Written evidence submitted by General Medical Council (MSE0076)

Safety of maternity services in England

Our role

The GMC's role is to protect patients and improve medical education and practice across the UK. As part of this, we decide which doctors are qualified to work in the UK, we oversee UK medical education and training, and we set the standards that doctors need to follow throughout their careers. We also act where necessary to prevent a doctor from putting the safety of patients – or the public's confidence in the profession – at risk.

While we are unable to comment on specific cases, we hope it will be helpful to the committee's inquiry to outline our views and our role, the importance we are placing on regulatory collaboration and to highlight what we see as some key recurring themes throughout this work.

The inquiry

We hope this submission is useful as the committee continues to look into these issues and identifies areas for improvement.

In particular we hope the inquiry will recognise the multidisciplinary challenges of maternity care and the significance of the culture in which these professionals work, as well as reinforcing the need to improve professionalism across the system. It is clear to us that this is a solution to many of the problems facing maternity care. Our standards, including those agreed jointly with the NMC, set out very clearly what is required in terms of behaviours and practice. Embedding those standards will need a system-wide and collaborative approach and we hope this is something the committee would support.

The committee's chair has been right to advocate a greater learning culture within the health system and we note that missed learning opportunities is a clear theme among many maternity inquiries and reviews. We'll continue doing what we can to create a positive, open and just culture as a vital component to patient safety and we hope the inquiry reinforces the system-wide approach that's needed.

We'll keep doing more to collaborate with other regulators and providers to help address these problems and hope the committee's work will help to underline the importance of this.

We also hope the committee will continue to support reform of our outdated legislative framework in order that, among other things, our registration pathways become more flexible and accessible, supporting a more sustainable workforce to help address the workforce challenges that we see. Reform could also help by making regulators' underpinning frameworks more aligned, which would simplify further collaboration.

Maternity care

1 Maternity care is unique. Childbirth is a natural, physiological process and normally requires only assistance and monitoring, rather than remedial treatment.

2 It should be a uniquely joyful time for the woman involved and her family. And for most people it is – but when something does go wrong it becomes a uniquely distressing time with consequences that can affect everyone involved for the rest of their lives. That can place extraordinary pressures on the clinicians involved and means that good culture and leadership (which are important in all healthcare settings) are of even greater importance in maternity care. It is therefore important that trusts and their managers continue to do more to foster open and supportive cultures in this area.

3 It also differs from other types of healthcare because it involves two patients, mother and baby. Care and risk monitoring are therefore required for two people individually yet simultaneously.

4 And, importantly, maternity care is multiprofessional, with that care being delivered over a long period of time and across different locations by a range of professionals. Professionals therefore need to have good working relationships and practices, with shared responsibility and leadership. For the same reason, improving patient safety requires collaboration from the organisations regulating those professions.

Recurring problems

5 As the committee has highlighted, several reviews and inquires have taken place on the standard of maternity services, some of which are ongoing. We'll keep engaging with these inquiries and the Healthcare Safety Investigation Branch's maternity investigation programme but at the same time we are mindful of continuing concerns around maternity care.

6 While some lessons have been learned, the picture remains depressing in a number of respects and too many of these issues are, regrettably, longstanding and leading to too many problems being repeated across incidents. It is clear a step change is needed.

7 We recently conducted a thematic review of maternity care to identify these recurrent themes that may have contributed to the serious patient incidents across different reviews and inquiries. The analysis also considered those unique features of maternity care that may be impacting the delivery of safe and effective care.

8 Following this analysis, we believe the following are key themes that can partly contribute to patient safety incidents in maternity care:

- Clinical governance
- Leadership
- Teamwork and communication
- Recognising the nature and severity of risks

- Continuity of care
- Recording, reporting and acting on patient safety incidents
- Openness and honesty
- Workforce experience and availability
- Missing learning opportunities

9 These are all important but it is clear to us that the culture of organisations and their leadership is a vital issue that affects the others as it has such a strong influence on how professionals work. Improvements in this area can therefore be particularly transformative.

