FINAL VERSION

Review of Bedford Maternity Services

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1.0 Executive Summary

Maternity Services operate in a complex and demanding environment and it is the responsibility of leaders at all levels within the organisation to ensure the safety of both staff and the women and babies in their care. The culture in which care is delivered has a huge influence on the quality of care provided. Cultures which promote safety share a number of key characteristics including the promotion of learning when things go well and from errors and enabling staff to speak up about concerns. This review was commissioned by the Bedford Hospital Director of Nursing and Patient Affairs with the purpose of providing an independent view of the leadership and management capacity within Maternity Services at Bedford Hospital NHS Trust in response to a number of cultural red flags noted by the Executive Team at the hospital. This includes direct whistleblowing from staff to CQC, reports of bullying from junior doctors and other staff and concerns raised by student midwives.

The report responds to five questions using a range of enquiry tools as detailed in Table 1 below:

Questions	Enquiry Methodology
What do we already know about culture in the Unit from all relevant data sources, focussing on human factors and Trust values?	Appreciative enquiry where the focus is on asking 'what is good' about what you are doing? The application of human factors based on consideration of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings
Is the leadership capacity and capability in Maternity Services enabling the delivery of high quality care?	
Are there clear systems and processes in place to support good governance, risk management, staff and service performance such as management of Serious Incidents, complaints and clinical audit?	
Is there a culture of improvement where staff are engaged and involved to support delivery of high quality services: through being aware of clinical quality indicators; have the competencies to deliver patient safety initiatives and improve patient experience; are supported to deliver change at all levels including the national maternity transformation agenda?	
Is there a culture of understanding, responsiveness and proportionality related to attitudes and behaviours, omissions and commissions? Are there positive relationships between staff members which supports inclusion and respect between teams?	

Key Insights

The culture of the Unit is fragmented despite a clear Trust and Maternity Services vision and statement of purpose. The change in leadership style in Maternity Services and organisational structure is viewed with distrust by a significant number of staff interviewed.

The maternity leadership team are committed to delivering change across the service and have good support from the Corporate and Executive Teams. A range of well recognised tools have been used to drive improvement in Maternity Services but their impact/effectiveness has not been fully evaluated or felt by the teams working actively delivering care.

There are good (although complex) governance processes in place with regular monitoring and review of quality in Maternity Services at Board level. However tracking and monitoring of actions/outcomes could be improved.

There are strong and experienced medical leaders across obstetrics but their inputs are not formally defined.

The organisation has a clear and defined improvement strategy which is not fully embedded in Maternity Services. This may be partially explained by the diversion of the attention of the leadership team to the national maternity transformation project. This is not of itself problematic but alignment of the two improvement projects is essential if staff within Maternity Services are to fully understand organisation and local service priorities and their role in contributing to them.

The report has found no evidence that disciplinary policies are disproportionally applied to individuals or staff groups.

Recommendations

The Executive and Divisional Management teams should consider the following suggestions for improvement:

- Undertake a cultural safety survey to establish the impact of the existing culture on safety within the Unit. I have found no evidence that safety is compromised but such a survey will provide a baseline on which to build change driven by shared values and a commitment to respond to the results. The inclusion of all staff groups in this is essential.

- The service and management teams should build on the work and feedback already commenced. I suggest that the team take stock of what has been done so far, distil key learning and messages from this and implement actions in a consistent and proportionate way.

- Review the Quality Impact Assessment (QIA) completed as part of the introduction of Continuity Schemes and consider introducing some performance metrics that monitor the impact on the core service.

- Medical leadership across the service should be reviewed to ensure consistency of expertise and input at divisional and service governance meetings.

- Ensure that all action plans are up to date and that learning from incidents and complaints is fully embedded across the service.

- Learning from exemplar sites, the introduction of a shared space for coffee/meal breaks used by all professional groups, including managers and consultants, has been shown to help create working relationships that are characterised by friendship and mutual trust. The service may want to consider this possibility.

