogs, podcasts, weekly newsletters and sometimes by letter. Such guidance covered issues ranging from providing postnatal care and the safety of waterbirth during Covid-19 to identifying, caring for and supporting women at risk of or with pre-existing perinatal mental health problems. I do not have any evidence to provide on access to antivirals and other therapeutics for pregnant women or the inclusion of pregnant and postpartum women in clinical trials related to Covid-19. I set out in the table below examples of relevant guidance.

Date	**Summary**	**Exhibit**
21/03/2020	Summary of updated advice for pregnant healthcare workers	[Exhibit GW/6 - **INQ000192259**
06/04/2020	Guidance for midwives on antenatal care for women without suspected or confirmed Covid-19 and living in a symptom free household. Subsequently updated in July and October 2020	[Exhibit GW/7 - INQ000280425]
06/04/2020	Guidance for midwives on antenatal care for women without suspected or confirmed Covid-19 or with a member of their household with suspected or confirmed Covid-19. Subsequently updated October 2020	[Exhibit GW/8 - INQ000280426]
09/04/2020	Guidance for midwives on public health considerations when caring for women during the pandemic. Updated October 2020, January 2021, April 2021 and June 2021	[Exhibit GW/9 - INQ000280427]
09/04/2020	Guidance for midwives on identifying, caring for and supporting women at risk of or with pre-existing perinatal mental health problems. Subsequently updated in January 2021, March 2021 and July 2021	[Exhibit GW/10 - INQ000280428]

09/04/2020	Guidance for midwives on providing bereavement care. Subsequently updated in June 2020, July 2020, April 2021 and September 2021	[Exhibit GW/11 - INQ000280443]
20/04/2020	Occupational health advice for employers and pregnant women	[Exhibit GW/12 - INQ000280449]
23/04/2020	Guidance for midwives on providing postnatal care for women without signs and symptoms or confirmed Covid-19. Updated May 2020, January 2021, September 2021	[Exhibit GW/13 - INQ000280450]
23/04/2020	Guidance for midwives on providing postnatal care for women with suspected or confirmed Covid-19. Subsequently updated in May 2020, August 2020 and January 2021	[Exhibit GW/14 - INQ000280451]
23/04/2020	Guidance for midwives on the safety of waterbirth during Covid-19. Subsequently updated in July 2020, September 2020 and June 2021	[Exhibit GW/15 - INQ000280452]
30/04/2020	Guidance for midwifery services on 'freebirths'/'unassisted births' during Covid-19. Subsequently updated September 2021	[Exhibit GW/16 - INQ000280453]
07/05/2020	Guidance for midwives on providing intrapartum care for women with Covid-19. Subsequently updated June 2020, July 2020 and January 2021	[Exhibit GW/17 - INQ000280454]
07/05/2020	Flowchart for midwives phone for phone triage of pregnant women with suspected/confirmed Covid-19. Updated January 2021	[Exhibit GW/18 - INQ000280455]
13/05/2020	Guidance for midwives on identifying, caring for and supporting women at risk of domestic abuse during Covid-19. Subsequently updated in January 2021 and September 2021	[Exhibit GW/19 - **INQ000119196**
15/05/2020	Guidance outlines principles of care for maternity staff caring for Black, Asian and minority women	[Exhibit GW/20 - **INQ000119185**

01/07/2020	Guidance on whether women should wear face coverings during labour and birth. Subsequently updated October 2020, March 2021 and June 2021	[Exhibit GW/21 - INQ000280458]
15/07/2020	Guidance for members on re-introduction of visitors to maternity units. Subsequently updated October 2020, and February 2021	[Exhibit GW/22 - INQ000280459]
24/07/2020	Guidance for members on appropriate application for virtual consultations. Subsequently updated October 2020, December 2020, January 2021 and June 2021	[Exhibit GW/23 - INQ000280460]
01/11/2020	Guidance includes advice for pregnant workers on managing risks relating to Covid-19	[Exhibit GW/24 - INQ000280461]
22/01/2021	Guidance for midwives on carbon monoxide monitoring. Subsequently updated June 2021	[Exhibit GW/25 - INQ000280462]
18/02/2021	Briefing to support midwives having evidence-based conversations with women and families on impact of Covid-19. Subsequently updated August 2021	[Exhibit GW/26 - INQ000280463]
10/06/2021	Briefing recommendation on re-introduction of parent education classes	[Exhibit GW/27 - INQ000280464]
12/07/2021	Briefing summarises evidence on impact of Covid-19 on minority ethnic women	[Exhibit GW/28 - INQ000280465]

Lack of guidance from central government and NHS England

16. That the RCM produced such an extent of guidance is both a testament to its commitment to the midwifery profession and an indictment of the lack of guidance and leadership provided by central government and NHS England.