10 These issues do not only apply only to the specific sites covered by the cases we reviewed but instead present challenges for maternity care across the UK. And each of the themes identified are interrelated, where problems arising in any one of these areas can create problems in another. This cascading effect, seen in all the inquiries and reviews, culminates in significant patient safety incidents that do not get recognised and investigated in the appropriate or proportionate manner.

Clinical governance

11 Clinical governance plays an important role within all areas of healthcare in ensuring patient safety and providing a framework which encourages learning and improvement. It's essential that there is effective monitoring and an appropriate response when patient safety incidents occur, as this will reduce the likelihood of similar incidents occurring in the future.

12 Governance systems are not always sensitive enough to detect issues at an early stage, and the wider system doesn't always identify significant patterns because not all indicators were signalling substantial problems, or because the system – including regulation – is as yet insufficiently coordinated, although good progress is being made. We say more about that below (paragraphs 32-38).

13 In our guidance on *Leadership and management for all doctors* we say early identification of problems or issues with the performance of individuals, teams or services is essential to help protect patients. We draw attention to clinical governance systems, saying doctors must be familiar with and use the clinical governance and risk management structures and processes within the organisations they work for.

14 Doctors must also follow the procedure where they work for reporting adverse incidents or near misses. We explain this is because routinely identifying adverse incidents or near misses at an early stage can allow issues to be tackled, problems to be put right and lessons to be learnt. Where doctors have reasons to believe that systems, policies, procedures or colleagues are, or may be, placing patients at risk of harm, they must follow our guidance on *Raising and acting on concerns about patient safety*.

15 Those with management responsibilities must make sure systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. They must make sure any such failures are dealt with quickly and effectively.

Leadership

16 We know clinical leadership plays a key role in protecting patient safety.

17 We commissioned independent research to understand how doctors can be most effectively supported during induction or when they return to work. This was published earlier this year and found that:

- Doctors' experiences of inductions varied by setting, specialty and career stage. The majority of the doctors interviewed had experienced a number of inductions and could cite both good and bad practice.
- Doctors and associate/directors of medical education agreed there were key elements that needed to be included in inductions such as providing information at a 'local' level and in advance of starting, and offering as much tailored and hands-on induction as possible
- Multiple drivers and barriers to good and safe induction were identified. These included the relative costs and benefits of inductions, such as staff time. But also broader factors such as doctors feelings unwilling or unable to complain about poor induction.
- The impact of poor induction was often linked to the effect it has on doctors and their wellbeing. But there were also cases where it was linked directly to patient safety, e.g. doctors being unaware of emergency procedures or where vital equipment was.
- Poor induction is also potentially a contributing factor to poor patient safety as doctors who feel 'out of their depth' are more likely to make mistakes.

18 We are also:

- Building strategic relationships with partner organisations with a focus on clinical leadership - FMLM, the CQC, NHS England and NHS Improvement, and similar bodies in Scotland, Wales and Northern Ireland. We have worked with the CQC on their Well-led Framework and with NHSE/I on work evolving around the interim People Plan and behaviour compact.
- Researching and collating materials to support the development of guidance and scoping and developing data and intelligence to deliver the recommendations of the three independent reviews we published last year and evaluate their effectiveness.
- Continuing to support the creation of supportive, safe and inclusive working environments. This was highlighted as particularly important in our *Caring for doctors, Caring for patients* report

alongside other recommendations like more compassionate leadership models that give doctors more say over the culture of their workplaces.

19 In *Openness and honesty: the professional duty of candour*, we say that:

- If you are managing or leading a team, you should make sure that systems, including auditing and benchmarking, are in place to monitor, review and improve the quality of the team's work.
  - You must work with others to collect and share information on patient experience and outcomes.
  - You should make sure that teams you manage are appropriately trained in patient safety and supported to openly report adverse incidents.
  - You should make sure that systems or processes are in place so that:
    - **a** lessons are learnt from analysing adverse incidents and near misses
    - **b** lessons are shared with the healthcare team
    - **c** action follows on from learning
    - **d** practice is changed where needed.

