Cover page	
Meeting	Board of Directors
Paper Title	Quality Improvement Plan
Date of meeting	30th July 2020
Date paper was written	22nd July 2020
Responsible Director	Maggie Bayley, Chief Nurse (Interim)
Author	Maggie Bayley, Chief Nurse (Interim)
Presenter	Maggie Bayley, Chief Nurse (Interim)

Executive Summary

This paper gives an overview of the quality improvement plan and progress on delivery against the plan at 58% completed as of 15th July 2020 and has been discussed in detail at the Quality and Safety Assurance Committee.

Information is also provided in relation to serious incidents reported and the position in relation to addressing the backlog of overdue incidents.

Additionally, an update is provided following the unannounced visit to the Trust on 9-10th June 2020 and subsequent action taken by the CQC. This includes additional conditions imposed on our registration under section 31 of the Health and Social Care Act 2008. The Trust also received a section 29A improvement notice on 19.06.20 with requirements for improvement in regards to the Mental Capacity Act to be demonstrated by 31st August 2020

The immediate and ongoing response by the Trust is detailed focusing on immediate actions and wider cultural changes needed.

The Board is asked to review the paper and discuss and take assurance from immediate actions taken.

Previously considered by	Quality and Safety Assurance Committee 22.07.20

The Committee is asked to:			
☐ Approve	☐ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	If we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients (BAF 1533)

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	N/A

The Shrewsbury and Telford Hospital NHS
NHS Trust

Quality Improvement Plan

Maggie Bayley
Interim Chief Nurse

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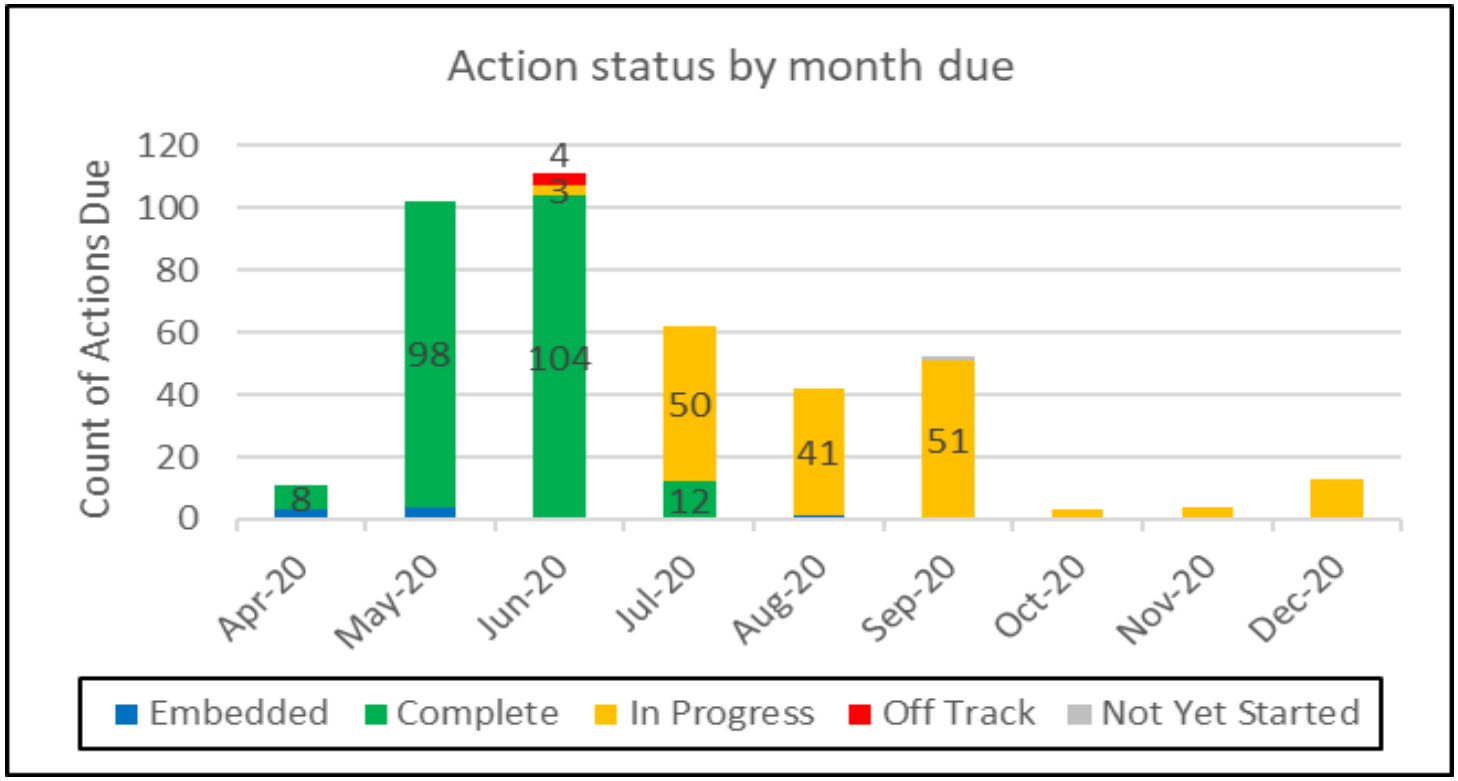
Quality Improvement Plan

