Written evidence submitted by the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives (PSN0024)

Evaluation of the Government's progress on meeting patient safety recommendations

Summary

1. The Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) support the work of MBRRACE-UK and are committed to acting on any recommendations directed towards us in MBRRACE-UK national reports.
2. One ongoing challenge for MBRRACE-UK is the delay in receiving data, which results in reports based on data which is at least 12 months old. It would be beneficial for the whole system if data could be provided in a timelier way. It is also the case that not all units comply with reporting requirements for PMRT.
3. Questions remain over the independence of the Maternity and Newborn Safety Investigations (MNSI) programme, given that it is hosted by the CQC. Staff in maternity services have raised concerns about this hosting arrangement and it is not clear what measures are in place to ensure MNSI work is fully independent from the related work of the CQC.
4. The increase in the number of maternity units downgraded as a result of CQC inspections, is indicative of the systemic pressures being exerted on services due to increasingly complex care, staff shortages and levels of burnout among staff. It is imperative that further action is taken at national level to boost workforce numbers so staff have time to undertake training and implement measures to improve cultures and working practices where necessary.
5. It is unclear whether Integrated Care Boards (ICBs) have the expertise to understand maternity services and the skills and experience to provide constructive, informed oversight and scrutiny. It is essential that maternity services are represented at senior leadership level, to provide appropriate and sound advice and guidance to ICBs.
6. Recent reports have highlighted problems with Board-level scrutiny of maternity services, with the response of Boards and senior managers to avoid taking responsibility for their organisation's performance and generally falling short of the standards that could reasonably be expected of them.
7. Taking the findings from these reports in the round, we believe further action is needed to ensure that:
    a. There is adequate scrutiny of Boards and managers, as there is rightly for clinical staff.
    b. This needs to be accompanied by a shift to a more collaborative culture, where Boards and managers support their staff, rather than scapegoating them when things go wrong.
    c. Board members and senior managers are supported and trained to understand and effectively fulfil their responsibilities.
    d. Trusts review their approach to reputation management.
    e. There is proper representation and voice for maternity services on trust Boards.
    f. There is clarity as to how NHS England assures and manages adherence to codes of ethics, standards and conduct, to ensure that they make a tangible, positive and ongoing impact on the performance of Boards and managers.
8. While the RCM has developed preceptorship guidance and implemented leadership programmes, financial constraints will limit the extent to which it is able to meet the significant demand from members for these programmes. Some form of funding support from the Government would be welcome, given that these programmes align with the recommendations in the Messenger report.

9. Support is particularly important for newly qualified staff, as they transition into their first NHS post following qualification. In addition to induction programmes, new staff should be able to experience a period of further development and confidence building. Which is why the RCM recommends that newly qualified midwives are provided with a period of preceptorship to complement any formal induction and orientation programmes.
10. Staffing shortages are limiting opportunities for preceptees to be given protected and supernumerary time or for the availability of named preceptors. More generally, understaffing is constraining opportunities for staff development and learning.
11. The examples of Shrewsbury and Telford and East Kent are testament to how far some Boards are from being able to demonstrate their commitment to creating and maintaining a safe learning culture.
12. The openness and transparency of trusts, and the confidence that staff have to raise concerns, is of critical importance to the development of a culture of safety and learning. We believe that maternity staff should feel able to speak out if they have any concerns about the quality and standards of care provided or if they suspect treatment or care will or has caused harm, or if they see cultures or behaviours that put colleagues or women and babies at risk.

About us

The Royal College of Obstetricians and Gynaecologists (RCOG) is a professional membership organisation made up of over 16,000 members worldwide. We work to improve health care for women, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health care.

The Royal College of Midwives (RCM) is the only trade union and professional association dedicated to supporting midwives and maternity support workers (MSWs). We provide workplace advice and support, professional and clinical guidance and information, and learning opportunities with our broad range of events, conferences and online resources.