Teamwork and communication

20 Delivering the highest standard of maternity care relies on effective multidisciplinary team working with fluid transitions and effective clinical handovers to subsequent treating teams. Typically, midwives lead on low-risk births unaided by obstetricians and without the requirement of instrumental intervention. Incidents where complications present, however, require a multidisciplinary approach involving doctors, midwives and usually neonatologists, where effective team working becomes essential. And the professionals are all profoundly influenced by the culture of the organisation in which they practise. This underlines how important it is for the regulators of these professions and of providers to collaborate in order to address these issues together.

21 We found that significant weight is attributed to dysfunctional team working throughout all the inquiries and reviews. For example:

- Both the Morecambe Bay and Northwick Park Inquiries describe problems with team working and communication amongst staff.
- The Northwich Park Inquiry outlined a breakdown in staff communication and reported the lack of consultant obstetric input in six out of the ten deaths.
- The National Maternity Review* also described a lack of interdisciplinary respect and a breakdown in communication between midwives and obstetricians as a major risk factor in compromising the

delivery of maternity care. The report also detailed significant parental concerns regarding insufficient clinical handovers and sporadic obstetric input in their personal experiences of delivery.

22 These problems are not unrecognised by professionals working in these teams. The National Maternity Review highlighted obstetricians' desire for greater training in multidisciplinary team working, and further training in disagreement and conflict resolution to address the 'cultural tensions'. It also highlighted that more midwives and trainee obstetricians report feeling unsupported in the workplace compared to other medical professionals. A particularly concerning finding from our own National Training Surveys (NTS) between 2016-19 is that 14.5% of trainees of obstetrics and gynaecology reported witnessing or being the victim of bullying or harassment. This was significantly higher than the mean for all doctors in training (6.1%). The causes of this pattern – which at least in part may relate to the unique context of maternity care – have previously been investigated by the Royal College of Obstetricians and Gynaecologists (RCOG); and in 2014 the GMC undertook its own thematic review of bullying and undermining in two postgraduate medical education specialties, one of which was obstetrics and gynaecology.*

23 Our review identified some very good practice as well as examples of poor practice. A crucial factor in improving the culture and therefore safety of a service was – unsurprisingly - found to be the quality of the senior leadership in a department:

> "Sites where progress was evident invariably had good support from an engaged senior management team that took an active interest in medical education and training, manifested, for example, in a standing agenda item for board-level discussion."

24 Despite examples of good practice of this kind, and many excellent initiatives in recent years on the part of RCOG, the Royal College of Midwives and other organisations, it is clear that much more needs to be done.

25 The review did not reach firm conclusions on the reasons for the observed greater prevalence of bullying and harassment in obstetrics and gynaecology training although it identified the following potential reasons:

- the acute nature of the specialty
- the significant on-call commitments, often with distant supervision
- the perfectionist characteristics exhibited by many consultants
- the high risk of being involved in clinical incidents and the need to ensure patient safety

* https://www.england.nhs.uk/mat-transformation/implementing-better-births/mat-review/
* https://www.gmc-uk.org/-/media/documents/under-embargo-05-03-15-building-a-supportive-environment_pdf-59988406.pdfi

Recognising the nature and severity of risks

26 The nature of maternity care means being alert to risk is a crucial part of care and acting on developing concerns is essential in its delivery. The recognition and management of these risks were significant in a number of inquiries, with cases where mothers who had died should have been classified as high risk and the hospital did not have adequate staff or facilities to manage these complications. These failings are reported across all stages of care and do not focus solely on one stage or profession.

27 Findings from the National Maternity Review suggest that neonatal outcomes could be improved if parental concerns were properly investigated, and supports the apprehensions shared by parents that appropriate responses to these concerns do not always occur. Our current consent guidance and forthcoming guidance on decision making and consent both emphasise the importance of good communication between patients and doctors. We set out the information doctors must provide to patients and are clear that they need to explore these matters with patients, listen to their concerns, ask for and respect their views, and encourage them to ask questions.

Continuity of care

28 Post-natal care is necessary to secure the health and well-being of both mother and baby in the early stages after labour and is particularly important to ensure that those women and babies who experienced complications in birth recover appropriately.

