Health and Social Care Committee Expert Panel: evaluation of the Government's commitments in the area of maternity services in England

Submission by NHS Providers, May 2021

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 £92bn of annual expenditure and employing more than one million staff.

Our evidence should be viewed alongside our submission to the Committee's inquiry into maternity services. In this submission we focus on the government commitment around safe staffing: "ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm".

Key messages

- Improving maternity care has been a priority for over two decades and NHS trusts have undertaken a great deal of work to improve the care of maternity services.
- Before the pandemic, the NHS was under significant pressure, with demand for health and care services increasing year-on-year in the context of constrained finances and workforce shortages. There will continue to be significant additional investment required across the NHS in the wake of COVID-19, and trust leaders are clear that funding to deliver improvements in maternity care remains a priority.
- In order to maintain safe levels of staffing within trusts, in maternity services and in other areas, the government must produce a fully costed and funded workforce numbers plan, with a long-term focus and strategic vision for the future size and skill mix of the NHS workforce.
- It would be helpful for the panel to consider whether there is sufficient overall clarity, consistency, and alignment underpinning national and local patient safety efforts across the NHS.
- The current scope of the review helpfully considers the appropriateness, impact and resource provided, with regard to the objectives set by government. This would be further helped by acknowledging the context in which providers will be striving to fulfil these commitments and the role government could play alongside national bodies and the frontline in better creating the conditions for success and addressing systemic barriers to quality and safety.

Introduction

1. As noted in our submission to the Health and Social Care Committee's recent inquiry into the safety of maternity services, improving maternity care has been a priority for the NHS for over two decades.[1] The expert report, *An Organisation with a Memory*, published in 2000 played a key part in focusing attention here.[2] Since then, NHS trusts and the broader healthcare system have undertaken a great deal of work to improve the care of maternity services. Our submission also outlines some progress to date.

[1] https://committees.parliament.uk/writtenevidence/10964/pdf/

[2] Department of Health (2000), *An organisation with a memory*, https://webarchive.nationalarchives.gov.uk/20130105144251/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065086.pdf

2. 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. We have continuing concerns that patient safety may be put at increasing risk due to the mismatch between demand for services and the funding, investment, and workforce available.[3]

3. The 2020 Spending Review allocated additional resources for maternity services which included "£9.4m to improve maternity safety, including through pilots aimed at reducing incidence of birth-related brain injuries".[4] In addition, in response to the First Ockenden Report, the March 2021 NHS England and NHS Improvement (NHSE/I) board papers confirmed funding of £95m in 2021/22, "with follow-on funding subject to decisions in future years".[5] The funding is for: (1) increasing workforce numbers; (2) training and development programmes to support culture and leadership; and (3) strengthening board assurance and surveillance to identify issues earlier, thereby enabling rapid intervention. Although this additional funding is welcome and will go some way to improving outcomes, we believe it does not go far enough in helping to address workforce pressures. In February 2021 we wrote to the Committee with our calculation that over £400m in extra annual recurrent funding could be needed to fully meet the Ockenden Report's recommendations on workforce.[6]

4. Organisations find it difficult to make changes effectively amid multiple competing priorities, and the NHS approach to patient safety improvement has previously added confusion on top of these pressures.[7] It would be helpful for the panel to consider whether overall there has been clarity, consistency and alignment in patient safety efforts across the NHS.

Staffing resource

5. Even before the pandemic, the NHS was under significant pressure, with demand for health and care services increasing year-on-year in the context of constrained finances and workforce shortages. After the longest and deepest financial squeeze in NHS history, the service entered the pandemic with over 100,000 workforce vacancies. Overall, the demand-capacity mismatch in the NHS has been further highlighted by the pandemic, but was clearly present in the months and years leading up to March 2020. Staffing resource has been insufficient for some time, and the wider nursing workforce has been the primary area of concern for trusts.

6. We have raised concerns with the Committee about the disparity between maternity service demand and the staffing resources which are available, and we know that there is variation between trusts in the quality of maternity care.[8] As the Better Births Review noted, the reasons for this must be fully understood and addressed.[9] Staffing levels which lead to realistic workloads are key to the quality of care as a whole.[10] Realistic workloads require enough staff not only to cover existing workforce gaps, but also to build flexibility into the system and for staff to have sufficient time to dedicate to maternity care.

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[3] https://nhsproviders.org/nhs-winter-watch-201920/week-5
[4] https://www.gov.uk/government/publications/spending-review-2020-documents
[5] https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-9.1.1-national-response-first-ockenden-report.pdf
[6] https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf
[7] https://www.cqc.org.uk/publications/themed-work/opening-door-change
[8] https://nhsproviders.org/nhs-winter-watch-201920/week-5
[9] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
[10] Dekker, Sydney. Drift into Failure: From Hunting Broken Components to Understanding Complex Systems (2018)

7. We are supportive of Health Education England's work to identify and plan to fill gaps in maternity staffing levels.[11] Any such plans must of course be fully costed and funded and must build flexibility into the system – as we outline above, we found that as much as an additional £400m annually could be needed to ensure sufficient resource across the teams who deliver maternity care.[12] Trust leaders have emphasised the transformation which such funding could bring about in maternity services, and are keenly aware of the increased burden which will be upon staff if teams are not sufficiently expanded.

8. There will continue to be significant additional investment required across the NHS in the wake of COVID-19, and trust leaders are clear that funding to deliver improvements in maternity care remains a priority.

Safe staffing

9. The number and skill mix of staff in any given ward is set by trusts locally. Following the Francis and Keogh reviews close to a decade ago, NICE developed detailed guidance on safe staffing in maternity services, published in 2015, which included a series of recommendations for local healthcare providers.[13] The NICE recommendations are wide-ranging and include a step-by-step guide to assist professional leaders and workforce managers to set the "midwifery staffing establishment". In line with the national approach to other specialities, the guidance does not prescribe an "appropriate number" or staff to patient ratio for trusts to implement. It notes that the process for setting the establishment will have to consider acuity, dependency, estimated time to perform routine and additional activities and the range of staff available. It also says these determinations will need to "allow for locally agreed midwifery skill mixes".

10. It is important that trusts are able to make these determinations and agree an appropriate skills mix within teams to meet the demand for care at a local level, as they are best placed to understand the skills, competencies and availability of the workforce within their local area as well as the care needs and levels of acuity at any given time within the local population.

11. However, the importance of local empowerment is not consistently recognised by regulators. For example, the conclusions drawn within CQC inspection reports around safe staffing have occasionally served to diminish the role of non-degree and support staff – including the maternity support workforce – which risks undermining the ability of trusts to set staffing levels and skills mixes based on their assessments of local demand for care and workforce availability.

12. A key part of establishing safe staffing levels within maternity services – as described by the NICE guidance – lies within workforce planning. To maintain safe staffing levels, in maternity services and elsewhere, it would be more appropriate to focus on national workforce planning. The government needs to produce a fully costed and funded workforce numbers plan, with a long-term focus and strategic vision for the future size and nature of the NHS workforce. It is increasingly evident that the lack of clarity around workforce funding beyond a single-year perspective has hampered the ability of local providers and systems to grow and develop their staffing teams.

13. We noted in a recent letter to the Committee the need for action to address shortages in maternity staffing and agree with the assessment of Gill Walton and Dr Edward Morris around

[11] https://www.hee.nhs.uk/our-work/maternity/maternity-workforce-transformation-strategy
[12] https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf
[13] https://www.nice.org.uk/guidance/ng4/chapter/1-Recommendations#organisational-requirements

the severity and persistence of workforce gaps. Our correspondence with the Committee has noted the need for urgent attention to ensure "full funding for the staffing levels required to provide safe, high quality care, and enable inclusive and compassionate cultures within the NHS generally, and specifically within maternity care"[14].

Further considerations

14. The current scope of the review helpfully considers the appropriateness, impact and resource provided, with regard to the objectives set by government. However, there are other areas that, if acknowledged and explored, could give a deeper and more rounded view of the context in which these commitments sit, and the role government could play in better creating the conditions for success. We set out our thoughts on these below.

Pre-conditions for quality and the complexity of safety

15. Extensive research has shown the pre-conditions for high quality, safe care are funding, staff, training, buildings, equipment and other infrastructure, alongside good processes.[15] For example, the CQC's *Opening the door to change*[16] report 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. In responding to the Committee's maternity safety inquiry, THIS Institute noted "…there is a need to acknowledge the ongoing importance of structural issues such as staffing, skill mix, estates, equipment etc – changes in culture and behaviour are not sufficient (or often possible) unless these issues are addressed too."[17] Arguably therefore, an evaluation of government commitments should take a view on what is required to meet the pre-conditions for quality and whether the government, the Department for Health and Social Care (DHSC) and NHS national bodies hold an aligned and supportive position on enabling these.

16. We would also note the prevalent safety expert view that safer care is not a linear and or easily controlled process, but that it is something deeply complex, dynamic and inter-related with the multitude of relationships, processes and events taking place day to day.[18] We would also encourage the panel to reference the complexity here and consider a view on the commitments in the round, rather than only in isolation, given their inter-related nature. We would also urge attention to the transparency and robustness of the evidence base underpinning any government commitments to ensure that trusts are being provided with well-researched guidance not just on what to do, but how to do it, with the impact well understood and implementation learned from.

Blame culture

17. 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. As we noted in our inquiry submission, the seminal report, *A promise to learn – a commitment to act* (2013), highlighted blame as one of the main problems affecting patient

[14] https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf
[15] BMJ 2019;367:l5514
[16] https://www.cqc.org.uk/sites/default/files/20181224_openingthedoor_report.pdf
[17] https://committees.parliament.uk/writtenevidence/11041/pdf/
18 Woodward S (2017) Rethinking Patient Safety. CRC Press, New York; Woodward S (2019) Implementing Patient Safety, CRC Press, New York; Wears RL and Sutcliffe K (2020) Still not Safe, Oxford University Press; Hollnagel, E, Braithwaite, J, Wears, R L (2013) Resilient Health Care. Ashgate Publishing Limited Surrey England; Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell G (2017) Association between organisational and workplace cultures, and patient outcomes: systematic review BMJ Open 7 e017708. doi:10.1136/bmjopen-2017-017708; Dekker S (2017) http://www.safetydifferently.com/the-original-hearts-and-minds-campaign-and-the-dereliction-of-behavior-based-safety/; 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; Woodward S (2018) Rethinking Patient Safety Blog via www.suzettewoodward.org

safety in the NHS and recommended it be abandoned as a tool and instead trust the goodwill and good intentions of staff.[19] 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".[20]

18. However, despite progress and commitment from providers, a tendency towards blame culture within healthcare remains a persistent challenge.

19. Any evaluation of government commitments to improve the safety of care must also consider the challenges of culture change and whether more can be done to maximise the chances of success. For instance, in our inquiry submission we highlighted there is room for confusion in what just culture really means in healthcare, which makes the task of achieving it harder, with different policy drawing from different definitions. The NHS Patient Safety strategy defines just culture in line with practice in the aviation industry.[21] Whereas *We are the NHS* highlights the Just and Learning Culture training which is drawn from the work of Dekker.[22] A consistent approach across all policy would be helpful. We also highlighted that 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 recognised in the NHS long term plan which pledged a new compact of agreed behaviours.[23] 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.

20. The role of trust boards is crucial in supporting this transformation and embedding an effective safety culture. However, trust leaders report a need for more support to access the latest thinking and expertise and be given clear guidance on what this means in practice, as well as being supported to role model the right behaviours. They also highlight the need for senior leaders to be better supported in learning how to tackle difficult behaviours.

19 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
20 Ibid. p3
[21] https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf
[22] https://www.merseycare.nhs.uk/about-us/just-and-learning-culture-what-it-means-for-mersey-care/
[23] Long Term Plan, NHS Improvement, Chapter 7, Section 4.51