**Health and Social Care Committee Inquiry: the safety of maternity services in England**

**Submission by NHS Providers, 4 September 2020**

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £87bn of annual expenditure and employing more than one million staff.

We welcome the opportunity to make a submission to this important inquiry. In line with our areas of knowledge and expertise, our submission focuses on the role of boards, reflections on trusts’ work to improve maternity care within the healthcare system and tackle a blame culture, and the role of the Healthcare Safety Investigation Branch (HSIB).

**Key messages:**

* Despite the pressures facing the health and care system, and its staff, over the last few years, quality overall has in most cases been maintained and most people have a good or excellent experience of care. However, we note that there is variation between trusts in the quality of maternity care, the drivers of which need to be better understood and fully addressed.
* We understand from trusts that although there is considerable scope for improvement, good progress is being made in maternity care; recommendations from the inquiry could therefore helpfully add value to existing improvement programmes locally and nationally.
* Trusts tell us how important meaningful patient engagement has been in successful maternity improvement. We are hopeful the forthcoming introduction of Patient Safety Partners, part of the National Patient Safety Strategy, expected next year will further embed and build on this.
* It would be helpful for the inquiry to explore how systemic barriers such as the mismatch between demand for services and the available funding and workforce capacity, can impact on safety.
* The NHS has rightly been developing a learning culture but despite progress and commitment from providers, a blame culture arguably still exists within the NHS. Compassionate and inclusive leadership from provider boards remains fundamental in addressing this but positive behaviours must also be modelled at all levels of the system including by national and regional bodies. NHS Providers recognises the value of ‘just culture,’ however the definition used across all policy needs to be aligned, for example in the National Patient Safety Strategy and *We are the NHS – the People Plan*.
* HSIB’s role should be to develop independent, expert-led analysis of the contributory factors behind patient safety incidents in healthcare and why they recur, by gaining a systemic view and supporting high standards in local investigations. In our view, the role of HSIB would therefore complement local learning and trusts’ efforts to support continuous learning and improvement as well as to meet their obligations to staff and patients.
* We welcomed the proposal that maternity investigations will return to the NHS next year, as there has been a risk within these specialist investigation programmes that the role of HSIB could prevent trusts from fulfilling their current responsibilities and implementing the learning following a serious incident. Any long term move for investigations to be led by an external body may damage trusts’ ability to remain accountable for the quality of care provided by their organisation.

**The impact of the work which has already taken place aimed at improving maternity safety:**

***Policy context***

1. Improving maternity care has been a priority for the NHS for over two decades, starting with *An Organisation with a Memory* in 2000 [[1]](#footnote-2). Since then, trusts have undertaken a great deal of work to improve the care of maternity services following a number of inquiries, investigations, alerts, policy guidance and patient safety programmes.
2. Examples of initiatives for safer and more personalised care include the Maternity Transformation Programme, to deliver the national ambition to halve the rates of stillbirths, neonatal mortality, and maternal mortality and brain injury by 2025. Other initiatives include Each Baby Counts, Each Baby Counts Learn and Support, Sign up to Safety and the work of NHS Improvement and the Patient Safety Collaboratives.
3. Trusts will also play a key role in implementing the NHS Patient Safety Strategy (NPSS) and forthcoming Patient Safety Syllabus, the Long Term Plan, and NHS People Plan – *We are the NHS.* We therefore feel that recommendations made as a result of this inquiry will be most impactful if they take into account this context, minimise the burden on trusts and add value to their existing efforts.
4. Despite the complexity of care increasing, the most recent review of the Better Births programme published in March 2020 has shown trusts are making good progress in reducing perinatal and maternal mortality; and in reducing stillbirth rates - the NHS met the 2020 20% reduction ambition in stillbirth rates two years ahead of schedule, with the other ambitions on trajectory to be delivered. Women’s experience of care is also improving, including their confidence in how safe their care is. Mental health support for perinatal women has also improved, with increases in staff and specialist capacity.[[2]](#footnote-3)
5. The Care Quality Commission (CQC) briefing on improvements in maternity safety in March 2020 highlighted that improvements had been seen in maternity ratings, but there is more work to do to ensure women receive consistently safe care across the country.[[3]](#footnote-4) Recent oral evidence to the *Black people, racism and human rights* inquiry by Professor Jacqueline Dunkley-Bent also highlighted inequalities that must be addressed.[[4]](#footnote-5)
6. The most recent Better Births Review identified a degree of variation and states “there remains a need to investigate and understand this variation at local and national levels, to ensure that improvements to maternity care are being made universally.” We fully acknowledge this needs to be addressed, and consider the planned initiatives to drive improvements in outcomes a great help. We also agree that it is crucial to better understand how to support those trusts who may be struggling with specific challenges locally, such as recruiting the right workforce, significant turnover in leadership and low volumes of case work, to help them achieve their ambition to improve maternity care.
7. Trusts tell us how important meaningful patient engagement has been in successful maternity improvement, with the patient voice crucial for learning. We are hopeful the forthcoming introduction of Patient Safety Partners, part of the NPSS, expected next year will further embed and build on this.

