Care Quality Commission – Supplementary written evidence (PRT0085)

1. **The Committee has heard that there is significant variation in how national guidelines relating to preterm birth are implemented by providers. What could be done to address this?**

- While we cannot comment specifically on all pre-term birth services, these services do form part of our overall approach to assessing maternity services.
- In our recent Workshop with Maternity providers and during our inspection of 131 maternity services, we have seen that maternity services are faced with a plethora of guidelines and recommendations from a range of organisations.
- We saw variation in how trusts and clinicians interpreted guidance and recommendations on key areas such as triage and reporting incidents. While this variation exists, there is room for confusion, loss of learning and potential harm.
- Consistency from national organisations and Royal Colleges would provide front-line staff with much-needed clarity when caring for women and babies.
- We have seen, and services have also reported, the huge administrative burden of submitting against the proliferation of requirements in recent years following maternity reviews.

Many maternity providers at our recent maternity workshop suggested that national organisations should streamline requirements and reporting into a single place to avoid duplication, have clearer guidelines and reduce administrative burden.

2. How does the CQC use its inspection and enforcement powers to ensure guidelines are implemented consistently?

- We use our powers under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment.[1] The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The relevant part of our guidance for this regulation is:

  "Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amended them to address changing practice."

- During assessment and on-site inspection activity of these services, evidence provided by the service in the form of data, minutes of meetings and policies are evaluated by our assessors and the evidence seen, heard and read on inspections is all used to evaluate how well guidelines are being followed.

- As part of our Single Assessment Framework[2] we expect providers, commissioners and system leaders to have a proactive and positive culture of safety, based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

- Providers are required to with Regulation 20: Statutory Duty of Candour which is a general duty to be open and transparent with people receiving care. The regulation also defines 'notifiable safety incidents' for which there are specific actions that registered

[1] https://www.cqc.org.uk/guidance-providers/regulations/regulation-12-safe-care-treatment
[2] https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/safe/learning-culture

persons must take. DHSC are currently carrying out a review of Regulation 20: Duty of Candour[3][4].

- We also expect providers, commissioners and system leaders to deliver evidence-based care and treatment[5], to plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

3. What is driving the ethnic and socio-economic disparities in care and outcomes for mothers at risk of preterm birth and their babies? What is the role of the CQC in addressing this?

- Women from Black and minority ethnic groups have poorer experiences of maternity care and face additional risks. While maternal deaths are rare, maternal mortality rates are significantly higher for women and their babies from Black and minority ethnic groups than for women and their babies from White groups. This has been well documented in national reports and we have seen evidence of this during our National Maternity Safety Inspection programme, where we inspected 131 maternity services[6].
- Our most recent annual State of Care report[7] looked closely at inequalities in maternity care for people from ethnic minority groups and our interviews with midwives from ethnic minority groups for this report gave us valuable insight on equality, diversity and inclusion in maternity services in England.

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[3] https://www.gov.uk/government/publications/duty-of-candour-review-terms-of-reference
[4] https://www.gov.uk/government/calls-for-evidence/duty-of-candour-review/duty-of-candour-review
[5] https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/effective/delivering-evidence-based-care
[6] We expect this to publish our findings from this work later this year.
[7] https://www.cqc.org.uk/publications/major-report/state-care/2022-2023/inequalities

- The negative experiences they told us about ranged from problems with language and communication, not having the information they need about their own or their baby's health, stereotypes and cultural awareness leading to negative experiences and safety issues. Subsequently, as well as the disproportional adverse effects of treatment in harm and mortality, these negative experiences can also lead to disengagement from services, and physical and mental ill-health.
- To summarise, Women from Black and minority ethnic groups experience racism in several different ways which has an impact on safety and outcomes. Firstly, they may experience inter-personal racism from individual clinicians such as stereotypes around pain thresholds, secondly they may experience institutional racism such as failure to provide culturally appropriate care or barriers to access or communication during childbirth and thirdly they may be impacted by structural racism, for example poorer housing, transport or education which impacts on their health.
- The report highlights what could be done to address these issues which includes developing channels for staff and people using services to feel safe in reporting inequitable care, developing maternity networks, developing specific roles such as cultural safety champions, more open acknowledgement of the root causes of disparities in care, developing the availability of interpreting and translation services, increasing the knowledge of staff around cultural practices and conditions and improving outreach and engagement with ethnic minority communities.
- Addressing inequalities in access and tailoring maternity services to best meet the needs of the local population is a critical area for action and something that good services have been prioritising.
- Our role is to shine a light on the importance of good leadership, effective governance, a strong safety culture and a proactive

approach to addressing health inequalities and institutional racism within services. Our forthcoming national maternity report will stress the importance of using demographic data to monitor and analyse outcomes for women from ethnic minority groups.

- However, the way many trusts currently collect and use this data varies and we are concerned that this data gap is preventing trusts from making improvements.
- As part of our Single Assessment Framework we have a specific Quality Statement aimed at reducing inequalities: 'Equity in experiences and outcomes[8]:

  "We expect providers, commissioners and system leaders to live up to the following statement:

  We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this."
- Part of this quality statement means that we will assess that:
  - People feel that their experiences of discrimination and inequality are listened to and acted on to improve care.
  - Leaders and staff are alert to discrimination and inequality that could disadvantage different groups of people using their services, whether from wider society, organisational processes and culture or from individuals. They proactively seek out ways to address these barriers to improve people's experience, act on information about people's experiences and outcomes and allocate resources and opportunities to achieve equity.

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[8] https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/responsive/equity-experiences-outcomes