Written evidence submitted by the Care Quality Commission (PSN0025)

Introduction

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Our role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve. We register and assess services and publish what we find. Where we find poor care, we will use our enforcement powers to take action. Through the Health and Care Act 2022, we also have new responsibilities to assess integrated care systems and local authorities.

2. The Maternity and Newborn Safety Investigations (MNSI) programme has been hosted by CQC since October. Until September 2023, it was previously part of the Healthcare Safety Investigation Branch (HSIB).

3. This response provides information from both CQC and MNSI, to assist the Expert Panel in its evaluation of progress on the recommendations related to maternity care and leadership, and culture of safety and whistleblowing.

Maternity care and leadership

Recommendation 1: *From the inquiry into Morecambe Bay Investigation, 2015*

4. The National Maternity Safety Ambition, launched in November 2015, aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care. This sets out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies.

5. The Secretary of State for Health and Social Care asked the MNSI programme to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan. This work started in April 2018, and achieved full national coverage in April 2019.

6. All NHS trusts in England are required to tell MNSI about certain patient safety incidents that happen in maternity care. This is so that MNSI can carry out an independent investigation using a standardised methodology, share findings and make safety recommendations where relevant to improve maternity services.

7. The patient safety incidents that are referred to MNSI are babies born following labour after 37 weeks and where the outcome is:
    - Baby dies during labour and before birth (intrapartum stillbirth).

- Baby born alive and dies in the first week (0-6 days) of life (early neonatal death).
- Baby born with a potential severe brain injury diagnosed as occurring in the first 7 days of life.

8. MNSI also investigate when mothers die whilst pregnant or within 42 days of the end of their pregnancy. There are some occasions where MNSI do not investigate. More detail about this can be found on the 'what we investigate' page on the MNSI website.

9. At the end of the investigation, MNSI shares a report with the family and trust. The trust is responsible for implementing any safety recommendations made in the report.

10. MNSI regularly reviews the safety issues identified from individual investigations to look for recurring themes. This way MNSI also share thematic learning to all organisations providing maternity care, with the aim of improving maternity services across the whole healthcare system in England.

Recommendation 2: *From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.*

11. As stated in this year's State of Care report, we continue to have concerns around the quality of maternity services. We reported that ten per cent of maternity services were rated as inadequate overall, while 39% were rated as requires improvement. Leadership remains a particular area of concern with 12% rated as inadequate for being well-led.

12. Over the last year, we have continued our programme of focused inspections of maternity services in NHS acute hospitals with a focus on improvement at a national - not just local - level. We committed to inspecting all services that we hadn't inspected and rated since April 2021.

13. We have recently completed inspections of all 131 hospitals that were in scope of the programme and continue to publish our findings in individual inspection reports. Once all reports have been published, we plan to report on the key themes and learnings from the inspection programme as a whole and share good practice to support hospitals to make key improvements. We will work with providers, families and other relevant stakeholders to help ensure what we share is helpful and complements other national guidance and information.

14. In our report on Safety, equity and engagement in maternity services, we highlighted the importance of having a strong maternity leadership team, where the service level manager, midwifery, and obstetric leaders are all working well together to provide care that meets the needs of people using the service.

15. Findings from our maternity inspection programme indicate that leadership remains an area of concern, with the quality of leadership varying between trusts. However, we have seen some good practice during our inspections,

including at board level, which can be found in our State of Care report. We've also seen examples of trusts actively taking part in national audits, surveys, and initiatives to benchmark performance and identify areas for improvement. Where local leaders have clear board-level oversight, scrutiny and support, services are empowered to improve.

16. We continue to find issues with governance and lack of oversight from boards, including challenges in identifying issues and packages of support at service delivery level. To address these leadership concerns and develop a positive safety culture, NHS England's Three year delivery plan for maternity and neonatal services includes a commitment that all neonatal, obstetric, midwifery and operational leads will have been offered the perinatal culture and leadership programme by April 2024. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Culture of safety, and whistleblowing

Recommendation 4: *From the Freedom to Speak Up Review, 2015*

17. 'Safety through Learning' is one of four strategic ambitions set out in our 2021 strategy, with the aim of creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences and taking clear and proactive action when safety doesn't improve.

18. As part of implementing our strategy, we have published a new single assessment framework which strengthens our approach to assessing safety cultures.

19. We are using 'I statements' as the starting point for this framework, taking the important first step towards truly regulating through the eyes of the public. The statements encapsulate the views and expectations of people using services, to help us to focus the whole health and social care system on them.

20. These are followed by 'quality statements' that are pitched at the level of 'good' to help us make our judgments about the quality of care. Expressed as 'we statements', they are the commitments that providers, commissioners and system leaders should live up to. They guide providers on what is needed to deliver high-quality, person-centred care, to make sure people's actual experience of care and support lives up to the I statements.

21. A quality statement for Learning Culture has been incorporated into our new framework, as has a quality statement for Freedom to Speak Up. Each quality statement is mapped to the relevant fundamental standard regulations, and if a breach of a regulation is identified then we can take action as set out in our enforcement policy.

22. From 21 November we started using our new single assessment framework in our South region, and this will roll out to other regions over the next few months.

We will initially be prioritising service level assessments for the NHS. This will allow us to:

- Update service level ratings
- Provide time for our teams to build relationships with providers
- Allow time for providers to familiarise themselves with changes to the regulatory model

23. We will publish more detail on our roll-out plans for NHS Trust level assessments in due course.

24. As part of the government review of our regulations, we are in discussion with the Department of Health and Social Care (DHSC) about a proposal (Safety through learning: Learning from concerns) which seeks to ensure providers develop and maintain a safety/learning culture. This would enable workers to speak up about patient and worker safety, well-being and other matters without fear of reprisal or detriment, giving CQC the regulatory power to use enforcement powers against providers who do not act on speaking up concerns, or penalise staff who speak up.

Recommendation 4, Action 1.2: *From the Freedom to Speak Up Review, 2015*

25. As above, a quality statement for Freedom to Speak Up has been incorporated into our new assessment framework, under the well led key question. This quality statement is assessed at service level, and also as part of the Trust level assessment.

26. We have published guidance, legislation and best practice to support the quality statement. Further guidance to support the Trust level assessment is being finalised and will detail national policies and best practice guidance that should be adhered to.

27. When we start to regulate using our new assessment framework, the scores we determine for the Freedom to Speak Up quality statement will have a direct impact on the rating for well led.

Recommendation 5: Action 19.3 *From the Freedom to Speak Up Review, 2015*

28. As part of our existing assessments, we consider arrangements to support staff to speak up in primary care settings. For example, in our GP assessments we consider:
    - If staff feel able to raise concerns without the fear of retribution
    - If the practice encourages candour, openness and honesty
    - If there was access to a Freedom to Speak Up Guardian

29. To ensure GP providers understand how we look at a practice's freedom to speak up arrangements, we have published relevant guidance for GPs. This details the areas we will check if there are concerns about the speaking up process and shares relevant guidance and best practice.

30. CQC is represented at the Freedom to Speak Up steering group chaired by NHS England, which aims to:
    - further understand the challenges for Freedom to Speak Up across all primary care contractor groups (and the support at system, regional and national level that would help address those challenges)
    - Explore and improve routes for freedom to speak up processes for primary care workers.

31. As mentioned in our response to progress on recommendation 4, we have introduced a quality statement on Freedom to Speak Up as part of the assessment framework we will be using under our new regulatory approach. When assessing primary care services against this quality statement, we'll look at evidence related to feedback from staff and leaders and processes. The quality statement sits under the Well-led key question and will be considered as part of our assessments of all primary care providers.

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