**Tackling systemic barriers and creating a system which supports trusts to improve safety**

1. Births have continued to happen regardless of demand, pressures and a recent pandemic. The NHS continued to deliver, on average, 1,800 babies a day every day over recent months. However recurrent issues can still be seen in a minority of cases and trusts are conscious of how devastating any patient safety incident is for the patients, families and staff involved. Extensive research has shown the pre-conditions for high quality, safe care are funding, staff, training, buildings, equipment, and other infrastructure, alongside good processes.[[5]](#footnote-6) The CQCs *Opening the door to change* similarly recognised the systemic barriers to safety. It found funding, rising demand and workforce challenges make it more difficult for organisations to learn from incidents.
2. NHS Providers have previously raised concern that patient safety may be at increasing risk due to the mismatch between demand for services and the funding, investment and workforce available.[[6]](#footnote-7) Despite the pressures of the last few years, quality has in most cases been maintained and most people have a good or excellent experience of care. However, we cannot rely on staff to continue to be stretched or resilient in the face of constant pressure without support to do so.
3. Organisations also find it difficult to make changes effectively amid so many competing priorities, and the NHS approach to patient safety improvement has previously added confusion on top of these pressures. [[7]](#footnote-8) It is vital that the forthcoming Patient Safety Syllabus gives all NHS organisations and staff the training, expertise and resources needed to fully embed an effective safety culture, whilst the NPSS continues to bring much-needed clarity, consistency and alignment to patient safety efforts across the NHS.
4. Trusts have highlighted the fragmented ways in which policy and safety information flows in and out of their organisation which increases risk. Lines of governance and communications between the national team and providers needs to be clear, with consistent approaches; for instance, the creation of the new Chief Midwifery Officer has been beneficial. However, one trust has highlighted it has the potential to create a two-tier approach to communications, with information by-passing the board, which could have an impact on oversight and assurance. This is especially important to be aware of as we move to more complex system and regional arrangements.