17. For example, the RCM, the RCOG and others were asked in March 2020 by the CMO, Jacqueline Dunkley-Bent, to provide advice and recommendations to Government regarding pregnant healthcare workers [Exhibit GW/115 - INQ000339578]. It is not the RCM's role to provide guidance for maternity providers, that is the job of the national Chief

Midwifery Officers ("CMOs"), appointed by their governments and, in England, by NHS England. At the time, the CMOs were not taking responsibility for such guidance, despite the RCM pressing them to show some leadership and set out what the implications were for pregnant NHS staff, as shown in an internal RCM email from March 2020 [Exhibit GW/29 - INQ000280466]. This was all taking place in the context of the Government's decision to classify pregnant women as 'clinically vulnerable', despite there being no clinical evidence at that time that pregnant women who are otherwise healthy have any additional risks of contracting the virus or, in the most part, experiencing a more severe illness. This announcement was made without any consultation with the RCM. Not only did this cause unnecessary anxiety and stress, it placed additional requirements on employers to ensure the health and safety of the pregnant workforce which were not reflected in the clinical guidance. We called for leadership from the Government on this – I said at the time, on 25 March 2020 [Exhibit GW/30 - **INQ000192258** "*We need the Government, through the four national Chief Medical Officers and NHS organisations, to provide urgent clarity on this, to ensure that all pregnant healthcare workers are afforded the right level of safety and support according to the law*". However, such clarity and leadership was not forthcoming.

18. This was a theme that continued throughout 2020. The RCM raised the issue of a lack of guidance for pregnant workers at a meeting of the Public Sector Forum (which brought together public sector unions, employers and the Government, under the auspices of the TUC and the Cabinet Office) on 24 March 2020 [Exhibit GW/31 - **INQ000119022** Then in May 2020, the RCOG, the RCM and the Faculty of Occupational Medicine ("FOM") sent a joint letter to Public Health England ("PHE") [Exhibit GW/32 - **INQ000308952** highlighting that, although we had produced occupational health advice for employers and pregnant women ([Exhibit GW/12 - INQ000280449] referred to above), this was produced as a matter of urgency and was based purely based on clinical evidence. We noted that, when making decisions about the entire population of the workforce who are pregnant, these judgements would need to be informed by additional factors, and we had received numerous requests asking for advice from employers and employees about how the guidance was being interpreted. We explained to PHE that, as medical professional bodies, we did not feel we had the expertise to advise beyond the point at which clinical evidence ends and we felt that occupational health advice for the pregnant population would greatly benefit from PHE's expertise, if they were willing to take that forward.

19. PHE did not reply until almost a month later [Exhibit GW/33 - INQ000280470]. To describe the response as disappointing would be an understatement. It showed no willingness to

engage with the RCM, the RCOG or the FOM on the issues we raised and simply advised that employees should have a risk assessment with their line manager in accordance with their local occupational health policy.

20. This continued into August 2020. The RCM and the RCOG had updated its occupational health guidance, which was included as an annex to the Government guidance on working safely during the pandemic [Exhibit GW/34 - INQ000280471]. However, there were real difficulties in getting Government departments to take ownership of it. The Department for Business, Energy and Industrial Strategy was refusing to publish the guidance and was not responding to requests for a meeting, whilst the Department for Education was effectively wanting to water down the guidance for teaching staff, as evidenced by RCM and RCOG emails in August 2020 [Exhibit GW/35 - INQ000280472] [Exhibit GW/36 - INQ000280473]. As a result, we decided that, if no progress was made, the guidance would be archived and replaced with a statement explaining why, referring enquiries from pregnant employees to their trade union or other relevant organisations such as Maternity Action. Whilst we recognised this would leave a void of guidance, it felt like it might be the only option to get the Government to act.

21. Eventually, in October 2020, the Department of Health and Social Care ("DHSC") agreed that its maternity policy team would 'own' the occupational health guidance for pregnant women in the workplace, agreeing to coordinate any future reviews and updates [Exhibit GW/37 - INQ000280474]. The Government then withdrew the advice in April 2022, which I address later in this statement.

D. CONTINUED OPERATION OF MATERNITY SERVICES

22. From the outset of the pandemic, the RCM and the RCOG were clear that it was vital to maintain all aspects of a safe maternity service and to designate maternity care as an essential service. This was a particularly urgent issue due to the way in which the pandemic exposed and exacerbated already serious staffing shortages in maternity services, with the number of midwives and MSWs absent due to sickness or self-isolation increasing significantly, with some services in London operating at up to 40% below their staffing establishments. Our arguments for the ringfencing of maternity services staff were generally accepted and this quickly ceased to be an issue of concern, following a

meeting with the CMOs for the four nations on 7 April 2020 where reassurances were provided [Exhibit GW/116 - INQ000339579].