We set out below our evidence in relation to those recommendations that are most relevant to maternity services.

Safety recommendation

Steps are taken, without delay, to implement in full a system based on the use of medical examiners to independently scrutinise maternal and perinatal deaths. (Morecambe Bay Investigation, 2015)

<u>Progress against the recommendation</u>

1. At a national level, the majority of maternal and perinatal deaths are scrutinised via MBRRACE-UK. The MBRRACE-UK online reporting form is a data collection tool for national surveillance while its Perinatal Mortality Review Tool (PMRT) has been designed as a review tool to assist units in completing a structured, standardised and thorough review. It is therefore important that both are used as they fulfil distinct functions. MBRRACE-UK regularly publishes reports and makes recommendations to improve maternal and perinatal

care, based on surveillance and reviews. The RCM and RCOG support the work of MBRRACE-UK and are committed to acting on any recommendations directed towards us in MBRRACE-UK national reports.

2. The most recent MBRRACE report[1] includes surveillance data on women who died during or up to one year after pregnancy between 2019 and 2021, along with confidential enquiries into the care of women who died between 2019 and 2021 from obstetric haemorrhage, amniotic fluid embolism, anaesthetic causes, infection, general medical and surgical disorders and epilepsy and stroke. The report also includes a Maternity Confidential Enquiry into the care of women with morbidity following repeat caesarean birth.

3. Key findings from the report included:

    a. A statistically non-significant increase in the overall maternal death rate in the UK between 2016/18 and 2019/21. When deaths due to COVID-19 in 2020 and 2021 were excluded, the maternal death rates for the two periods were similar, "which suggests that an even greater focus on implementation of the recommendations of these reports is needed to achieve a reduction in maternal deaths."
    b. The persistence of a nearly four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women. Of the women who died during this period, 12% were at severe and multiple disadvantage while women living in the most deprived areas continue to have the highest maternal mortality rates.
    c. Deaths from cardiovascular disorders, thrombosis, thromboembolism and psychiatric disorders accounted for 38% of maternal deaths. During 2020 and 2021, maternal mortality attributable to COVID-19 was at a rate well in excess of that due to any other single cause.
    d. There was a significant 33% increase in maternal death rates from direct causes between 2016-18 and 2019-21, with thrombosis and thromboembolism the leading cause of direct maternal death during or up to six weeks after the end of pregnancy.
    e. Deaths from mental health-related causes accounted for nearly 40% of deaths occurring between six weeks and a year after the end of pregnancy, with maternal suicide remaining the leading cause of direct deaths in this period.
    f. For women with records available, overall, a post-mortem examination was carried out in only 67% of deaths (84% for women who died from direct causes, 63% amongst women who died from indirect causes, 55% amongst women who died from coincidental causes and 63% amongst women who died between six weeks and one year after the end of pregnancy. "As noted in previous reports, establishing the cause of women's deaths with a high-quality autopsy is essential not only to improve future care, but to ensure any family counselling or testing is appropriate."

4. Where, in a small number of cases, MBRRACE-UK does not review maternal deaths, this is predominantly due to the death being coincidental to or outside of the maternity episode of care.

[1] MBRRACE-UK (2023) *MBRRACE-UK Saving Lives Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21* MBRRACE-UK_Maternal_Compiled_Report_2023.pdf (ox.ac.uk)

5. According to the most recent PMRT report2, covering the period March 2022 to February 2023, during 2022 a review of care was started for 97% of all babies who died in the perinatal period, comprising 97% of stillborn babies and those who died in the late second trimester, and 95% of babies who died in the neonatal period.

6. There has been a steady improvement in the composition of review teams, with the median number of staff present increasing from five in 2018/19 to eight in 2021/22. The proportion of reviews including the presence of a neonatologist or paediatrician has increased from 23% of all reviews in 2018/19 to 83% in 2021/22.