**The extent to which medical advice and decision-making is affected by a fear of the blame culture:**

1. Over the last few years, the NHS has rightly been developing a culture based on learning from individual or systemic mistakes and continuously driving improvement, rather than seeking to apportion blame. However despite progress and commitment from providers, a blame culture still exists, most recently highlighted in First Do No Harm, the Independent Medicines and Medical Devices Safety Review.[[8]](#footnote-9)
2. *A promise to learn – a commitment to act* (2013) highlighted blame as one of the main problems affecting patient safety in the NHS and recommended it be abandoned as a tool and instead trust the goodwill and good intentions of the staff.[[9]](#footnote-10) The job of the review was to distil learning from a number of reports and inquiries to identify changes needed. It also noted that “NHS staff are not to blame – in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems”, that “incorrect priorities do damage” and "fear is toxic to both safety and improvement".[[10]](#footnote-11)
3. The Rt Hon Jeremy Hunt MP, then Secretary of Health and Social Care, made tackling the blame culture an ambition in 2013, with subsequently a range of work committed to understanding more about what it takes to make this shift.[[11]](#footnote-12)
4. Safer care is not a linear and or easily controlled process, but is something that is deeply complex, dynamic and inter-related with the multitude of relationships, processes and events taking place day to day. The work of Dekker and Hollnagel and others are important in this regard. [[12]](#footnote-13) [[13]](#footnote-14) [[14]](#footnote-15) [[15]](#footnote-16) [[16]](#footnote-17) [[17]](#footnote-18) [[18]](#footnote-19) [[19]](#footnote-20) Safety experts have been calling for a re-alignment of safety, to widen the focus from purely looking at failure (Safety I) to also considering what is needed to ensure as much care as possible goes right (Safety II), recently acknowledged in the NPSS.[[20]](#footnote-21) This change in emphasis could help shift away from blame onto learning, as could an increased understanding of healthcare as a complex adaptive system and the implementation of a just and learning culture. Trusts have told us they see Safety II potentially playing an important role in moving from reactive to proactive approaches to safety, encouraging significant, open conversations around the realities of work as it really happens and bringing a more realistic, humble approach to managing risk in what is a high-risk industry.
5. NHS Providers has strongly supported the expansion of ‘human factors’ approaches in the NHS that do not punish people for speaking honestly about their involvement in safety incidents. We agree that people should be seen as the solution to harness, not the problem to blame.[[21]](#footnote-22)
6. The NPSS sets out the case for a safety culture, building on two decades of work in the NHS. It requires that providers "focus on the development and maintenance of a just culture by adopting the NHS Just Culture Guide or equivalent". We believe that having such a tool is valuable to help organisations evolve. It is important to note however that those providers further ahead in this work show that it takes a whole board and whole organisation approach to really start to embed a just culture.
7. We believe there is currently room for confusion on what a just culture really means specifically in health and social care which makes this task harder. The NPSS defines just culture in line with practice in the aviation industry.[[22]](#footnote-23) Whereas *We are the NHS* highlights the Just and Learning Culture training which is drawn from the work of Dekker.[[23]](#footnote-24) A consistent approach across all policy would be helpful.
8. An acknowledged, critical part of a safety culture is openness, transparency, and a willingness to recognise and learn from those times when care does not turn out as expected or desired. [[24]](#footnote-25) Trusts tell us that openness and reflection are essential for assurance and learning, with fear of blame a hindrance.
9. Patient Safety everywhere, but particularly in maternity services, is dependent upon a psychologically safe environment so that people can speak up when concerned or if they do not know something. The work of Edmondson is important in this regard.[[25]](#footnote-26) The Freedom to Speak Up (FTSU) Index helps organisations monitor their speaking up culture, with the index rising from 75.5 per cent in 2015 to 78.7 per cent in 2019, with a score of 70 per cent perceived as a healthy culture in other sectors.[[26]](#footnote-27) There continues to be variation however, both within and between organisations, which providers are focused on improving.
10. The role of trust board is crucial in supporting this transformation. However boards need more support to access the latest thinking, and be given clear guidance on what this means in practice, as well as being supported to role model the right behaviours. Compassionate leadership is also at the heart of the NHS mission as outlined by *Developing People, Improving Care*, with a key role for provider boards.[[27]](#footnote-28) They recognise the importance of role modelling, whilst highlighting the need to support senior leaders in learning how to tackle difficult behaviours.
11. Whilst provider organisations prioritise safety, as we set out above, it is critical to recognise that safety and culture are not entirely within their control. Safety is affected by wider system pressures under which they have no control, and there are large classes of hazards that are deep structural challenges within healthcare as a whole that make managing safety harder within organisations (for example the design of machinery, and look-alike and sound-alike medication).
12. Behaviours must align at all levels of the system, with recognition of the dilemmas facing providers and their staff, and a reduction in the blame and burden of the current regulation system. Senior leadership must also be supported as stated by the Long Term Plan which pledged a new compact of agreed behaviours.[[28]](#footnote-29) We consider this an important step in shaping a positive, open and transparent culture nationally and at a local level. The acknowledgement of a just culture in national policy also needs to be reflected through the reporting practices around harm, and the national bodies’ endorsement of appropriate management responses to harm.
13. As the NHS moves to local system working and outcomes based measurement, the openness and transparency that underpins a just culture will need to extend across organisations as well as within them. This requires clarity and alignment at all levels of leadership on what behaviours and attitudes represent a just culture approach, as well as the systems and processes that support it.

**The role and work of the Healthcare Safety Investigation Branch in improving the safety of maternity services, and the adequacy and appropriateness of the collection and analysis of data on maternity safety:**