29 But poor post-natal care is inferred throughout many inquiries and reviews. The issues are two-fold, with problems occurring both following healthy births or in response to significant neo-natal or maternal complications and fatalities.

30 In some cases mothers had not been properly monitored for post-natal complications. In one instance a failure in referral systems meant that a patient received no post-natal care when discharged and was not aware that this was standard protocol. Unfortunately, this patient later died after presenting to A&E. The post-mortem recorded the cause of death as an intracerebral bleed, recent pregnancy and high blood pressure, complications which may have been picked up with suitable postnatal care.

31 The National Maternity Review reports mothers feeling that post-natal check-ups are inadequate. More than half of mothers experiencing perinatal depression and anxiety go undetected by professionals, and maternal reports reflected the lack of mental health support available

Recording, reporting and acting on patient safety incidents

32 Because childbirth is a natural physiological process, fatalities or major incidents should occur with relative infrequency when compared to some other types of healthcare. What this means is that consistent patient safety incidents or fatalities at a specific facility, even in much smaller numbers than expected for other types of care, are likely to signal substantial problems in the way that maternity care is being delivered.

33 Appropriate and detailed recording and subsequent reporting of patient safety incidents is necessary in medical practice. The cascading effect of insufficient reporting and recording is that the trust/

board or services identify significant patterns and learning opportunities that may help prevent similar incidents arising in the future.

34 Inquiries have noted the insufficient or incomplete recording of incidents in patients' clinical notes by both midwives and obstetricians and in some cases the total absence of information for surgical procedures that had taken place. We explicitly draw attention to the importance of good record keeping in our consent guidance, where we say doctors must use the patient's medical records or a consent form to record the key elements of their discussion with the patient. We add this should include the information they discussed, any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made.

35 Furthermore, the under-reporting of patient safety incidents is recognised as a significant issue across all the reviews and inquiries considered. What commonly occurs is that following the announcement of an inquiry or review, the number of incidents brought within the scope of the investigation increases substantially. This may be due to incorrect or insufficient recording of incidents at the time, which then relies on patients or family members to make their cases visible to the inquiry.

36 The recurrent issues around insufficient detail and incomplete reports highlighted in several of the inquiries may be related to the administrative burden experienced by maternity staff. The National Maternity Review reported staff frustration at the use of paper-based records and the time taken to complete these tasks, which could result in considerable time spent away from the mother and/or baby.

37 Staff should be encouraged and empowered to report incidents and alert others to issues which they feel make practice unsafe or jeopardise patient safety, and appropriate structures should be reinforced to facilitate this.

38 We've produced guidance, *Raising and acting on concerns about patient safety*, which sets out doctors' responsibilities to take prompt action if they think patient safety, dignity or comfort is being compromised. It also covers who the best person or organisation is for them to raise their concerns with, as well as how to raise their concerns and how to overcome any barriers that might be preventing them doing so. It includes that:

- All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work. They must also encourage and support a culture in which staff can raise concerns openly and safely.

- All doctors have a responsibility to encourage and support a culture in which staff can raise concerns openly and safely.

- If you are responsible for clinical governance or have wider management responsibilities in your organisation, you have a duty to help people report their concerns and to enable people to act on concerns that are raised with them.

39 We are seeing increased openness from employers and doctors to raise concerns, encouraged by regular contact with our Outreach teams. Our confidential helpline for doctors has also helped to raise over 5,400 concerns about colleagues since 2012. And in 2019 we tested a new pilot programme – Professional behaviours and patient safety – to equip doctors with the tools and confidence to challenge unprofessional behaviours - this cultural shift must now also be embedded in the independent sector.

Openness and honesty

40 As well as having the freedom to speak up, it's important that doctors are honest and transparent. This should include when things haven't gone right, not just when they've gone wrong. This is covered in several areas of our guidance.

