Leadership and culture

Effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred maternity care and help to drive a culture of safety and improvement.

The first Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust highlighted the need for strengthening leadership and oversight, preventing toxic cultures and fostering more collaborative approaches in maternity services. Similarly, Dr Bill Kirkup identified a culture of denial and described 'a resistance change' in his investigation into maternity failings at East Kent Hospitals University NHS Foundation Trust. To drive meaningful change and address systemic issues, a joined-up approach from organisations, colleges and system leaders is essential.

Our inspection programme supported these findings, demonstrating the importance of strong leadership and an inclusive culture. We found that many of the issues raised in these reviews of individual trusts not only persist but are widespread.

We observed a wide range of maternity service leaders who demonstrated dedication and passion in making their service effective in caring for women and babies, but the quality of leadership remained varied. We identified numerous factors involved in effective leadership, including:

- a stable leadership team, with consideration of succession planning and backfilling to enable seamless provision of services

- leaders with the capacity to support service development, address issues in a timely way and drive continuous improvement
- a detailed understanding of immediate issues and priorities faced by the service to form the basis of an effective management plan
- a leadership team that is accountable for acting on risks identified and making tangible improvements
- supportive and approachable leaders who listen to staff and act on what they hear in a way that the workforce recognises
- regular and clear communication and transparency from leaders.

In his report into failings at East Kent, Dr Bill Kirkup highlighted "the divergence of objectives of different groups" as an issue that is particularly striking in maternity care. He highlighted a "struggle for 'ownership' of maternity care" where "rather than contributing as equal partners, midwives may be encouraged to see themselves as being 'there for women', defending them from the 'medicalisation' of maternity care" and putting them in conflict with obstetricians. We saw one instance of a team not working holistically, which we escalated to the trust leadership team when identified and issued a Warning Notice to drive urgent action.

In maternity services, it is vital that multidisciplinary teams work towards the same aim – safe care for women and babies throughout the maternity pathway. As previously seen in the East Kent report, divisions within professions can place women at a greater risk of harm.

Culture

An open and positive culture can demonstrate examples of teamwork, professionalism, and listening to women. Healthy cultures, where staff feel supported and empowered to thrive, improve staff retention and are crucial to ensuring high-quality, safe care for people.

We expect leaders at all levels to understand the context in which they deliver care, treatment and support, and to embody the cultures and values of their organisation. They should have the skills, knowledge, experience and credibility to lead effectively, with integrity, openness and honesty. Good leadership is vital in creating an inclusive team culture with effective communication, escalation and clear routes of accountability. This is necessary for good clinical care for women and helps to drive a culture of safety and improvement.

In our Safety, equity and engagement in maternity services report, we found variation in the culture of services we inspected. There was evidence of poor working relationships between obstetric and midwifery teams in some services, staff did not always feel valued, and some services could not demonstrate a clear culture of learning.

Throughout our inspection programme, we were encouraged to find examples of leaders taking responsibility for providing a safe service, often seeking external support and guidance and being open to scrutiny at all levels. However, more work is needed to ensure these cultural values are present in every service.

In many maternity services, we observed a positive, just and learning culture of reporting incidents and near-misses, with staff encouraged to raise concerns without fear. For example, one service shared regular newsletters and posters of 'you said we did' with staff and patient feedback from recent visits from non-executive directors. This is vitally important, as a poor culture can mean staff do not feel confident to speak up and issues can become exacerbated. A positive culture is also marked by the quality of interpersonal relationships in a service. We were encouraged to visit multiple services where staff reported feeling respected, supported and valued by their colleagues. More examples can be found in our improvement resource.

Unfortunately, not all services demonstrated these values. For example, at one service, staff spoke of low morale and described a blame culture, where managers did not listen to their concerns. We are concerned that while these cultures persist, services will not be able to address issues raised in reports such as the Ockenden review, and ultimately, families will continue to suffer. We heard that a decline in enthusiasm, burnout and low morale were having a negative impact on culture.

As highlighted in the section of this report on inequalities, staff feeling ignored or dismissed emerged as a theme in our interviews with midwives and obstetricians from ethnic minority backgrounds. When staff do not feel empowered to speak up, or their concerns are dismissed it can be indicative of a closed culture, in which people are more at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture and we monitor for signs or risk factors associated with closed cultures throughout our inspection activity.

Some trusts recognised that they needed to address cultural issues. For example, one trust that had recently been through significant structure changes made sure staff had a common purpose of providing safe, quality maternity care.

Throughout our inspection programme we came across leaders at all levels who challenged our findings. We heard from some leaders that our inspection reports were contributing to poor morale among maternity staff, making it even more challenging to recruit. In contrast, we heard from staff who wanted to share their experiences, and in some cases thanked us for going into their services and highlighting areas for improvement.

There is no doubt that maternity services receive a great deal of publicity and much of that describes poor experiences and, at times, devastating outcomes. Some women told us they are frightened of what might happen if things go wrong. This is unacceptable.