7. The report does however voice concern about an increase in reports from parents of communication issues, not feeling listened to and feeling unsupported. For 12% of trusts and health boards, fewer than half of parents had provided feedback by the time of the review, although it was unclear the extent to which this was based on informed choice as opposed to a lack of support in being empowered to do so.

8. There was at least one issue with care identified in 98% of reviews and over time there has been a general decline in cases graded as having 'no issues with care identified' and a commensurate increase in the proportion graded as either 'issues which may have made a difference to the outcome' or 'issues which were likely to have made a difference to the outcome'. In the context of generally decreasing perinatal mortality rates, this may reflect a greater propensity for review teams to be self-critical of the care their organisations provided and seeking to improve future care, rather than evidence of poorer care being provided.

9. While the report concluded that the overall direction of travel was positive, it did however stress the continuing need for multiple, incremental and sustained improvements across all aspects of care if further improvements in the perinatal mortality rate are to be achieved and sustained.

10. One ongoing challenge for MBRRACE-UK is the delay in receiving data, which results in reports based on data which is at least 12 months old. It would be beneficial for the whole system if data could be provided in a timelier way. It is also the case that not all units comply with reporting requirements for PMRT.

11. In terms of investigating incidents in maternity care, although many organisations have recognised the need for independent reviews and scrutiny of perinatal and maternal deaths, this has not yet been fully achieved.

12. The initial intention for HSIB maternity investigations to become a new special health authority ended with a last-minute decision to move maternity investigations to the CQC in the form of the Maternity and Newborn Safety Investigations (MNSI) programme. The MNSI programme became operational in October 2023.

13. The purpose of MNSI is to provide independent, standardised, and family focused investigations of maternity cases, within the NHS, for families and to analyse data to identify key trends and provide system-wide learning, to be a system expert in standards for

[2] National Perinatal Mortality Review Tool (2023) PMRT: *Learning from Standardised Reviews When Babies Die* PMRT_Report_19-Dec-2023_-_Main_Report_v10_.pdf (ox.ac.uk)

maternity investigations, and to collaborate with system partners to escalate safety concerns.

14. Questions remain over the independence of the MNSI given that it is hosted by the CQC. Staff in maternity services have raised concerns about this hosting arrangement, questioning the ability of the MNSI to be truly independent when housed at the regulator that has undertaken an extensive maternity inspection programme. It is not clear what measures are in place to ensure MNSI work is fully independent from the related work of the CQC.

15. It is worth noting that the CQC inspection programme has frequently resulted in down-grading of units, with many services now rated as inadequate. We would suggest that this is indicative of the systemic pressures being exerted on services due to increasingly complex care, staff shortages and levels of burnout among staff. It is imperative that further urgent action is taken at national level to boost workforce numbers so staff have time to undertake training and implement measures to improve cultures and working practices where necessary.

16. As part of a research and workforce planning exercise, the Department of Health and Social Care (DHSC) commissioned the RCOG to more accurately quantify the number of obstetricians required in maternity units in England. A tool describing obstetric and anaesthetic staffing has been developed to support this work. The prototype Workforce Planning Tool has been submitted to DHSC with a final report providing an estimate of the required number of obstetric staff in England. However, continuation of this work is dependent on DHSC confirming plans for the next phase of the project. Information is not available at this point on when this confirmation may be expected.

17. We welcome the findings and recommendations of the East Kent report[3] around early warning of adverse events. The report calls for a "more reliable" system to be put in place nationally to give early warning of problems before they cause significant harm, without the need to rely on families to raise concerns of harm. It says that the system should be based on "better outcome measures that are meaningful, reliable, risk adjusted and timely, with trends and comparators for individual units, and to provide a national overview." The RCOG and RCM are active members of the taskforce set up to drive the introduction of new maternity and neonatal outcome measures.

18. We have concerns about the extent to which Integrated Care Boards (ICBs) understand their role in the oversight and scrutiny of maternity services. It is unclear whether ICBs currently have the expertise to understand maternity services and the skills and experience to provide constructive, informed oversight and scrutiny. It is essential that maternity services are represented at senior leadership level, to provide appropriate and sound advice and guidance to ICBs.

19. In April 2023, the Government confirmed next steps towards the statutory medical examiner system, to provide independent scrutiny of the causes of death to provide greater

[3] Dr Bill Kirkup CBE (2022) *Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation* Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk)

safeguards for the public by ensuring independent scrutiny of all non-coronial deaths. Full introduction of the statutory system will be from April 2024.

Safety recommendation

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. (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)

Progress against the recommendation

1. The principal response from the Government to this recommendation was to refer to the Professional Standards Authority's *Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England*. These standards covered the personal behaviours, technical competencies and business practices that Board members would be expected to commit to and abide by. These standards are arguably in keeping with the spirit of the recommendation in the Francis Report, but they fall short of being a code that employers could be expected to enforce. While the standards remain as a live document on the PSA's website, there does not appear to have been any further iterations or updates since they were first published in November 2013.

2. In *Hard Truths*[4]*,* the official response to the Francis Report, the Government was clear that Boards needed to take responsibility for the culture and performance of their organisations while also acting as a source of internal scrutiny and challenge: *"The temptation to fall back into simply defending the organisation and advancing its interests is strong; but Boards that do this risk not seeing the real issues and problems of their organisation…..Boards need to be supportive of their organisations but not at the expense of their critical distance: sometimes an organisation's board needs to be its harshest critic. All too often, Boards have avoided this role."*

3. Unfortunately, recent reports have highlighted problems with Board-level scrutiny of maternity services, with the response from Boards and senior managers to avoid taking responsibility for their organisation's performance and generally falling short of the standards that could reasonably be expected of them.

4. The Ockenden Review of maternity services at The Shrewsbury and Telford Hospital NHS Trust[5] included reviews of the experiences of nearly 1,500 families over a 20-year period

[4] Department of Health (2014) *Hard Truths: The Journey to Putting Patients First. Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry* Hard Truths: The Journey to Putting Patients First: Volume One (publishing.service.gov.uk)

[5] Independent Maternity Review (2022) *Ockenden report – Final: Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*

from 2000. Among the many deficiencies in care that the review identified were failings in the Trust leadership team up to Board level, with a failure *"to foster a positive culture to support and encourage service improvement. In addition, the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans….Where investigations took place there was a lack of oversight by the Trust Board, unfortunately the review believes this has persisted in some incident investigations as late as 2018/19 considered as part of this review."*

5. The report recommended that trust Boards should work with their maternity departments on developing regular progress and exception reports, and assurance reviews and regularly review the progress of any maternity improvement and transformation plans.

6. The Independent Investigation of maternity and neonatal services in East Kent found that, during the period 2009 to 2020, the provision of maternity care was often suboptimal, that this led to significant harm, to a failure to listen to the families involved and that the Trust acted in a way which made the experience of families unacceptably and distressingly poor. Senior managers and the Trust Board would have been aware of the individual and collective failings in maternity care, as these were outlined in a series of reports throughout the period reviewed and could at any time have taken action to acknowledge and tackle the problems. Instead, the review identified:
    a. A disconnect between 'ward and Board,' exacerbated by Executives not being on location enough to visit maternity services.

    b. A *"disposition to minimise problems, so it is unsurprising that the Trust has given the appearance of covering up the scale and systematic nature of these problems"*

    c. A tendency *"to replace staff in key managerial roles who identified and challenged poor behaviour. The staff who remained were those who either personified the poor culture or were prepared to live with it rather than question it."*

    d. A series of missed opportunities by the Trust Board *"to properly identify the scale and nature of the problems and to put them right."* While the Board did endorse a succession of action plans, the way in which the Board engaged with these masked the true scale and nature of the problems. *"Instead, the plans supported an imagined world where there were fewer problems, and where the plans associated with newly appointed staff were deemed to be sufficient despite the previous recurring pattern of failure."*

    e. Where issues became public, due to the efforts of families or media interest, rather than prioritising patient safety and learning, the Trust focussed on reputation management, reducing liability through litigation and a 'them and us' approach.