23. The challenge of trying to maintain maternity services, while operating with severe staffing shortages, led many service providers to make the difficult decision to rationalise care. This usually took the form of suspending home birth services, temporarily closing birth centres, concentrating intrapartum care within obstetric units and providing some antenatal and postnatal consultations online or by telephone. I exhibit a spreadsheet summarising alterations to maternity services made by trusts in London in response to pandemic during March 2020, by way of example [Exhibit GW/38 - INQ000280477]. A survey of Heads of Midwifery on the impact of Covid-19 on service provision, carried out in March/April 2020 by the RCM, showed that staff shortages were almost double the number pre-pandemic, 80% of Heads of Midwifery reported that face to face visits for both ante and postnatal appointments were now restricted, there had been a slight increase in the number of homebirth services being suspended, but nearly half of services continued to offer homebirth as normal and access to waterbirths was actually increasing, possibly due to greater clarity on how the virus may be transmitted [Exhibit GW/39 - INQ000280478]; [Exhibit GW/40 - INQ000280479]. Furthermore, a survey of senior midwives across the UK, carried out by RCM, found that in April 2020, 29% of midwifery-led units were closed and 4 in 10 senior midwives had had to suspend homebirth services, as we set out in our April 2020 press release [Exhibit GW/41 - INQ000280480]. A 2022 article in the journal 'Midwifery', '*Impact of the COVID-19 pandemic on midwifery-led service provision in the United Kingdom in 2020-21: Findings of three national surveys*', summarises results of surveys of maternity services, including the RCM survey of Heads of Midwifery, into the impact of Covid-19 on the organisation of care, finding that the pandemic led to increased centralisation of maternity care and the disruption of midwifery-led services, especially in the first wave [Exhibit GW/42 - INQ000280481].

24. We recognised that Directors and Heads of Midwifery services were having to make decisions based on being able to provide the safest possible care for women and babies, depending on available staffing levels and local circumstances. Staffing levels, availability of PPE and the capacity of paramedic ambulances all impacted on the ability to provide maternity services, with home birth services being particularly disrupted, as I explained in my oral evidence to the Health and Social Care Committee in May 2020 – the increase in pressure on ambulance service capacity, due to responding to the substantial increase in Covid-19 cases, meant that there was less availability of ambulances to respond to

requests for assistance for women giving birth at home or in midwife-led units [Exhibit GW/43 - INQ000119189

25. Throughout the pandemic, the RCM and the RCOG (with input from others) produced and updated joint guidance for healthcare professionals on Covid-19 in pregnancy, including advice to be shared with pregnant women. The latest version of this guidance, version 16, was published in December 2022 [Exhibit GW/44 - INQ000280483]. We also contributed to clinical guidance alongside the RCOG and NHS England on the temporary reorganisation of intrapartum maternity care [Exhibit GW/45 INQ000421169]. This covered restrictions on visitors, suspension of services and place of birth choices and provided a template as to how to communicate with women and their families. It also advised that Trusts may need to develop a clear standard operating procedure with their regional ambulance service, in the context of issues with ambulance service capacity. This could include local alternative transport pathways for women where a timely response is likely to be delayed, making it clear that women should always be given information that reflects locally agreed pathways for transfer to enable informed decision-making.

26. Furthermore, we wanted to support maternity services to get the message out to women and families that, despite the reduced care options available, maternity services were still open and that women should keep their routine appointments, so that services could maximise their safety – see for example our press release in April 2020 [Exhibit GW/46 - INQ000280485] and the information sheet we produced providing advice to pregnant women [Exhibit GW/47 - INQ000280486]. This was in response to early indications that some pregnant women were reluctant to attend hospital appointments, due to anxieties about Covid-19, and may therefore have been missing consultations or not seeking advice (see for example the April 2020 RCM Clinical Briefing Sheet on 'freebirth' or 'unassisted childbirth' during the pandemic [Exhibit GW/16 - INQ000280453]). We received correspondence from AIMS raising concerns regarding the provision of maternity care during the pandemic and the balance between attending maternity units and receiving home visits, including the provision of antenatal care in the community [Exhibit GW/2 - INQ000280420]. Our response explained that available services did vary at a local level, dependent on staffing levels but that maternity services were putting in place a range of contingencies to facilitate as high quality care as possible, for example including providing some antenatal and postnatal care through telephone and video calls and providing as much antenatal and postnatal care as possible through community midwives, focussing face-to-face contacts on women and families with particular high need. I address the use of technology in further detail in the following section.

27. While restrictions on the availability of home births and care in birth centres gradually eased, ambulance shortages remained a constraint on the ability of services to provide a full range of birth options. This was evident from the questions raised by pregnant women as part of the RCM's January 2021 Q&A update [Exhibit GW/3 - INQ000280421].

Increased use of technology

28. There was a large rise in the use of video and other technology in maternity services during the pandemic. We encouraged services to adjust and adapt, using video or telephone where appropriate, as can be seen from our written evidence and updated written evidence to the Health Committee inquiry into the impact of the pandemic on the NHS in May 2020 [Exhibit GW/48 - INQ000280487]; [Exhibit GW/49 - INQ000280488]. We also published guidance on virtual consultations in August 2020 [Exhibit GW/50 - INQ000280489]. However, we stressed that in-person maternity care should not be overlooked and that it was particularly important for vulnerable women and those with existing medical problems.