We heard an overwhelming message from trusts' maternity leaders that they did not want any more recommendations on what they need to do to improve. However, as our report highlights, on a national level there are some fundamentals of care that need systemic improvement. Until these are addressed, women and babies will not consistently receive the level of safe care they should be entitled to and the level of care that staff want to be able to deliver every time.

Visibility of leaders

In our Safety, equity and engagement in maternity services report, we previously raised concerns about a lack of clear, consistent and visible leadership. When we assess whether services are well-led, we expect leaders at every level to be visible and lead by example, modelling inclusive behaviours. This can help make staff feel supported in their role and enable them to escalate concerns promptly to improve outcomes for women and their babies.

We were encouraged to see examples of visible leadership on many inspections, which are outlined in our improvement resource. Several trusts benefitted from the use of maternity safety champions. These were introduced as part of the Safer maternity care action plan, where maternity clinical networks were asked to designate a maternity safety champion to promote learning, seek out best practice and share it across the system. At one service, the board safety champion ran regular open forums both virtually and in the maternity unit to gather feedback from staff and listen to their concerns or queries. They were regularly visible and approachable on the wards, taking a proactive stance in maintaining and improving standards of care.

However, on several occasions, we heard about leaders who were not always visible. At one trust this meant that not being present prevented them from recognising the scale of issues the service faced. Here, safety champions had limited, superficial knowledge of the service and executive leaders failed to recognise the severity of issues faced within maternity. The impact of this lack of oversight and visibility was clear on our inspection – the delivery suite was chaotic and not having clear organisation or leadership hindered a calm and systematic way of working.

Information sharing

Information sharing is paramount for safe and effective care. Without it, leaders may be hampered in their ability to make effective decisions. At ward-level, when caring for women, it is essential that staff communicate well, especially during handovers, to make sure they are aware of potential risks and can deliver compassionate care.

Throughout the programme, we saw examples of good information sharing between staff and managers, but we are concerned that leaders do not always have a full picture of their service and may miss opportunities to learn. At one hospital, there were clear communication systems for sharing information from ward level to service managers, who were routinely available to respond to any issues. In addition, meeting minutes and information on notice boards displayed positive feedback to staff.

Another service had a risk and governance midwife who was responsible for sharing learning from incidents. At a different service, sharing information was an important element in safeguarding training and included examples of harm, how incidents were reported in the trust, and actions that had been taken as a result.

Reporting incidents is key to providing leaders with a clear picture of their service. Although we saw evidence of trust boards being presented with incident data, this was usually limited to incidents graded moderate and above. Given the potential issues with the grading of incidents outlined in the safety section, we are concerned that trust boards may not have the full picture of maternity incidents, themes and trends. This presents a missed opportunity for boards to check and challenge, and limits the ability of services to learn and improve.

In addition, we found no regional or local oversight of incidents reported and graded by perinatal services. NHS England regional midwifery teams, integrated care boards (ICBs) and local maternity and neonatal systems (LMNS) do not have access to the NRLS data set. Again, this could mean a missed opportunity for analysing trends, identifying inequalities and benchmarking at a local or national level.

Leadership decision-making

Clear oversight of challenges enables leaders to identify issues, make effective decisions and drive meaningful change. While we saw evidence of strong leadership and good decision-making at several trusts, we also found examples of poor decision-making and issues with vacancies within leadership teams.

One service exemplified how effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred care. Here, staff at all levels demonstrated commitment to sharing data and using information proactively to drive internal decision making as well as system-wide working and improvement. Another service had a clearly defined management and leadership structure, led by a triumvirate comprising a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology. This helped leaders to make effective decisions based on a clear understanding of the challenges faced by the service.

However, we also saw instances of poor decision-making, which was sometimes compounded by a lack of leadership support and communication. For example, a small number of services did not always collect and analyse reliable data, which meant they were unable to make effective decisions and drive improvements. We also saw evidence of a lack of decision-making where, following a period of instability within the leadership structure across the trust, a number of senior posts remained vacant. This led to delays in implementing improvements.

Leadership vacancies for maternity services are a problem. We saw a high turnover of staff in senior leadership roles in some trusts. We could also correlate this with our ratings of the well-led key question. Maternity services usually have a head of midwifery and/or a separate director of midwifery who reports to the trust's chief nurse. In addition, there are maternity leadership roles in ICBs, NHS England's regional teams and other bodies such as MNSI, and NHS Resolution. Some midwives expressed concern that there was only a finite pool of capable leaders, which makes recruiting for these posts challenging. While there is no doubt maternity services need leaders who understand the complexities of delivering a safe maternity service, there may be a further argument to explore the greater need for effective, strong compassionate leaders, supported by maternity experts.