41 *Good medical practice* says that:

- You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:
  - put matters right (if that is possible)
  - offer an apology
  - explain fully and promptly what has happened and the likely short-term and long-term effects

42 Our existing guidance on consent already says doctors must give patients information they want or need about any uncertainties regarding diagnosis or prognosis, and the potential benefits, risks and burdens, and likelihood of success, for each option. We say doctors should encourage patients to ask questions and explore these matters with patients, listening to their concerns and asking for and respecting their views. Our forthcoming guidance on *Decision making and consent* continues to emphasise these provisions. We're also working with RCOG to develop a specialty-specific version of the guidance and will collaborate with them and others on a resource demonstrating good decision-making practice before and during childbirth.

43 In *Openness and honesty: the professional duty of candour* (which we developed jointly with the NMC and is guidance which – uniquely – applies to doctors, nurses, midwives and nursing associates) we say that:

- When something goes wrong with patient care, it is crucial that it is reported at an early stage so that lessons can be learnt quickly and patients can be protected from harm in the future.
- Healthcare organisations should have a policy for reporting adverse incidents and near misses, and you must follow your organisation's policy.
- In addition to contributing to these systems, you should comply with any system for reporting adverse incidents that put patient safety at risk within your organisation

- Your organisation should support you to report adverse incidents and near misses routinely. If you do not feel supported to report, and in particular if you are discouraged or prevented from reporting, you should raise a concern in line with our guidance

- You must not try to prevent colleagues or former colleagues from raising concerns about patient safety. If you are in a management role, you must make sure that individuals who raise concerns are protected from unfair criticism or action, including any detriment or dismissal

- You must take part in regular reviews and audits of the standards and performance of any team you work in, taking steps to resolve any problems. You should also discuss adverse incidents and near misses at your appraisal

- Senior clinicians have a responsibility to set an example and encourage openness and honesty in reporting adverse incidents and near misses. Clinical leaders should actively foster a culture of learning and improvement

Workforce experience and availability

44 Providing a high standard of maternity care (and the ability to recognise developing risks in both mother and baby) is a complex task that requires experience and relevant training.

45 Recommendations from the Morecambe Bay Inquiry included the development of a new recruitment and retention strategy to help build a more sustainable workforce. The recommendations suggested making links with other centres so that knowledge and skills may be shared whilst offering greater development opportunities within the Trust.

46 Some problems with services may be exacerbated by an overreliance on locum doctors, which may be caused by location and recruitment issues. RCOG has previously reported that 90% of obstetric units report middle grade rota gaps, as well as reporting high attrition rates.

47 We're also exploring the use of our revalidation data to help us identify emerging risks. The data we hold on the register means we're able to track who is licensed to practice, the body to which they connect for revalidation, and their revalidation outcomes. This allows us to track which doctors have struggled to revalidate.

48 Using a combination of data, we are working towards being able to identify at a doctor level movement to and from organisations over time – including spotting anomalous patterns, such as 'outflow' when a trust loses experienced staff, or inflow of new staff when it recruits. We're also already able to use our registration data to examine the workforce composition of obstetrics and gynaecology consultants, for example, connected to each designed body. Our ambition is to get to a point where these data, when combined with data from other regulatory bodies, will enable early warning signs of emerging risk to be identified – and the necessary corrective action to be taken.

49 Overall, analysis of our existing data has shown that obstetrics and gynaecology training has the highest bullying rate by specialty, low satisfaction, a high rate of trainees leaving during training and high burnout risk. We can also see that more obstetrics and gynaecology trainees work less than full

time compared to the average, and this specialty also has a high rate of consultants leaving the profession once qualified.

50 Since 2017, we've used our National Training Survey to ask doctors how often (if ever) they feel forced to cope with clinical problems beyond their competence or experience. The groups who were most likely to report this are doctors in the foundation and general practice programmes, followed by obstetrics and gynaecology and core training.

51 Where inquiries have highlighted concerns about a lack of fully trained staff and an over reliance on locum or junior doctors, those trusts could have benefited from improved clinical leadership and oversight from experienced consultant obstetricians.

Missed learning opportunities

52 The fact that maternal or neonatal fatalities are so rare means that lessons could and should be learnt from every fatality or patient safety incident. However, we've noted that missed learning opportunities is a clear theme amongst most inquiries and reviews.