29. Our response to the NHS' survey on clinical innovations in May and June 2020 sets out some of the innovations in the provision of maternity care during the pandemic [Exhibit GW/51 - INQ000280490]; [Exhibit GW/52 - INQ000280491]. Such innovations included: Trusts providing antenatal education classes via online video platforms; email and telephone communication pathways for women to raise questions or concerns; and remote early abortion services. The general impression of these innovations was positive and our experience suggested that the NHS could embrace more technology and that it can improve care. We saw maternity care as a perfect candidate for any such initiative and made a number of recommendations to the Public Accounts Committee inquiry into digital transformation in the NHS [Exhibit GW/53 - INQ000280492]. However, we recognised such a transformation would be a huge challenge and would require leadership and investment.

30. To date there has been only very limited progress in meeting the RCM's recommendations regarding: ringfencing funding; all women having digital maternity records and being able to self-refer using digital technology; and on interoperability. Progress has been made in the following areas:

    a) Almost all maternity services now have a digital midwife in place;
    b) Digital Maternity Leaders groups have been established in each region to network, collaborate and adopt a system thinking approach;

c) NHS England established a £52m funding pot for accelerating implementation of online maternity records;
d) The 'What Good Looks Like' Framework aims to describe good practice and organisational and system level. As such there is scope for including learning from maternity services;
e) The Clinical Negligence Scheme for Trusts includes a requirement that NHS Trusts have up-to-date digital strategies for maternity services, which are aligned with their wider digital strategy and reflects the success measures within the 'What Good Looks Like' Framework;
f) The single delivery plan for maternity and neonatal services includes an objective for better utilisation of digital technology, supported by a range of measures to assess progress made; and
g) The Maternity Digital Capabilities Framework was established to help with roll-out of electronic patient records.

Adherence to guidance

31. Despite our best efforts to plug the gaps in guidance and ensure the continuation of services, we became aware that this guidance was sometimes not being adhered to and pregnant and postnatal women suffering from Covid-19 may not have been receiving the best treatment. In July 2021, I stated that it was vital that maternity services followed the guidance and emphasised the importance that pregnant and postnatal women should attend appointments and not delay in getting treatment [Exhibit GW/54 - INQ000280493].

Visiting restrictions

32. While broadly supportive of measures to limit the presence of women's partners when women were attending for scans or routine appointments, we did encourage services to allow the presence of partners during labour, birth and the period immediately after the birth. Maternity services were able to accommodate this in all but an extremely limited number of circumstances.

33. As services emerged from the initial phase of the pandemic, the balance that maternity services sought to achieve between openness and safety came under increasing pressure. In the absence of a national lockdown and with different parts of the country subject to different restrictions and regulations, we recognised that maternity services required a more nuanced and localised approach rather than the one-size-fits-all response to the first wave of the pandemic. Accordingly, the RCM and the RCOG formulated a set

of service planning principles [Exhibit GW/55 - INQ000280494], published within the Covid-19 information hub on the RCM website and based on: maintaining day assessment and triage services, along with active encouragement to women to attend appointments; maintaining options for place of birth, subject to local staffing capacity; and offering the full schedule of antenatal and postnatal care.

34. By September 2020, we reviewed and updated our Covid-19 guidance, reconvened the working groups we had set up during the first wave and renewed our collaborations with the RCOG, the TUC, other health unions and professional bodies and with user groups, such as Maternity Action. We repeated our call for the ringfencing of maternity staff in a joint statement with the RCOG and a press release on 30 September 2020 [Exhibit GW/117 - INQ000339580] and, based on feedback from frontline services confirming that maternity staff were not being redeployed, it seemed this was again heeded.

35. In the summer and autumn of 2020, maternity services came under increasing pressure from groups representing maternity service users, sections of the media and some politicians to effectively end visiting restrictions for maternity services. Sometimes these calls were based on misleading and inaccurate reports that women were being denied support during labour and birth. Feedback from our members also indicated that the way in which this issue was covered was contributing to an increase in abuse that midwives and MSWs were receiving from pregnant women, their partners and families [Exhibit GW/56 - INQ000280495]. We issued a briefing to members in July 2020, providing advice on how the reintroduction of visitors to maternity units might best be managed, including the importance of recognising that restrictions on visiting and support at appointments will have had a disproportionate impact on some women [Exhibit GW/22 - INQ000280459].

36. While we recognised that visitor restrictions were far from ideal, they were designed to maximise the safety of women, their partners and families and maternity staff. They also had to be seen in the context of the reality that many maternity services went into the pandemic with capacity at or near breaking point.