- Review and, where still applicable, the implementation of actions arising from previous reviews and inspections. Where actions are no longer applicable, be clear about why and share the decision making process with clinical teams using relevant messages.

- Support the staff and management teams to develop their own culture together: how do they want to work, what questions should be asked to determine next steps, what is a proportional response to the event?

- Think about promoting and sharing positive messages: there is much that is good about the Maternity Service as evidenced in the recent CQC maternity survey and indeed in the most recent CQC report. Celebrate the positive and change the narrative.

2.0 Terms of Reference and Scope of the Review

Leading and managing in healthcare is complex and challenging particularly in the context of changing systems and expectations. There is no single model of leadership that can be applied to this complex system, rather leaders must develop styles and approaches that work within and through the culture of their organisation. A review into leadership and management cannot focus on individuals alone but must also take account of the culture in which they work, lead and make decisions.

The review was commissioned by Bedford Hospital Director of Nursing and Patient Affairs. The purpose of the review is to provide an independent view of the leadership and management capacity within Maternity Services at Bedford Hospital NHS Trust in response to a number of issues raised by members of the clinical team.

It seeks to answer the following questions:

- What do we already know about culture in the Unit from all relevant data sources, focussing on human factors and Trust values?

- Is the leadership capacity and capability in Maternity Services enabling the delivery of high quality care?

- Are there clear systems and processes in place to support good governance, risk management, staff and service performance such as management of Serious Incidents, complaints and clinical audit?

- Is there a culture of improvement where staff are engaged and involved to support delivery of high quality services: through being aware of clinical quality indicators; have the competencies to deliver patient safety initiatives and improve patient experience; are supported to deliver change at all levels including the national maternity transformation agenda?

- Is there a culture of understanding, responsiveness and proportionality related to attitudes and behaviours, omissions and commissions? Are there positive relationships between staff members which supports inclusion and respect between teams.

3.0 Methodology

The review was undertaken by Ms Anne Crompton, Associate Director of Quality and Safety at Nottingham University Hospitals NHS Trust and SRO of the Nottinghamshire Local Maternity and Neonatal System. It covers the period September 2018 - February 2020 and considers the following information:

- Review of available data to answer review questions on culture, leadership, management, governance and change, including complaints, whistleblowing concerns and grievances raised by members of staff.
- Review of exit interview findings.
- Conversations with a representative sample of additional staff who have left the organisation in the last 12 months.
- Review of staff and maternity survey findings.
- Review of the work completed by the Trust into the culture of maternity services at BH.
- Interviews with staff who work closely with the leadership team including but not limited to: Heads of Nursing, Corporate Governance teams and corporate support teams including HR and Finance. External to BHT ie RMO, LMS MVP, RCM and Unison.
- Focus Groups with B7 and above midwifery staff.
- Interviews with obstetricians.
- Focus Groups with Band 5/6 midwives and midwifery support workers.
- Interview with BAME council lead/ Equality and Diversity lead.

I visited the Unit on four occasions (20/21 November 2019, 10th December 2019, 10th December 2019, 11th February 2020) and completed a series of interviews with staff and others who work alongside the team at Bedford Maternity Unit. In addition I reviewed a large amount of documentation made available to me. Unless otherwise referenced all of the data used in the report has been supplied by BHT. I apologise (but am not responsible for), any conclusions reached on the basis on inaccurate data.

The report was compiled using a framework based on the following:

- The use of appreciative enquiry where the focus is on asking 'what is good' about what you are doing?
- The application of human factors based on consideration of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.

I'd like to thank the staff that gave up their time to speak to me. All staff members to whom I spoke were open, honest and demonstrated commitment both to the service they provided and to each other as members of the Maternity Team.

4.0 Background and Context

Bedford Hospital NHS Trust has approximately 400 in-patient beds and provides a range of services to the local population of approximately 270,000 people mainly from north and mid Bedfordshire. Most acute services are provided at the South Wing site including maternity services which are the subject of this review.