7. The CQC has conducted focused inspections of maternity services, with 73% of services inspected in the last year, as of September 2023[6]. In the context of services and staff operating under huge pressure, one of the emerging themes from the inspections has been that leadership remains an area of concern. While CQC has identified examples of good practice, including at board level, it has also found issues with governance and a lack of oversight from boards, including challenges in identifying issues and packages of support at service delivery level.

OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)

[6] CQC (2023) *The state of health care and adult social care in England 2022/23* Quality of care - Care Quality Commission (cqc.org.uk)

8. One consequence of these reports and investigations has been to increase the focus of maternity and neonatal services at Board level. Furthermore, NHS Resolution's *Maternity Incentive Scheme* offers financial incentives for trusts that can demonstrate that they have: *"robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues."*

9. Taking the findings from these reports in the round, we believe further action is needed to ensure that:
    a. There is adequate scrutiny of Boards and managers, as there rightly is for clinical staff.

    b. This needs to be accompanied by a shift to a more collaborative culture, where Boards and managers support their staff, rather than scapegoating them when things go wrong. As the East Kent report stated: *"Clinicians should not have to live in fear of clinical error and its aftermath; it is an inescapable accompaniment to practice everywhere."*

    c. Board members and senior managers are supported and trained to understand and effectively fulfil their responsibilities.

    d. Trusts review their approach to reputation management.

    e. There is proper representation and voice for maternity services on trust Boards.

    f. There is clarity as to how NHS England assures and manages adherence to codes of ethics, standards and conduct, to ensure that they make a tangible, positive and ongoing impact on the performance of Boards and managers.

Safety recommendation

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

Progress against the recommendation

1. While the Government accepted all seven recommendations in the Messenger report, when it was launched on 8th June 2022, the national induction scheme for staff of all grades (recommendation one) will not be launched until April 2024.

2. Regardless of whether the proposed launch date is met, we remain concerned about the impact that staffing shortages will have on the ability of maternity staff to participate in and receive a full induction programme, including on collaborative leadership and organisational values.

3. The RCM has developed preceptorship guidance[7] and implemented a Band 7 leadership programme (completed by 30 participants in 2023) and a Director of Midwifery Leading with Impact and Intent programme (completed by 20 participants in 2023). While the RCM will be putting on additional programmes in 2024, financial constraints will limit the extent to which we will be able to meet the significant demand from members for these programmes. Some

[7] RCM (2023) *Preceptorship guide: How to get the most from your midwifery preceptorship* rcm-preceptorship-document_digital.pdf

form of funding support from the Government would be welcome, given that these programmes align with the recommendations in the Messenger report.

4. Support is particularly important for newly qualified staff, as they transition into their first NHS post following qualification. In addition to induction programmes, new staff should be able to experience a period of further development and confidence building. Which is why the RCM recommends that newly qualified midwives are provided with a period of preceptorship to complement any formal induction and orientation programmes.

5. Current staffing shortages in midwifery are, unfortunately, limiting the opportunities for preceptees to be given protected and supernumerary time or the availability of named preceptors to provide defined support to the preceptee.

6. More generally, understaffing is severely constraining opportunities for staff development and learning, as detailed in a 2022 report by the Baby Loss and Maternity All Party Parliamentary Groups[8] into the impact of staff shortages. Responses from staff and organisations alike revealed how staff shortages were severely limited opportunities for continuous professional development (CPD) and leading to the cancellation of mandatory training courses or their being moved to online only.

7. With little opportunity for CPD, the report found that many staff were unable to develop the breadth and depth of knowledge and practice, which would equip them with the learning, skills and confidence to give women and families the safest and best quality care.