37. The Government could have acted to clarify visiting arrangements and reassure women and families about the support that they would continue to receive. At the beginning of August 2020, a framework agreement to support the safe re-introduction of partners to attend appointments and scans, had been developed by the RCM, the RCOG and the Society and College of Radiographers [Exhibit GW/57 - INQ000280496]. Unfortunately, it took NHS England a further month before it agreed to publish it and it largely failed to take

ownership of this issue, as can be seen from internal RCM emails in August 2020 [Exhibit GW/58 - INQ000280497] and a September 2020 RCM briefing on maternity visiting [Exhibit GW/59 - INQ000280498], the key messages of which were: that women should be able to have a birth partner with them during labour and birth and immediately after the birth (as we had said throughout the pandemic); that maternity services staff were working under extreme pressure to accommodate the wishes of women to be accompanied by their partners to appointments, scans and during labour; and that NHS England/NHS Improvement (NHSE/NHSI), politicians and the media needed to understand and appreciate the effort that maternity staff were making to deliver the best possible care to women and families, but that also they needed to make local decisions based on risk assessments and with the safety of women, families and staff uppermost. We also made a press release on the issue in September 2020 [Exhibit GW/60 - INQ000280499].

38. I exhibit relevant email correspondence with NHSE at the time and some internal RCM emails showing our concern with the delay:

    a) An email exchange between the RCM and NHSE/NHSI in June 2020 regarding inconsistent visitor guidance [Exhibit GW/61 - INQ000280500];
    b) Email exchanges between the RCM and NHSE/NHSI and internal RCM emails in July 2020 regarding a request from NHSE/NHSI for the RCM to communicate advice on visitor restrictions through its members in lieu of formal NHSE guidance [Exhibit GW/62 - INQ000280501]; [Exhibit GW/63 - INQ000280502]; [Exhibit GW/64 - INQ000280503];
    c) An email from the RCOG to NHSE in August 2020 pointing to the delay in publishing the framework agreement and asking for it to be expedited [Exhibit GW/65 - INQ000280504];
    d) Email exchanges between the RCM, the RCOG and NHSE/NHSI in August 2020 regarding the delay in publication of the visitor guidance, with RCM asking for urgent attention to be given to the 'roadblock' in NHSE [Exhibit GW/66 - INQ000280505]; [Exhibit GW/67 - INQ000280506];
    e) An email from the RCOG to NHSE in August 2020 seeking clarification of arrangements for publishing the guidance [Exhibit GW/68 - INQ000280507];
    f) Email exchanges between the RCM and NHSE/NHSI in early September 2020, with the RCM seeking an update as to publication, asking "*Is there any update when it might see the light of day? It was signed off by the relevant board weeks ago now*" [Exhibit GW/69 - INQ000280508];

g) Internal RCM emails in early September 2020, expressing a hope that "*NHSE get their finger out and actually publish the guidance this week*" [Exhibit GW/70 - INQ000280511];

h) An internal RCM email on 8 September 2020, regarding NHSE annoyance at an RCM statement on the lack of visitor guidance, with NHSE accepting the delays had been too long [Exhibit GW/71 - INQ000280512];

i) An RCM response to messages sent by an individual via RCN Connect, explaining the RCM's dismay at the delay in NHSE publishing the visitor guidance [Exhibit GW/72 - INQ000280513].

Had NHS England acted in a timelier manner, there was every likelihood that visiting would have become less of an issue, especially at a point when it was becoming clear the country was facing a second wave of the pandemic.

39. The way in which this issue was handled and communicated was indicative of the pressure that NHS services were under to 'return to normal'. Our concern was that the understandable desire for the restoration of maternity services needed to be weighed against the considerable physical and mental toll that the pandemic took on the NHS workforce. While midwives and MSWs remained determined to support the women in their care, their health and wellbeing had been depleted, staffing shortages had been exacerbated by self-isolation protocols and the pressure to return to work as normal was causing real anxiety. We were disappointed that the NHS was again slow to support their staff and that, at a higher political level, there appeared to be little attempt to understand or mitigate the pressures that frontline staff were under.

40. In the continued absence of guidance from the Government or NHS England, maternity services faced further pressure to remove visiting restrictions, despite rising Covid rates and the fact that many maternity waiting areas were shared with other services and the challenges in maintaining social distancing in some antenatal and postnatal wards. See for example an email from Western Sussex Hospitals NHS Foundation Trust to NHSE in September 2020 [Exhibit GW/73 - INQ000280514], internal RCM emails from September 2020 regarding the Scottish Government guidance letter regarding visitor restrictions [Exhibit GW/74 - INQ000280515] and email exchanges between the RCM, the RCOG and NHSE/NHSI regarding visitor restrictions in November 2020 [Exhibit GW/75 - INQ000280518]; [Exhibit GW/76 - INQ000280521].

41. In November 2020, the RCM and the RCOG reiterated the need to reduce the number of people coming into maternity departments, in order to protect women, babies and families and maternity staff at a time when community infection rates were rising across England and when increasing numbers of midwives and MSWs were either testing positive or needing to isolate [Exhibit GW/77 - INQ000280524].