Maternity Services sit within the Women and Children's Division and are led by a leadership team comprising a General Manager, Clinical Director and Head of Midwifery. This team are supported by matrons and deputies who provide day to day operational leadership.

The Trust provides maternity services on one site with an overall birth rate of 2787 for the year 2019. The Birth rate has declined slightly over the last three years from 2882 in 2017. It offers both obstetric and midwifery led services and community midwifery services including home birth service to the local population.

Antenatal services for women with complex pregnancies who require additional surveillance, are provided from a consultant led antenatal clinic and a day assessment service that operates from 09:00 hours to 19:00 hours, Monday to Friday. A dedicated maternity telephone triage service is available 24 hours a day seven days a week. Outpatient maternity services are also provided within local Childrens' centres and GP practices. There are currently six community midwifery teams based in various locations across the county.

The service has a midwife-to-birth ratio of 1:28 which reflects the national average with 60 hours of dedicated consultant presence for the delivery suite. Senior anaesthetic cover is provided 24 hours a day for and consultant paediatricians are available 24 hours a day, seven days a week.

The service was rated as 'Requires Improvement' in CQC Inspections of 2015 and 2018. The 2018 inspection judged that the service required improvement in the safety and well led domains.

4.1 National Context

This review has taken place in the context of the national Maternity Transformation Programme drive to implement the Better Births (2016) programme. Implementing the vision set out Better Births supports the Secretary of State's ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030.

During 2016/17 a number of Local Maternity Systems (LMS) were established comprised of providers and commissioners of maternity services with responsibility for planning the design and delivery of maternity services of populations of 500,000-1,500,000 people. The Bedford Maternity Service is a member of the Bedfordshire, Luton and Milton Keynes LMS (BLMK). BLMK serves a population of 970,000 which is younger than England as a whole, with 19.7 per cent aged 0-14 years and just 6.2 per cent aged 75+. 14.8 per cent live in the most deprived areas of England.

The LMS drives delivery of key work streams through engagement with service users and with the support and commitment of local maternity providers. One of the key deliverables within the national programme is the provision of Continuity of Care (defined as care by known midwives over the whole of the pregnancy journey including birth) with a target to achieve 51% continuity for all women by March 2021.

Since 2016, BMU has implemented three CoC teams and achieved a continuity rate of 20% (March 2020). This is less than the national target of 35% but comparable with units within the LMNS.

5.0 Key Findings

5.1 What do we already know about culture in the Unit from all relevant data sources, focussing on human factors and Trust values?

The Maternity Unit at Bedford is friendly and welcoming. Staff were engaged, willing and responsive throughout this review. Overall there are good working relationships between members of the leadership team with evidence of a common purpose and goal. In particular I observed strong and supportive relationships between the matrons and Head of Midwifery. The relationships with members of the executive team appear strong and appropriately supportive.

During my interviews with team members it became apparent that there are tensions between the working relationships of the clinical (obstetric and midwifery teams) and the management team. The management team was variously described as the Divisional Leadership Team (DLT), the Matrons, the Head of Midwifery and Deputy General Manager. I drew the conclusion that the term management applied to anyone who was not in a role with the primary focus of providing direct patient care. It was used interchangeably.

I was made aware of disciplinary processes which took some time to conclude, some of which were commenced a significant period of time after the event. This in my view has contributed to a culture of mistrust which is very difficult to break through. The consultant body did not appear cohesive in their approach and the absence of clinical leadership was felt in the day to day experience of midwives and junior doctors. I was presented with myriad examples of bullying behaviours, some of which, in my view, fell within the description of day to day operational management. It is recognised that the introduction of a performance management framework in a system which has not previously been subject to a robust approach can be misunderstood particularly if the change has not been clearly communicated.