53 A significant impact of the insufficient reporting or recording of patient safety incidences is that it decreases the likelihood that lessons will be learnt from recurring issues – even 'minor' patient safety incidents. This is evidenced in the National Maternity Review, which describes substantial differences in culture between high and low reporting maternity facilities, with those high-reporting facilities having a stronger lesson learning and team working culture.

54 A positive, open and just culture in the NHS is vital to patient safety. Creating an environment where doctors' wellbeing is prioritised, where they're supported professionally and where they can raise concerns and learn from their mistakes without blame, will dramatically improve the quality of care patients receive. Creating such a culture and enabling doctors to provide safer care is therefore in the interests of both doctors and patients.

55 We understand being a doctor involves uncertainty and emotional intensity because of the nature of their work. Mistakes will happen but they don't have to be repeated. That is why staff should feel confident to speak up when things go wrong, and to work in an environment where they're able to do so without fear of blame, so that doctors can learn how to prevent similar mistakes in the future.

56 Our reflective practice guidance for doctors encourages continuous learning and reflection. We have also signed a joint statement with nine other healthcare regulators on the benefits of becoming a reflective practitioner.

Postgraduate medical education and training

Education and training standards

57 We set out our standards for education and training in *Promoting excellence*. Our education standards say that the learning environment must be safe for patients and supportive for learners and

educators, and that culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

58 The standards, introduced in 2016 following the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013, require a culture of learning and improvement, effective multiprofessional working and collaboration and support the professional duty of candour. Local education providers must:

- demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.
- demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.
- support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.
- demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.

59 The Nursing and Midwifery Council's new standards framework for nursing and midwifery education was developed alongside the framework of *Promoting excellence*, so the standards in place for the environments in which doctors, nurses and midwives learn should now be more consistent than ever before.

Outcomes and curricula

60 In addition, leadership and team working are central to the outcomes we require both at undergraduate and postgraduate level. At undergraduate level, *Outcomes for graduates* sets out that medical students must:

- recognise the role of doctors in contributing to the management and leadership of the health service;
- learn and work effectively within a multi-professional and multi-disciplinary team and across multiple care settings.

61 At postgraduate level, Excellence by design sets out the standards all postgraduate curricula in the UK must meet for approval. And the Generic professional capabilities (GPCs) framework describes educational outcomes which must be incorporated into all postgraduate curricula, reflecting the principles and professional responsibilities in *Good medical practice*. One of the six key domains of this is around leadership and team working. This includes, amongst other requirements, that doctors demonstrate:

- appropriate leadership behaviour and an ability to adapt their leadership behaviour to improve engagement and outcomes;

- that they are promoting and effectively participating in multidisciplinary and interprofessional team working.

62 The generic professional capabilities are designed to be included in all curricula, and include requirements around communication, informed consent and, crucially, that that they can participate in and promote activity to improve the quality and safety of patient care and clinical outcomes.

63 Both are important levers through which we can help ensure the right learning is embedded into the curricula doctors follow. For example, the new curricula for obstetrics and gynaecology has embedded GPCs with specific outcomes related to managing conflicts, team working, reflecting on patients' views and preferences.

Safeguarding quality of training

64 We're responsible for assuring the quality of education and training, identifying where our standards are not being met, and taking action where necessary.

65 When deaneries and local offices are concerned about training, they work with trusts and health boards to make improvements. If the situation doesn't improve, they inform us. We then work with all the organisations involved to deliver a sustainable resolution to the concerns through a process called enhanced monitoring. The list of currently open cases is publicly accessible here.

66 Through enhanced monitoring we closely monitor medical training organisations with concerns about the quality and safety of training. Issues that require enhanced monitoring are those that could affect patient safety, or training progression or quality.

67 Where concerns are not resolved in a timely way, we can and will where necessary impose conditions on our approval of training to protect patients and trainees.

68 We've noted that obstetrics and gynaecology has been overrepresented in enhanced monitoring cases across England and Wales: we've analysed these and found that 6 of the 42 (14%) open issues in enhanced monitoring are related to obstetrics and gynaecology. Furthermore, the common issues across cases relate to clinical supervision, educational governance and access to learning, and undermining.