42. We raised many of these issues in our written evidence to the Science and Technology Committee and Health and Social Care Committee Inquiry, 'Coronavirus: Lessons learnt', in November 2020 [Exhibit GW/78 - **INQ000119192** and in our written evidence to the Joint Committee on Human Rights inquiry into the Government's response to Covid-19, in December 2020 [Exhibit GW/79 - INQ000280526]. Then later that month, we called on NHS Trusts in England to exercise common sense when considering whether to increase attendance of supporters and visitors at maternity services [Exhibit GW/80 - INQ000280527]. This followed new guidance published by NHS England that urged NHS Trusts to do all they could to open the doors of maternity services. In consultation on previous drafts of this guidance we had provided feedback to NHS England based on 10 'common sense principles', not all of which were adopted. The following emails from December 2020 show the process of this consultation and development of the feedback [Exhibit GW/81 - INQ000280528]; [Exhibit GW/82 - INQ000280531]; [Exhibit GW/83 - INQ000280534]; [Exhibit GW/84 - INQ000280536]; [Exhibit GW/85 - INQ000280539], and the December 2020 RCM open letter to maternity staff outlines the 10 principles [Exhibit GW/86 - INQ000280542]. We therefore reiterated that these principles, alongside health and safety legislation and the Nursing and Midwifery Council Code, should be applied to decisions about opening up access so that maternity staff would be able to carry out their work as safely as possible, while ensuring that the women in their care received the support they wanted and needed from partners, friends and family.

43. In April 2021, NHS England issued new guidance for NHS trusts to enable pregnant women to have a partner, family or friends with them at all stages of their maternity care, while ensuring safety for maternity services users and staff alike [Exhibit GW/87 - INQ000280543]. The guidance was welcomed by the RCM and RCOG as striking the right balance between enabling women to have the support they need, while ensuring the safety of maternity services staff, as can be seen from internal RCM emails in April [Exhibit GW/88 - INQ000280544] and our subsequent press release that same month [Exhibit GW/89 - INQ000280545].

44. Along with the RCOG, we did however continue to raise concerns about rising infection rates among pregnant women, due to the easing of restrictions on NHS services, continuing high rates of prevalence of Covid-19 in the community and vaccine hesitancy among some pregnant women [Exhibit GW/90 - **INQ000192226**]

45. At the same time as urging women who were pregnant, or considering pregnancy, to get vaccinated as soon as possible, we continued to advocate the continuation of social distancing measures and for pregnant workers to follow occupational health guidance.

Lack of PPE

46. The ability to continue to provide maternity services, and the level of access for women to maternity healthcare, was also impacted by the availability of suitable PPE. Our members were understandably very anxious about the risk of exposure to Covid-19, about the availability of PPE and testing and, for community-based midwives, the risks involved in entering women's homes. A survey of RCM members in April 2020 found that one-third of respondents reported experiencing shortages of PPE [Exhibit GW/91 - INQ000280547].

47. In response to these concerns from members, we worked with other health trade unions and professional bodies to hold the Government and employers to account for providing appropriate and adequate protection for our members working in healthcare, on ensuring that services were properly resourced and equipped to protect staff and on ensuring that new staff or those returning to services were properly supported through training and supervision. For example, we issued a press release in March 2020, calling on Government to ensure adequate provision of PPE to midwives, MSWs and other NHS healthcare professionals [Exhibit GW/92 - INQ000280548]; a further press release in May 2020, calling on NHS Trusts and Boards to provide advice, training and support for maternity staff to provide care and minimize risk [Exhibit GW/93 - INQ000280549]; and a press release in April 2020 outlining our concerns regarding the safety of midwives carrying out home visits due to exposure to Covid-19 and a lack of PPE [Exhibit GW/94 - INQ000280550]. We further raised concerns regarding the provision of PPE to maternity services staff through our response to the March 2020 PHE consultation on guidance on PPE in secondary care [Exhibit GW/95 - INQ000280551].

E. VULNERABLE GROUPS

Classification of pregnant women

48. As I have already explained above, Government advice placing pregnant women in the vulnerable persons category, was announced in March 2020, without any prior consultation with the RCM and without any supporting evidence, particularly in respect of the designation of the 28th week of pregnancy as determining the precise level of risk for pregnant women. Had the RCM and the RCOG received prior notification from the Government, we could have worked with them to ensure that guidance and advice was in place before any announcement was made. Regrettably, the Government missed this opportunity to provide clear and timely information to pregnant women, which could have prevented much unnecessary stress and uncertainty. This was an abdication of the part of the Government, requiring the RCM and the RCOG to step in to undertake a role outside of our usual responsibilities.