The unit experienced a significant change in its culture and management style following the introduction of a Divisional Structure in 2015. Initially part of the Planned Care Division, the Women and Children Services became a standalone Division in 2017. Whilst this model of management is widely used across the NHS, even in a small Trust like Bedford, it has the potential to be multi-layered and can impact on both decision making and flexibility of response. Such a structure can also give rise to a perception of a command and control style which does not deliver devolved clinical leadership. Over the last two years there have been a number of reports of what might be described as horizontal bullying (Betcher et al 2012) from Band 7 co-ordinators to junior doctors, between Band 7 midwives themselves, from matrons to Band 7s and from consultants to midwives. It is beyond the scope of this report to comment on these individual reports directly but a range of reasons why bullying occurs have been identified including hierarchical management, a lack of involvement in decision making and heavy workloads with tight deadlines, all of which apply in some degree to this Unit.

Despite five years having passed since the introduction of the revised management approach, many staff I spoke to described feelings of loss and sadness about the change. The management culture previously in place at Bedford was one of autonomous service units which in maternity translated to a Head of Midwifery and Clinical Director supported by a general management function. The Head of Midwifery had been in post for upwards of 15 years, was well known and liked by staff with a leadership style that was described variously as nurturing and parental. The DLT structure introduced a different expectation in relation to individual accountability and responsibility.

In addition, I heard reports that the introduction of the DLT structure came about as a result of a poor CQC report in 2015 which unexpectedly assessed maternity services as ‘requires improvement’ and was implemented as a reaction to this. I have been provided with evidence that a change in structure was planned ahead of the CQC

report publication but this perception was prevalent in many of the conversations that I had.

This change in style and approach has impacted to a greater or lesser extent on many of the staff who work in Bedford Hospital Maternity Service. This has been compounded by a number of other nationally driven changes. These include the removal of statutory supervision for midwives the function of which was heavily criticised in the Kirkup Report into Morecombe Bay (2016) but which nonetheless was a familiar and often supportive feature of practising midwifery. Further the publication of the Better Births report in 2016 which outlines a rapid and challenging transformation plan for maternity services based on two key principles, improving safety in maternity care and implementing continuity of maternity care for the majority of women who use the service.

I have seen and reviewed evidence that the Divisional Leadership Team has worked hard to try to effect a change in perception and belief of clinical staff and it is important to note that not all staff I spoke to share the sense of loss/unhappiness that I have described above. Nerveless, there is enough disquiet and concern expressed by the teams to suggest that a different approach is required.

5.2 Is the leadership capacity and capability in Maternity Services enabling the delivery of high quality care?

The leadership team were open, caring and committed to high quality service delivery. I have not completed a formal assessment of leadership capacity and my observations are based on review of documentation and conversations with individuals.

There is good evidence that the leadership team have taken steps to address the concerns about culture within the maternity services and some of the actions are outlined below. The tools used are well recognised and have been shown to deliver improvement elsewhere. I have seen evidence that queries and concerns raised by staff are responded to and that efforts have been made to engage with staff about the future direction and organisation of the service. The leadership team are visible in wards and departments and described positive reinforcement of good practice and appreciation of staff. It was recognised by the team that staff appreciate fairness and expect managers and leaders to hold everyone to account at the same level

However feedback from staff about the leadership team was mixed with some members describing a closed and sometimes coercive management style and others openly welcoming about the management approach and the changes it has brought. Some staff described being concerned about the repercussions of speaking openly and I heard evidence from midwives of disciplinary procedures being put in place almost a year after an event had occurred, of over-zealous use of the disciplinary policy, limited right of reply and of a reluctance to speak out. This finding challenges managers and leaders in the service to consider the proportionality of actions taken. It is not unreasonable for staff to question the validity of decisions taken so long after an event regardless of the event itself and to ask whether a different intervention may have sufficed. In order to drive safe cultures, staff need to feel psychologically

safe. Improving local culture requires highly visible actions and clear, role modelled expectations about accountability and acceptable behaviour.

In common with NHSI (2018) findings, I found that managers/leaders at all levels had more confidence that their interventions and responses 'fix things' than the staff who work in the service. This finding challenges leaders and others within the service to consider whether their energy and focus is in the right place. It is beyond the scope of this review to consider where management/leadership time is focused and I did not explore this within my questioning. However as a general point, it is all too easy for leaders/managers to become distracted by performance targets, by external demands and by internal expectations. Learning from safety culture reviews in other organisations supports consistent application of a limited number of key actions including a focus on fixing small things as soon as possible, open discussion of defects/concerns and solutions in operational huddles and positive re-enforcement of safety critical actions.

The staff I spoke to described limited engagement with and/or awareness of the Local Maternity System. Whilst there was a basic understanding that Continuity of Care (CoC) was a key national imperative, individuals were more concerned that the development of CoC teams was having a disproportionate impact on Maternity Unit staffing. This was a recurring theme through all my conversations and across all staff groups.

In contrast the leadership team (including the matrons) described a flexible model of staffing which includes midwives accompanying women to give birth in the Unit, an escalation process that calls on community midwives to support the Unit when it is busy. I received assurance that the vacancy rate at BMU was low, that the Unit met its Birth-rate plus requirements and that there was a clear escalation process in place supported by an on call midwifery manager rota which requires a 1:5 on call commitment.

The leadership team has embraced and fully supported the implementation of the Better Births agenda and had achieved a 20% continuity rate against a national target of 35%. However, scaling up Continuity of Care models requires removal of staff from a traditional model of working in a Maternity Unit to one where care is provided to the women in a community setting and where midwives follow women into the Unit to support birth. While the over-arching staffing template has not changed, the number of midwives who actually 'turn up' for a shift has reduced. The impact of scaling up models of continuity and the impact on Maternity Services as a whole in terms of workforce, system impact and cost benefit is not yet fully evaluated (Cochrane 2019). In a small Unit like Bedford, the removal of even 1 midwife from the rota (even though they are present in another venue) has a significant impact. Compounded by a high level of midwifery sickness (currently 7.6% but has been as high as 11%) and maternity leave (6%), the result has been a perception that staffing is worsening, that midwives in the Unit are not always supported and that the workload is not evenly shared. This view was clearly expressed in interviews with members of the maternity team.

It is important to recognise the BMU is not significantly different from other comparable units in the country. The leadership team have little choice but to embrace a national agenda and have developed systems and processes to manage this change. I was provided with a planning model that supported this change in an intelligent way and a Quality Impact Assessment was completed before change was implemented. However, I have seen no evidence that the impact of CoC on staffing in the Unit has been monitored through regular quality committees particularly on impact of delivery of inductions within agreed timeframe and the impact on provision of elective caesarean section list.

This is a seismic shift in the way care is delivered and requires engagement and support from all professionals involved in the delivery of maternity care. Trusts where CoC models are more embedded have recognised this (Warwick 2018) and workforce modelling tools are being developed to support Trusts as they scale up this programme. Midwives at all levels require support to manage and implement this transformation and different staffing models should be considered particularly in relation to the use of MSWs and dedicated teams to ensure that elective and planned work is not adversely impacted. As things stand at BMU, my observation is that there is a disconnect between the experience of staff based in the Unit and the narrative that accompanies the delivery of the national agenda. Staff do not appear to fully understand why decisions are being made, are living with the consequences of a changing staffing template and are worried that this places their individual accountability and responsibility to patients at risk.

5.3 Are there clear systems and processes in place to support good governance, risk management, staff and service performance such as management of Serious Incidents, complaints and clinical audit?

Effective clinical governance depends critically on the quality of information being communicated to the Board about clinical services and their outcomes, to enable informed assessments of the safety and effectiveness of services and, if necessary, action to improve them. The generation of meaningful clinical information is very reliant on clinical staff, who have not always been quick to see the need to engage with clinical governance. Learning from other reviews of Maternity Services (Kirkup 2016) informs us that without clinical engagement, clinical governance is bound to remain poorly informed and ineffective.

How does clinical governance function at Trust Level?

The Trust Board is supported in its role by five sub-committees, each chaired by a non-executive director:

- Audit Committee
- Quality and Clinical Risk Committee
- Finance Committee
- Remuneration Committee
- Charitable Funds Committee

The terms of reference for these committees are reviewed annually.

There is a Quality Board and an Executive Management Committee where all committees report prior to information being shared at the Board meetings. A Quality Board has been established reporting directly to the Executive Management Board. There are a considerable number of committees and groups reporting up to the Quality Board and quality and Clinical Risk Committee which the CQC report (2018) notes as having the potential for duplication rather than suggesting that issues are being missed. The current structure remains complex with a large number of committees and groups reporting directly to the Quality Board.

Divisional reports are submitted to the Quality and Clinical Risk Committee (QCRC) on a monthly basis and I reviewed these against the QCRC agenda and minutes from September to December 2019. The Maternity Quality Report and escalations are reported monthly and there is evidence of appropriate discussion and consideration of key issues.

How does Clinical Governance Function at Service and Divisional Level?

There are clear service level arrangements in place with a matron holding responsibility for risk management and clinical governance. She works closely with the DLT and liaises with corporate governance teams in order to oversee and monitor compliance and safety across this agenda. I saw evidence of good working relationships between corporate and service teams with quality assurance processes in place for complaints and Serious Incident reports. Learning was identified and disseminated through the minutes that I reviewed and I heard evidence that learning from feedback and incidents was used to inform training, I was less clear about the process in place for ensuring that lessons learned and actions taken were sustainable and embedded into practice.

There is a clear Divisional and Service level meeting structure in place. I reviewed a series of minutes from the Service Governance meetings. Attendance from the DLT and matrons is consistent, evidence of consistent consultant engagement is less apparent. The medical leadership for clinical governance across the service is not well defined. Given the importance of shared understanding, multi-disciplinary contribution and decision making, this is of concern.

The Maternity Quality Report is produced monthly and provides a high level overview of the key quality issues in the Division. The report contains a scorecard which reflects relatively standard key performance metrics and is accompanied by an escalation report. I reviewed a series of reports and the minutes which accompanied their presentation. Whilst there was evidence of follow through in many of the reports, some identified actions which I did not see referenced again. That may be because there was an expected time lag but this was not always clear in the documentation that I reviewed. Additionally, the CQC action plans whilst comprehensive showed many overdue actions which did not provide sufficient assurance of progress.

There is limited evidence of obstetric involvement in review of risks/ incidents/ complaints based on the reports and evidence that I reviewed. The service employs many experienced obstetricians who have knowledge and capability across the clinical governance agenda and whose involvement should be actively facilitated. I

was told that meetings/sessions often happened at inconvenient times and clashed with clinical commitments, making attendance difficult.

In addition there is a belief that involvement of clinical teams in decision making is not actively encouraged and that decisions are made without reference to the wider team. I have seen evidence that the leadership team have invested significant effort into promoting clinical engagement with limited positive results. This disconnect must be addressed urgently as if left to continue is likely to impact negatively on the safety of care delivery within the Unit.

5.4 Is there a culture of Improvement where staff are engaged and involved to support delivery of high quality services: through being aware of clinical quality indicators; have the competencies to deliver patient safety initiatives and improve patient experience; are supported to deliver change at all levels including the national maternity transformation agenda?

Following the CQC inspection of 2015, the Executive Team commissioned an external review into Maternity Service provision at BHT led by Debbie Graham and Dr Robert Sherwin. The report provides a comprehensive overview of maternity services and details 34 recommendations. It was published in June 2016. A subsequent paper to Trust Board in October 2016 outlined the plans in place to address these recommendations, the progress that had been made to date and outlined the oversight arrangements. The transformational work was originally led by the previous Trust COO and was subsequently then handed over to the Division. It was used to inform the wider OD and culture work that has taken place over the last two years. This work has included the development of listening events led by the Executive Team, the establishment of focus groups with regulators and the roll out of 'let's talk about work events' across the Maternity Service. In addition there has been the offer of 360 degree feedback for Band 7 and above.

Despite a comprehensive action plan put in place to address concerns raised by CQC in 2015, the subsequent inspection in 2018 again rated maternity services as requires improvement. It is not possible to compare ratings as the 2015 inspection reviewed maternity and gynaecology services together but it is evident that some of the recommendations outlined in the 2015 report had not been embedded by 2018. Moreover the 2018 report makes reference to the reports from some staff of a bullying and intimidation culture from the senior leadership team whilst acknowledging that this view is not universally held.

Staff perception is an important feature of the concerns that have been raised both internally and external to the organisation. Since the publication of the CQC report in 2018 there have been six incidents of whistleblowing to CQC about Maternity Services, four internal reports from staff about the management culture within the service, evidence from junior doctors surveys that the culture of labour suite is unsupportive, and three 'Let's talk about Work' events which describe a context in which maternity staff feel undervalued, 'put upon' and unable to fully function in their

role, particularly at Band 7 level. There is a tendency to 'blame' the leadership team for lack of understanding and/or effort to improve. This tendency is consistent with poor safety cultures and whilst I have no evidence that it is impacting on direct patient care, I am concerned that left unremarked or unattended the potential to become a risk to patient care will be realised.

The availability of staff is a theme which runs across all the verbal and written concerns which I have reviewed and manifests in reports about people being expected to stay on past shift finishing times, lack of support for junior and newly qualified staff, delays in elective caesarean section lists and delays in planned inductions. There is a disconnect between the evidence that I have reviewed which confirms that midwifery numbers are in line with Birth-rate plus requirements, that ratios are well within national averages and vacancy rates low and the consistent reports from all members of the maternity team that the numbers of staff rostered on shift do not meet capacity demands of the service. Staff reported that training is often cancelled at the last minute, is not always multi-disciplinary and is not consistently applied in practice. I reviewed this concern further and have been advised that no role critical training has been cancelled but that sometimes decisions to cancel mandatory training sessions were made without reference to the management team. Following feedback to the DLT a new system of oversight has been introduced whereby decisions about cancelling training will be made by the matron or above and only after all alternative options have been considered.

The relationship between the culture of an organisation/service and the quality of care delivered is well defined (Dixon–Wood et al 2018). Characteristics which are known to undermine a safety culture include inability or lack of established responsibility, silo working, hierarchical orientation and a punitive approach to problems (Vaughan et al 2016). Whilst there are elements of all 4 present in BHT maternity services, there is no evidence that the leadership team directly contribute to their continuation. Rather, my assessment is that the improvement methodologies previously implemented have either not yet delivered and require further input or have stopped prematurely and before their value could be felt. Cultural and behavioural change takes time.

5.5 Is there a culture of understanding, responsiveness and proportionality related to attitudes and behaviours, omissions and commissions? Are there positive relationships between staff members which supports inclusion and respect between teams?

The management team are conversant with and report application of Trust policies and procedures fairly and I did not observe or find evidence that decisions are disproportionately applied to any particular staff group or group of individuals. The change in management culture and approach set out in response to Section 3.1 above has changed the way behaviours and challenges are managed within the service. There is an increased and reasonable assumption that all members of the

team will behave responsibly and professionally, act within role and provide support to others.

This expectation is experienced differently across staff groups and I heard submissions that this is sometimes felt as interference in individual practice and behaviours which on the face of it have little impact on direct patient care. The example of the removal of the ritual of allowing a tea trolley at the nurse's station was heard on a number of occasions. I make no comment on the proportionality of this decision but it is worth noting that something so seemingly small and reasonable has generated ripples of discontent and feeds the 'narrative that management do not understand us'.

I heard evidence from individual staff members that they felt singled out and blamed for actions that were not theirs alone and that some were unwilling to speak up for fear of retribution. I was not however provided with systemic examples of this behaviour, rather a belief is apparent in the service that their voice is not of value. This was compounded by a recurring theme of not being heard even when concerns are expressed, a kind of 'what's the point' approach. I asked a number of staff directly why they had not taken up offers to attend staff meetings/development events and received a similar response. Some members of the team expressed concern that there was inconsistency of decision making with different managers making different decisions, even about the same issues.

Conversely, I saw evidence of a management team who are keen to listen and to implement effective and sustainable change. There is a clear maternity services vision that has been developed in conjunction with staff and a number of policies and processes are in place to support decision making. There is evidence that some staff members approach a number of more senior members of staff about the same issue and that this can result in a slightly different answer each time which whilst understandable has the potential to contribute to the prevailing narrative.

A recently completed report by the Trust Associate Director of Organisational Development and Learning makes reference to a culture of learned helplessness amongst members of the maternity team, regardless of role and band, with an over-reliance on hierarchical structures to make decisions and to then be held responsible for those decisions. This finding is consistent with the observations that I have made above.

Inclusivity within the workplace is recognised to promote well-being and positivity amongst staff which in turn translates into better patient care. The conditions that promote inclusivity extend beyond the creation of a diverse workforce to a culture in which people feel valued and respected and where their contribution is appreciated. Despite assurance that the senior managers are following disciplinary policy and applying this fairly, I heard examples from staff which contradicted this. Examples include delays in applying disciplinary processes, inconsistent use of disciplinary

processes and implementation of decisions which had not been shared or socialised within the service. This has translated into a perception of unfairness and lack of inclusion with a strong underlying belief that different rules apply to different people depending on their place in the system. It is important to stress that I found no substantial evidence of this in practice but I am concerned that these perceptions limit the development of inclusive workspaces and contribute to the belief that the culture is not supportive of individuals. Bedford Maternity Unit is not alone in describing a difference between what managers/leaders believe to happen and how it is perceived by staff but in developing an open and inclusive culture, perception is an important contributor.

Dekker (2011) describes the difficulties inherent in building a just culture in organisations and a persistent belief that such a culture can be built simply by applying a simple formula which distinguishes between error, at risk behaviour and recklessness. The concepts of accountability and individual responsibility are often conflated and misunderstood and can be used to drive responses to situations/events that do not necessarily improve patient safety or patient outcomes. Blame and defensiveness thrive in a culture which is perceived as unjust and unfair. Much of this comes from a lack of understanding about different perspective. These are generic findings and apply much more widely than to Bedford Hospital Maternity Services. However, they can be applied both to the observations that I have made and to those made as a result of the 'Let's talk about Work' outputs.

6.0 Recommendations

The Executive and Divisional Management teams should consider the following suggestions for improvement:

- Undertake a cultural safety survey to establish the impact of the existing culture on safety within the Unit. I have found no evidence that safety is compromised but such a survey will provide a baseline on which to build change and is driven by shared values. The inclusion of all staff groups in this is essential.

- The service and management teams should build on the work and feedback already commenced. I suggest that the team take stock of what has been done so far, distil key learning and messages from this and implement actions in a consistent and proportionate way.

- Review the QIA completed as part of the introduction of Continuity Schemes and consider introducing some performance metrics that monitor impact on delivery of core service.

- Medical leadership across the service should be reviewed to ensure consistency of expertise and input at divisional and service governance meeting.

- Ensure that all action plans are up to date and that learning from incidents and complaints is fully embedded across the service.

- Learning from exemplar sites, the introduction of a shared space for coffee/meal breaks used by all professional groups, including managers and consultants, has been shown to help create working relationships that are characterised by friendship and mutual trust. The service may want to consider this possibility.

- Review and, where still applicable, implementation of the actions arising from previous reviews and inspections. Where actions are no longer applicable, be clear about why and share the decision making process with clinical teams using relevant messages.

- Support the staff and management teams to develop their own culture together: how do they want to work, what questions should be asked to determine next steps, what is a proportional response to the event?

- Think about promoting and sharing positive messages: there is much good about the Maternity Service as evidenced in the recent CQC maternity survey and indeed in the most recent CQC report. Celebrate the positive and change the narrative.

7.0 References

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