Written evidence submitted by The Midlands Patient Safety Research Centre (PSN0010)

The Midlands Patient Safety Research Centre (PSRC) would like to respond to the questions raised by the committee as follows. We are responding on behalf of the directors and theme lead for maternal health.

Maternity care and leadership

1. "There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay." (From the inquiry into Morecambe Bay Investigation, 2015)

The medical examiners system combined with MBRRACE (https://www.npeu.ox.ac.uk/mbrrace-uk) allows collection of data about maternal and perinatal deaths including stillbirth, although the latter is relatively poorly captured by existing systems. Establishment of any new system would be less helpful than ensuring better data within MBRRACE – although there are now high rates of capture, in particular for maternal death, the data completeness is poor, which undermines it's utility. Adequate funding and systems to enable Trusts to submit their data, and MBRRACE or appropriately approved researchers to analyse it might maximise benefit.

2. "A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.)

Many senior leaders are also healthcare professionals hence any such system should avoid duplication with professional regulation and oversight, such as revalidation. Arguably employers already assess compliance with professional standards including medical ethics within existing appraisal systems which feed into revalidation for doctors. Annual appraisal exists already for NHS staff (not restricted to doctors or nurses) and can be reviewed by the CQC (https://www.cqc.org.uk/guidance-providers/regulations/regulation-18-staffing); whilst this does not allow for prosecution it does allow regulatory action to be taken. As for the first question, using such systems effectively may be higher priority than developing a new one.

Health and social care training

3. "Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the Health and social care review: leadership for a collaborative and inclusive future report, 2022)

Culture of safety, and whistleblowing

4. "Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

> *Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.*
>
> *Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led." (From the Freedom to Speak Up Review, 2015)*

The CQC assesses aspects of culture already, such that Trusts are aware they need to collect data or evidence about this for inspection. Annual quality accounts (https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements/) do not have to include such measures within mandated numerical data, but improvement and overall status ought to be covered by the summary statement provided by a senior manager. However measurement of culture typically focusses on behaviours that can be captured numerically such as communication or information exchange, safety culture outcomes such as reporting rates, and patient outcomes such as falls, length of stay, or readmission rates. Staff outcomes are less well studied, and soft intelligence is rarely incorporated. This means that data inputs about culture to regulators may not reflect culture adequately, hence could be uninformative about the true state of an organisation. This probably reflects the difficulty of culture measurement outside of research, as opposed to the willingness of organisations to understand themselves. Systematic review of factors that could enhance safety learning systems has recently been published (Mahmoud et al, BMJ Open Qual (2023);12(2):e002134) and could inform structure of reporting on safety learning in future.

Although systematic review of safety culture has linked positive measures to outcomes (n=62 studies, Braithwaite et al, BMJ Open (2017);7(11):e017708), the evidence linking culture improvement initiatives (the next logical step) to improved outcomes is not always consistent. In specific settings some interventions aimed at aspects of safety culture have been shown to both improve culture and improve outcomes (for example Alsabri et al, J Patient Saf (2022);18(1):e351-e361), but impact on outcome for patients is by no means assured (or reported in publications). Further research into the impact of culture change and optimal method of assessment of culture in the NHS is required.

Jan 2024