49. The effect of this announcement was to leave many pregnant women workers feeling anxious and vulnerable about their employment situation, particularly if they were frontline workers. Despite this, the NHS was slow to provide advice and support about the implications for pregnant workers. The three Royal Colleges (the RCM, the RCOG and the Royal College of Paediatrics and Child Health) recognised this and offered reassurance to pregnant women and those who care for them in a media release on 17 March 2020 [Exhibit GW/96 - INQ000280552]. In the absence of guidance from their employers, the RCM worked at pace with colleagues at the RCOG to provide pregnant women with guidance, which made it clear that the obligation was on employers to protect their health and safety, including undertaking work-based risk assessments and, if necessary, offering suitable alternative work or suspending staff on full pay – see, for example, our April 2020 occupational health advice for employers and pregnant women [Exhibit GW/12 - INQ000280449].

50. Despite numerous requests for the Government to publish this guidance, given that it was Government policy that necessitated the guidance in the first place, it was only in October 2020 that the DHSC finally agreed to do so (after BEIS had repeatedly refused our requests to publish).

51. We repeated our concerns in February 2021, in the RCM's written response to the Public Accounts Committee's call for evidence on supporting the vulnerable during lockdown

[Exhibit GW/97 - INQ000280553]. In this, we highlighted that, following the classification of pregnant women as vulnerable, the Government did not then provide adequate protection for those women – for example, pregnant women were being sent home on sick pay or unpaid leave, as opposed to full pay, and Statutory Maternity Pay calculations were often including periods of furlough, Statutory Sick Pay or unpaid leave, resulting in significantly lower payments.

52. Then, in April 2022, the Government withdrew the guidance, a move that the RCM opposed on the grounds that it undermined the legal regulations and requirements in place to manage the risk of Covid-19 in the workplace for pregnant women [Exhibit GW/98 - INQ000280554].

Black, Asian and minority ethnic (BAME) women

53. We also responded to emerging evidence BAME women were at higher risk of experiencing severe Covid symptoms and that, allied to general anxieties about exposure to Covid-19, this was resulting in missed appointments and a reluctance to attend hospital. Accordingly, we launched a targeted campaign to raise awareness and reassure BAME pregnant women of the availability and safety of maternity services [Exhibit GW/99 - INQ000280555]. We developed guidance for midwives and MSWs to ensure they were aware of the increased risks for BAME women and could have informed and reassuring discussions with them [Exhibit GW/20 - **INQ000119185** [Exhibit GW/28 - INQ000280465].

54. In June 2020, the Chief Medical Officer and the National Clinical Director for Maternity and Women's Health outlined a series of actions to address disparities experienced by BAME women, including: a lower threshold for admission and referral for BAME women and their babies; better and more tailored communications; additional nutritional support and the collation of more accurate data on ethnicity [Exhibit GW/100 - INQ000280429]. While we supported these initiatives, we argued for further and more extensive action and publicly called for an explicit target for the elimination of racial disparities in rates of maternal mortality – see our August 2020 letter to Harriet Harman MP (Chair of the Joint Committee on Human Rights) [Exhibit GW/101 - INQ000280430] and our November 2020 written evidence to the BAME committee [Exhibit GW/78 - **INQ000119192**

55. We were also concerned about how the pandemic was exacerbating inequalities experienced by BAME staff. During the first wave of the pandemic, 60% of healthcare workers who died from Covid-19 were from BAME backgrounds [Exhibit GW/102 -

INQ000280431]. The mental health of midwives from BAME backgrounds was particularly impacted – they reported considerable trauma and a lack of support from employers who largely failed to undertake appropriate risk assessments [Exhibit GW/103 - INQ000280432]. We raised awareness among our BAME members about the need to be risk assessed at work [Exhibit GW/104 - **INQ000119184** and we called on employers to act on the evidence of the risk assessments [Exhibit GW/105 - INQ000280434]. With other NHS trade unions, we produced a set of principles on health and safety risk assessments in June 2020, we encouraged our local representatives to develop local policies and procedures and we produced wraparound guidance to aid understanding among our members [Exhibit GW/106 - INQ000280435]. We were also aware of the issue of gaps in ethnicity data and we pushed for better data collection, through our presence on the Equality, Diversity and Inclusion Group of the NHS Staff Council [Exhibit GW/107 - INQ000280436], and we partnered Leicester University in a major study on the impact of Covid-19 on BAME healthcare workers [Exhibit GW/108 - INQ000280441].

56. At a Ministerial Roundtable Meeting in July 2020, attended by Nadine Dorries and a number of relevant organisations, we set out several findings and recommendations regarding BAME women's experience of maternity care, including: further research on factors associated with BAME mortality; ethnographic research on barriers to maternity care; continuity of care; cultural safety training; and investment in translation services [Exhibit GW/109 - INQ000280442]. However, our impression was that this meeting was not particularly useful, with a feeling that the Government was reluctant to fully engage.