Safety recommendation

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 practice, as identified in this report, as relevant to whether an organisation is safe and well-led. (Freedom to Speak Up Review, 2015)

Progress against the recommendation

1. Examples of Shrewsbury and Telford and East Kent are testament to how far some Boards are from being able to demonstrate their commitment to creating and maintaining a safe learning culture. At Shrewsbury and Telford, the Ockenden Review concluded that the Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period.

[8] APPG on Baby Loss, APPG on Maternity (2022) *Safe Staffing: The impact of staffing shortages in maternity and neonatal care. Report of the Baby Loss and Maternity All Party Parliamentary Groups* Staffing shortages - APPG report, Oct 22 (final).pdf (sands.org.uk)

2. According to the report into maternity and neonatal services in East Kent, a recurring theme throughout the period under review was that of individuals and agencies questioning the extent to which the Trust was learning from incidents and embedding improvements. The report found that maternity featured little in Board discussions, governance sessions and discussions about maternity and neonatal services were rarely detailed and issues became diluted and their significance not realised as they were reported up the chain.

3. As previously stated, the CQC's most recent report on the quality of health and care services in England highlights continuing concerns with the leadership of maternity services and with a lack of Board oversight.

4. We therefore welcome the ambition, set out in the three-year delivery plan for maternity and neonatal services[9], for a shared commitment to safety and improvement at all levels, including the trust board, underpinned by:

    a. Appointing an executive and non-executive maternity and neonatal board safety champion and supporting all senior leaders, including Board maternity and neonatal safety champions, to engage in national leadership programmes, by April 2024.
    b. Requiring Boards to regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their freedom to speak up (FTSU) strategy.
    c. Ensuring there are clear and structured routes for staff to escalate clinical concerns and that staff have access to FTSU training modules and a Guardian who can support them to speak up.
    d. Maintaining and ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
    e. Regularly reviewing the quality of maternity and neonatal services, supported by clinically relevant data.
    f. Listening to and acting on feedback from staff, including FTSU data, concerns raised, and suggested innovations.

5. The openness and transparency of trusts, and the confidence that staff have to raise concerns, is of critical importance to the development of a culture of safety and learning. We believe that maternity staff should feel able to speak out if they have any concerns about the quality and standards of care provided or if they suspect treatment or care will or has caused harm, or if they see cultures or behaviours that put colleagues or women and babies at risk.

6. The Independent Maternity Working Group (IMWG) is chaired jointly by the RCM and RCOG and set up in response to the publication of the final Ockenden Report. One of the aims of this group is to act as a collective voice to amplify the case for change, using our networks to spread best practice and gain evidence of the opportunities and hurdles, using our experience and expertise to support the entire system, from policy makers to individual clinicians, all of whom have a role to play.

[9] NHS England (2023) *Three year delivery plan for maternity and neonatal services* NHS England » Three year delivery plan for maternity and neonatal services

7. The RCM has published a position statement and guidance[10], which outlines how midwives, student midwives and maternity support workers (MSWs) should be supported if they have concerns at work. This reflects the RCM's commitment to encourage professionals to be candid with women and families, colleagues and those undertaking statutory responsibilities as part of a culture that promotes transparency as a means to improving health outcomes, and in which those who shed light on wrongdoing do not fear for their careers. While the RCM is not an inspectorate and does not have the authority to investigate, it will work with members to help resolve any concerns that are raised or will escalate them to the Head or Director of Midwifery, Director of Nursing/Chief Executive and, in necessary, the Regional Chief Midwife.

[10] RCM (2022) Position statement: *Raising concerns* rcm_raising-concerns_position-statement-final.pdf; RCM (2022) *Standing up for higher standards: How the RCM will support midwives, student midwives and maternity support workers (MSWs) if they have concerns at work* standing-up-for-higher-standards_-publication_final.pdf (rcm.org.uk)