Leadership response to staff concerns

The final report of the Ockenden review highlighted that many members of staff reported a fear of speaking out as well as a culture of 'them and us' between midwifery and obstetric staff. As we previously raised in our Safety, equity and engagement in maternity services report, the result of this is 'working in a silo', which can have a hugely detrimental impact on women, particularly when concerns need to be escalated. During the inspection programme, although we found some good examples of leaders engaging with staff about their concerns, this was not always the case. Where there was a failure to listen and respond to issues about safety, this put women and babies at risk of preventable harm.

But it was encouraging to see instances of leaders being responsive to concerns.This included holding listening events, displaying 'you said, we did' posters and at one service, having non-executive directors undertake regular safety walkabouts to give staff an opportunity to voice concerns.

A key component of an open culture is creating an environment where staff feel supported to raise concerns. We were pleased to see many members of staff feeling able to speak to leaders about difficult issues and incidents. Issues were raised through a number of routes, including Freedom to Speak Up teams, guardians or ambassadors, who supported staff when they wished to voice their concerns.

However, on a small number of inspections we found that while some staff felt that they could speak up when they needed to, not all of them felt that leaders always listened to them or felt confident that the organisation would address their concerns. This could contribute to a poorer culture where staff are deterred from raising concerns in the future, and ultimately opportunities to improve care may be missed.

At another service, we were concerned to hear that staff had raised issues directly to senior leaders several times regarding safety and staffing levels, but did not see the quick action or improvement they had expected. A similar picture emerged at another service, where we heard there was sometimes unkindness between staff and that following incidents, leaders did not provide compassion and support.

Governance

Effective governance structures support the flow of information from frontline staff to senior managers and trust boards, ensuring leaders have the insight needed to make effective decisions and vital improvements. While some of the services we inspected had clear and established governance processes in place, this varied between trusts. Without effective governance processes, leaders do not have oversight of the risks and issues in maternity services and cannot address them in a timely way.

In a small number of services with limited oversight at board level, opportunities to address issues were missed. This meant, for example, that leaders only heard about the impact of an understaffed triage and delays in medical care when staff raised concerns, rather than regularly monitoring key areas on an ongoing basis using performance metrics. A review of board papers for 7 NHS trusts by the Sands and Tommy's Policy Unit raised questions over the ability of boards to fully understand the performance of maternity units. It highlighted a need to step back and reflect on metrics over a longer timeframe, as well as ensuring sufficient time for meaningful scrutiny.

While some trusts had well-established maternity governance teams, in other services, the teams were under-resourced. This was sometimes because of staffing pressures and the need to redeploy governance teams to provide frontline care. There are further opportunities to explore the skill mix within governance teams and make use of generalist risk and governance expertise when required. At times, we found an over-reliance on using midwives rather than recognising the different benefits that a non-maternity team member who is trained in the fundamentals of governance and risk can contribute.

Many of the concerns we identify in this report are about the fundamentals of safe care and treatment and are similar to the requirements in any other healthcare service.

Vision and strategy

It is vital that leaders ensure there is a shared strategy, and that staff understand and support the vision, values and strategic goals. Staff need to be clear on how their role helps in achieving these goals and be motivated to work towards them. Where staff had the opportunity to develop the strategy at a local level, this resulted in an engaged and motivated workforce, with staff who not only understood the service's vision and how to apply it to their roles, but were also able to explain the vision to women.

In a small number of services, we were concerned to find an absence of a maternity-specific vision and strategy, or that the overall trust vision and values did not include maternity services. The nature of maternity care means that attempting to apply broad visions of principles is likely to be an ineffective approach and could fail to recognise the unique position of women using maternity services. Having a specific maternity strategy helps staff ensure their services are responsive, evidence-based, and sustainable. In a minority of cases, although services had a strategy, they failed to communicate it well to staff, meaning they were prevented from understanding how their work contributed to the wider vision.

Gathering feedback and handling complaints

As a regulator, we believe people using care services, their carers, families, friends and advocates are the best sources of evidence about their lived experiences of care, and we champion this in our work. We are also clear about our expectation of services: providers should make it easy for people to share feedback or raise complaints about their care, treatment and support.

In several services, we were encouraged to see how staff effectively handled feedback from their investigation of incidents, both internal and external to the service. At one service, the governance midwife collated feedback to identify themes or trends related to health inequalities and included these in staff training and feedback sessions. At several other services, staff knew how to acknowledge complaints and women received a response from managers after the investigation into their complaint.

Conversely, in a smaller number of services, feedback was not handled as well. For example, at one service, there was limited evidence that changes had been made following feedback. At a different service, we were concerned to hear that senior staff sometimes took several months to review feedback, with staff reporting limited meaningful action and improvement following feedback. A lack of serious consideration of feedback or delay in taking action presents a missed opportunity for trusts to make vital improvements at an earlier stage of risk of harm and increases the likelihood of mistakes being repeated.

We urge system leaders to prioritise improvements in maternity services, both from a cultural and financial perspective, to drive much-needed change.

We recommend NHS England ensures trusts are proactively managing succession planning in midwifery services, and, in line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders.