The Royal College of Midwives
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The Royal College of Midwives' response to 'Developing a patient safety strategy for the NHS' consultation

The Royal College of Midwives (RCM) is the professional organisation and trade union that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

RCM welcomes this consultation on developing the very first patient safety strategy for the NHS and is very pleased to have the opportunity to support this ambition by providing feedback and further suggestions.

Developing an all-encompassing patient safety strategy is timely and we support the principle of a guide for all of the NHS as to ensure safety whatever the setting, whatever the professional. But we ask if the proposals included in the consultation document go far enough? The White Paper "From Safety I to Safety II" states,

> 'Safety management should therefore move from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'. We call this perspective Safety-II; it relates to the system's ability to succeed under varying conditions. A Safety-II approach assumes that everyday performance variability provides the adaptations that are needed to respond to varying conditions, and hence is the reason why things go right. Humans are consequently seen as a resource necessary for system flexibility and resilience. In Safety-II the purpose of investigations changes to become an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong.'[1]

Whilst the strategy conceived by NHSI at this early stage is heading in this direction, it seems to fall short of a complete commitment to this as a methodology. The safety systems that are in place in the NHS currently are on the whole reactive and this consultation document seems to remain in this space when in reality it should be striving for a significantly more proactive approach to safety.

Harnessing of new technology to interrogate data is a huge positive step towards proactive management of patient safety. RCM would like to see a firmer commitment to using new techniques to explore enhancing *what goes well* in healthcare and the combination of Safety I and Safety II as stated above. There is a wealth of patient safety expertise which supports this shift in focus to things that go well and learning these lessons as a way of improving patient safety. RCM would urge NHS

[1] Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia. https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf

Improvement to fully embrace this methodology as a way of impacting patient safety as this would also have such a positive impact on women and families, patients and workforce.

RCM notes that although this proposal's focus is on developing a national patient safety strategy, the lack of proposals relating to workforce is obvious by its omission. Whilst we await the workforce plan needed for the delivery of the Long Term Plan, we must report our members' increasing concerns about too few midwives in the system, large gaps in the rotas and the obvious detrimental effect this has on women, babies and families. Any patient safety strategy implemented as this time, in any form it takes, will be coming into a NHS already under severe workforce pressures. RCM supports members who are working in highly complex, highly stressful environments, adjusting their clinical decisions based on the woman, the baby and the environment at a particular moment in time. This requires high levels of professional expertise and judgement along with effective, excellent communications skills and effective multi-disciplinary team working to deliver safe compassionate care. To consider staff "infrastructure" is not an appropriate term. The systems in which they work - but on the whole have little control over - are the infrastructure. Staff are the biggest resource the NHS has and *human* factors is a key consideration in modern understandings of patient safety.

A culture of blame is still prevalent within the NHS and this is perpetuated by the current investigation styles, reporting in the media and ongoing revelations of poor care scandals, which the consultation document acknowledges. There is a gap between policy and what is actually happening in the frontline services of the NHS. There is a perception amongst members that policy makers are far, far removed from the realities of working in the NHS. As a way of bridging the gap this national patient strategy could go a long way in raising the profile of the concept of a just culture amongst staff and patients alike. The incidence of PTSD experienced by midwives after serious incidents[2] shows that a just culture is not a 'nice to do' but absolutely essential to safeguard our workforce from ongoing harm.

We are also conscious, as the document shows, of many new safety initiatives and processes that have been implemented in the NHS England in recent years and the overall strategy proposed as the unenviable task of knitting these together, avoiding duplication and confusion. Speaking Up Guardians, maternity safety champions, the new Healthcare Safety Investigation Branch, and the Duty of Candour have all been created in the last five years but we are yet to see some robust evaluation of what all these initiatives have achieved, for staff and for users of the NHS alike. We are conscious of midwifery managers' concerns that different safety initiatives can be confusing and feel like duplication. We do believe that all of these initiatives are worthy and have potential, but it is poor practice to not evaluate and test the impact before we expand and build upon them in this overarching patient safety strategy. We need to get this right.

The shift towards a no-blame culture is welcome, and we note that the midwives' regulator – the Nursing and Midwifery Council – has made great strides recently in looking beyond the faults of the individual registrant and into the systems, process and teams the registrant is working within. We too note the changes with NHS Resolution in regards to maternity claims. NHSR's Early Notification Scheme mirrors the pillars proposed in this consultation: openness, improved learning, and a supportive, no-blame culture. A key part of the scheme is to improve the overall experience of families and staff as well as quick financial redress. And ourselves, with the Royal College of Obstetricians and Gynaecologists, are beginning Each Baby Counts Learn and Support, which is a programme of support and learning for local maternity teams to roll out national recommendations to improve the care of mothers and babies. It builds on the learning from previous collaborative initiatives to improve maternity safety, such as the Labour Ward Leaders training and Each Baby

[2] Slade et.al (2018) A programme for the prevention of post-traumatic stress disorder in midwifery (POPPY): indications of effectiveness from a feasibility study. Eur J Psychotraumatol. 2018; 9(1): 1518069.

Counts programmes.[3] These examples show that building safety in the NHS is beyond individual clinicians and NHS trusts; we would like to see the Strategy include all those who help shape NHS safety culture, like regulators, professional organisations and the ALBs of the NHS.

We also ask that co-production is given serious consideration. The current document and proposal has the patient "voice" as passive; a general feeling that patients are done to rather than with, which is not in line with current thinking. Patient safety incidents are the main concern of the patient; to include their perspective, voice and experience will enrich the patient safety strategy and give it credence amongst the general population. This would also reflect the ambitions of the Long Term Plan and would align better with other policy in the NHS towards personalisation and patient-centred service development. Maternity is leading the way in co-production and the *Better Births* report (2016) sought the views of women and families in a collaborative sense from the outset. RCM would like to emphasise the importance of including patients to gain insights and we believe they should be central to this national safety strategy. We note the driver diagram detailing the proposed national patient strategy on page 11 does not actually feature a patient perspective . We suggest patients should be front and centre so some reworking of the diagram would be good to see in the final strategy.

Some points on the practicality of the proposals: The use of data within patient safety is of particular importance; page 16 states that currently accurate data on the total level of harm in the NHS does not exist, so we have to ask how improvements in safety – a 50% reduction in harm as a matter of course, for example - be measured? Any new metrics need to be weighed against the current data collection and burden on providers and making the most of whatever we already measure and count.

There are also very practical workforce issues to bear in mind with introducing any new digital technology, such as protected time for training and learning. If patients and staff are going to fully benefit from new technology, planning to deliver training on this must be factored in. It is worth noting that 7% of heads of midwifery in a recent survey say that no CPD training is provided during working hours.[4]

We look forward to working with NHSI in further iterations of the Safety Strategy as it develops and we again thank you for allowing us to contribute at this early stage of development.

Royal College of Midwives

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[3] RCOG and RCM Each Baby Counts Learn and Support, See https://www.rcog.org.uk/en/news/each-baby-counts-learn-and-support-receives-1.7-million-to-improve-maternity-care/

[4] Royal College of Midwives (2019) *Evidence to the NHS Pay Review Body.* https://www.rcm.org.uk/sites/default/files/Royal%20College%20of%20Midwives%20Pay%20Review%20Body%20Evidence%202019.pdf