57. We raised similar issues again in our written evidence to the Women and Equalities Committee Inquiry 'Unequal impact? Coronavirus and BAME people' in July 2020 [Exhibit GW/110 - INQ000280444]. Our submission set out many of the issues facing BAME groups and, particularly, BAME healthcare workers. Within maternity we urged swift implementation of the four-step action plan that had been recently developed by NHS England and circulated to all maternity units on 27 June 2020, those four steps being:

    a) Increasing support of at-risk pregnant women – for example, making sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women from a BAME background;
    b) Reaching out and reassuring pregnant BAME women with tailored communications;
    c) Ensuring hospitals discuss vitamin, supplements and nutrition in pregnancy with all women; and

d) Ensuring all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area, co-morbidities, BMI and those aged 35 years or over, to identify those most at risk of poor outcomes.

58. We also called for proper consultation with BAME healthcare staff to better understand their experiences and appropriate solutions, better representation of BAME staff in senior NHS roles, appropriate training for NHS staff to support and empower them to challenge racism, and for joint working with trade unions to create a culture of zero tolerance for bullying and harassment in the NHS.

59. Frustratingly, little progress has been made since the publication of the four-step action plan. The Government decided not to publish a white paper on health inequalities (originally promised for Spring 2022) [Exhibit GW/111 - INQ000280445]. The Government has subsequently confirmed that it will no longer publish a white paper but will instead produce a 'Major Conditions Strategy' (yet to be published). The lack of progress was detailed in the report of the Black Maternal Health All-Party Parliamentary Group [Exhibit GW/112 - INQ000280446], a report welcomed by the RCM [Exhibit GW/113 - INQ000280447].

F. CONCLUSIONS AND LESSONS LEARNED

60. The Covid-19 pandemic had a profound impact on pregnant women and new mothers. Midwives and MSWs worked tirelessly to try and ensure that the provision of maternity services could continue throughout, and to provide the support that is so vital to women through pregnancy, during and after childbirth. It is a testament to their hard work and dedication that services were able to continue to the extent they did.

61. However, the pandemic highlighted pre-existing serious staffing shortages, which inevitably resulted in disruption to maternity services. This, alongside a lack of suitable PPE and capacity of paramedic ambulances, meant that difficult decisions had to be made in terms of rationing care. Furthermore, a distinct lack of leadership and guidance from central government and NHS England caused uncertainty and created unnecessary anxiety amongst many women and midwives.

62. As a result, the RCM, as well as other organisations such as the RCOG, found itself having to plug the gaps and step outside its usual role, producing swathes of guidance on a variety of clinical and employment matters. At the same time, we continued to pressure the Government and NHS England to take ownership of these issues, unfortunately in the most part to no avail.

Recommendations

Consultation

63. A recurring issue during the pandemic was the lack of leadership from the Government and NHS England and the resulting lack of clear guidance for pregnant women, new mothers and those working in maternity services. Going forward there needs to be much more dialogue and consultation with the RCM, the RCOG and other representative bodies, particularly in advance of guidance being produced. There needs to be:

a) A willingness on the part of Government and NHS England to take responsibility for publishing guidance and advice on both clinical and employment matters;
b) More streamlined and efficient processes for obtaining sign-off for joint communications and information; and
c) A commitment from Government and NHS England to see trade unions and professional bodies as genuine partners in working for the interests of patients, the public and staff in tackling pandemics and other public emergencies. While there were examples during the early days of the Covid-19 pandemic of positive collaborations between Government ministers, officials and trade unions, it soon became apparent that the Government had little interest or commitment in sustaining these relations.

Staffing numbers

64. The increase in complexity and acuity in many pregnancies and births has assumed ever greater significance as a driver of workforce demand. Staffing numbers have not kept pace with this changing demand and the shortages are now chronic. We estimate that the current shortage is around 2,500 full time midwives, based on the total number of live births and stillbirths and therefore the number of midwives required for one-to-one care, as we set out in a letter to NHSE and DHSC in April 2023 [Exhibit GW/114 – INQ000280448]; [Exhibit GW/118 - INQ000339581]. There needs to be a significant increase in real investment and concerted recruitment and retention strategies if we are to avoid a deterioration in the quality and safety of maternity care.

Technology

65. Maternity care has, like other parts of the NHS, seen a huge acceleration in the availability of digital technology to support remote access to care and information, as a result of the Covid-19 pandemic. However, to ensure that the provision of remote maternity care is safe, acceptable to women and of high quality, there will need to be significant ongoing investment in training, research and technological support for midwives. A greater reliance on digital technology to provide high quality maternity care will require a larger IT and technology workforce within maternity services. There will be a need to develop a new range of online and app based antenatal education resources for women and service users, as well as significant developments in the use of AI technology in identifying women at higher risk of complications and babies at higher risk of compromise. This will require a dedicated workforce to plan, develop and implement, supported by clinical personnel to shape the content, advise on usability and provide training and support to clinical staff.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Personal Data**

Gill Walton

Dated: 17 November 2023