1. NHS Providers contributed extensively to the Joint Committee’s pre-legislative scrutiny work on the proposed Health Services Safety Investigations Bill and responded further to the revised version of the bill, consideration of which may be helpful for the Committee’s work in this area.
2. HSIB’s national investigations have added to the number of parallel responsibilities and processes undertaken following an incident in an NHS trust or foundation trust, differentiated by their independence, their safe space provisions, and their systemic perspective. As such, they fill a gap in how the English healthcare system learns from patient safety incidents and improves safety. NHS Providers has strongly supported the creation of the HSIB since it was announced. We support the principle of creating an independent statutory organisation through the Health Service Safety Investigation Bill.
3. The HSIB’s original remit was to carry out a small number (around 30 a year) of systemic safety investigations within safe space provisions, which would be carried out in addition to local trust investigations. As the Committee will be aware, HSIB has been required to carry out all maternity investigations (in cases of specified outcomes – expected to number around 1000 a year) in the place of local trust investigations in order to facilitate rapid learning and an improvement in the way these investigations were handled.
4. As HSIB is in this instance replacing a trust’s investigation, safe space provisions do not apply. It is understood that the maternity investigations will be returned to the NHS – and to individual trusts to carry out - in 2021. We welcomed the proposal that those investigations will return to the NHS as there has been a risk within these specialist investigation programmes that the role of HSIB could prevent trusts from fulfilling their current responsibilities and implementing the learning following a serious incident.
5. For an organisation to be properly governed and to be held accountable, it must have appropriate oversight and control of its operations. It must also have a role in coordinating these multiple processes, for the benefit of patients, their families and staff, as well as to reduce duplication and risk. It is therefore not appropriate for the HSIB/HSSIB to have a long term role in taking on any such investigations, not least because of the loss of skill within the NHS itself in carrying them out.
6. We do, however, recognise that, HSIB does have a valuable role in identifying how NHS providers can sustainably and systematically improve the quality of their maternity investigations and then appropriately support those providers to make the required improvements.
7. There is widespread agreement, evidenced by a range of cases, that the provider sector as a whole needs to significantly improve the quality of its own investigations. We hope that the new Patient Safety Incident Response Framework currently being piloted and, as we understand it, expected to roll out in 2021, will further help providers undertake high quality investigations, but we believe this should work in partnership with, not replace, the expertise and learning from HSIB, and that they could play a welcome role in helping NHS providers to improve accordingly, in line with the organisation’s focus, purpose and structure.
8. It is not sustainable for the HSIB to systematically take over such investigations long term without damaging trusts’ ability to remain accountable for the quality of care within their organisation.
9. In our view, HSIB’s role should be to bring an independent, expert-led analysis of the contributory factors to patient safety incidents in healthcare and why they recur, by gaining a systemic view and supporting excellence in local trust led investigations. There is no reason that this should come at the expense of local learning and trust’s ability to meet their obligations to staff and patients.
10. We also recognise that there is a relatively pressing operational need to provide certainty and clarity on the future of HSIB, in order for them to do the best job they are able to do, recruit and retain high calibre staff and develop their operating model and relationships across the sector effectively. We fully support colleagues at HSIB in this endeavour and remain keen to see HSIB placed on a statutory and independent footing in any forthcoming NHS Bill.
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3. <https://www.cqc.org.uk/publications/themed-work/getting-safer-faster-key-areas-improvement-maternity-services> [↑](#footnote-ref-4)
4. <https://committees.parliament.uk/oralevidence/743/pdf/> [↑](#footnote-ref-5)
5. BMJ 2019;367:l5514 [↑](#footnote-ref-6)
6. <https://nhsproviders.org/nhs-winter-watch-201920/week-5> [↑](#footnote-ref-7)
7. <https://www.cqc.org.uk/publications/themed-work/opening-door-change> [↑](#footnote-ref-8)
8. <https://www.immdsreview.org.uk/downloads/IMMDSReview_Web.pdf> [↑](#footnote-ref-9)
9. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf> [↑](#footnote-ref-10)
10. Ibid. p3 [↑](#footnote-ref-11)
11. <https://www.gov.uk/government/news/plans-to-end-the-cover-up-culture-in-the-nhs> [↑](#footnote-ref-12)
12. Woodward S (2017) Rethinking Patient Safety. CRC Press, New York [↑](#footnote-ref-13)
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18. Woodward S (2019) Moving towards a safety II approach Suzette Woodward Journal of Patient Safety and Risk Management DOI: 10.1177/2516043519855264 journals.sagepub.com/home/cri [↑](#footnote-ref-19)
19. Woodward S (2018) Rethinking Patient Safety Blog via [www.suzettewoodward.org](http://www.suzettewoodward.org/) [↑](#footnote-ref-20)
20. <https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf> [↑](#footnote-ref-21)
21. Dekker, Sydney. Drift into Failure: From Hunting Broken Components to Understanding Complex Systems (2018) [↑](#footnote-ref-22)
22. <https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf> [↑](#footnote-ref-23)
23. <https://www.merseycare.nhs.uk/about-us/just-and-learning-culture-what-it-means-for-mersey-care/> [↑](#footnote-ref-24)
24. Being Fair (2019) NHS Resolution [↑](#footnote-ref-25)
25. Edmondson A C (2019) Creating Psychological Safety in the Workplace the HBR IdeaCast via [www.hbr.org](http://www.hbr.org) [↑](#footnote-ref-26)
26. <https://www.nationalguardian.org.uk/wp-content/uploads/2020/07/ftsu_index_report_2020.pdf> [↑](#footnote-ref-27)
27. <https://improvement.nhs.uk/resources/developing-people-improving-care/> [↑](#footnote-ref-28)
28. Long Term Plan, NHS Improvement, Chapter 7, Section 4.51 [↑](#footnote-ref-29)