National Training Surveys

69 These are annual surveys that cover both doctors in training and trainers of doctors.

70 We see these as an important source of data on the experiences of doctors in training. The data we get from these is available by individual doctor, by post, trust, site, or specialty and by location at a point in time each year. It also includes data analysable to an individual level on a number of key topics like workplace experiences, training and support quality.

71 They sit alongside our one-off surveys, like our survey of specialty and associate specialist (SAS) doctors, which gives us more data to examine workplace support, bullying, burnout, and career plans of these professionals. Using our direct and indirect regulatory levers as appropriate we can then prioritise interventions.

Regulatory collaboration

72 Regulators have many modes in which they collaborate, including our most senior strategic links at the Chief Executives Steering Group; the Joint Strategic Oversight Group (which at both national and regional levels brings together NHSE/I, CQC, the GMC, NMC and HEE) which focuses on providers who are in special measures or at risk of entering special measures; our Joint Escalation Protocol for sharing identified concerns; and teams across organisations sharing known concerns.

73 But it is clear that there is both a need and further scope to deepen the ways in which regulators specifically collaborate. This has been underlined by a number of recent inquiries including the report into Ian Paterson*. The Covid-19 pandemic has further intensified the need for regulators to demonstrate that we can support the NHS in its recovery and renewal and contribute proactively to securing the improvements and innovations introduced by the NHS during the crisis. Regulators need to demonstrate that they are part of a sustainable and resilient solution capable of dealing with both routine operational and pandemic challenges.

74 The GMC, CQC and NMC have been discussing how we can work together more closely to rise to this challenge. Together we share a joint ambition to do more in how we work collaboratively. Given the strength of the evidence, the seriousness of the issues and the longstanding nature of the problems from both a professional and provider perspective we have decided to focus initially on maternity care, and we have identified several areas that we think are crucial and that we are prioritising for how we do this:

- We want to improve our shared understanding of risk related to maternity services. This will mean building agreement on common areas of risk to prioritise across regulators and to improve how we identify, analyse and address these shared risks together. This would enable the earlier detection of emerging problems and, therefore, earlier intervention.

- To achieve this, we want to improve the way in which we collaborate in sharing data. This will help us jointly analyse and identify common issues that cross organisational boundaries.

- We also see an important need to work together to improve the culture of the environments in which the professions we regulate work. This should mean doing what we can to make them more supportive and improving professionalism across the system. Given the pivotal role of leadership in influencing workplace culture, the greater the extent to which we are able to align with other regulators our perspective on what good leadership looks like, the more powerful that aligned view will be.

* https://www.gov.uk/government/publications/paterson-inquiry-report

75 We hope that collaboration on these lines will widen out into a longer-term and more sustainable platform for proactive collaboration.

Next steps

76 It is clear that there is no one, single cause of the safety and quality issues seen in many maternity services over the past 20 years and more.

77 The Morecombe Bay report pointed out the need for a strategy to build and retain a multi-professional workforce of the scale and resilience required. That largely lies outside the scope of the GMC, although we will contribute in every way we can, including using our powers to ensure training environments are safer, more supportive and inclusive – allowing doctors in training in O&G to develop and progress. We also want to see major reform of our outdated legislative framework in order that, among other things, our registration pathways become more flexible and accessible, supporting more doctors to join the UK workforce, and sustaining the skills and flow of workforce post-Brexit.

78 Over and above the workforce supply challenge, it is clear that the solution to many of the problems seen in some maternity services lies in supporting culture change within those organisations. Our standards for doctors – and those of regulators for other professions – set out very clearly what is required in terms of behaviours and practice. Embedding those standards will need a system-wide and collaborative approach.

79 Through the work of our Outreach teams at a local level, we will support quality improvement and patient safety, as well as promoting fair, transparent and representative clinical and staff governance. In doing so, in our work in England we will support where we can the initiatives set out in the *People Plan* 2020/21 which sets out actions to support the transformation of the NHS.

15 September 2020