The Trust CQC Improvement plan has been developed and was agreed by Trust Board in May 2020. Weekly Confirm and Challenge sessions are being held with the Care Groups to drive and assure actions. Update of action status by Care Group as at 15th July as detailed below.

Group	Scope	Total Actions	Embedded	Complete	In Progress	Off Track	Not Yet Started	Percentage Complete
Trustwide	Trust Wide	121	-	46	72	2	1	38%
Urgent and emergency care	Urgent and emergency care	157	7	98	52	-	-	67%
Medical care	Medical care	25	-	18	5	2	-	72%
Scheduled Care	Surgery	37	-	27	10	-	-	73%
	End of life care	9	-	5	4	-	-	56%
	Outpatients	2	-	2	-	-	-	100%
	Critical Care	2	-	-	2	-	-	0%
Women & Children	Maternity	34	1	21	12	-	-	65%
	Children and Young People care	13	-	5	8	-	-	38%
Total		**400**	**8**	**222**	**165**	**4**	**1**	**58%**

CQC Improvement Plan

Improvement Plan Trajectory:



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The Shrewsbury and Telford Hospital NHS
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CQC Unannounced Visit
9-10th June 2020

Maggie Bayley
Interim Chief Nurse

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CQC unannounced visit 9-10th June

- The CQC undertook a risk based visit to the Trust on 9th and 10th June
- The areas they visited included a number of medical wards on RSH and PRH sites
- The CQC provided feedback in relation to number of areas including:
  - End of life care and ReSPECT Forms
    - Plan for implementation
    - Use of the form
    - Mental capacity assessment recording
    - Full completion of forms
  - Risk Assessments
    - Completion and review of risk assessments
    - Individualisation to mitigate risks
    - Documentation of comfort rounding
  - Care Planning
    - Not all Person centred/ individualised
    - Consistency of evaluation
    - Cross reference to risk assessments
  - Restraint
    - Best interest assessment – use of and rational

Outcome of the visit - The Trust has received further conditions applied for regulated activity and received an improvement notice

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CQC unannounced visit 9-10th June - Actions Taken

Following the notice of intention received on 15.06.20 an action plan was developed and submitted to the CQC on 16.06.20

To address immediate concerns:

- Immediate brief to all Senior Nurses, mangers and medical Staff of the outcome of the visit
- Targeted review of issues raised to address failure to document and maintain patient safety, including tissues viability, falls use of beds rails
- Immediate review on 10th June of concerns re safeguarding and mental health assessment reviewed by CCG safeguarding lead to assist in implementing change. Agreement reached with CCG to second the Safeguarding lead to the Trust team from Mid July. Additional staff to support training in place as from 23.06.20
- All ward managers to work clinically within their areas daily acting as a role model and undertaking check and challenge in relation to the care received by patients and documented by staff as form 11th June
- Additionally as from 11th June, matrons to work a minimum of two shifts per week in clinical areas to undertake a revised brilliant basics audit to assist in the monitoring of care for their patients and improve the oversight of the care being delivered.
- New nursing documentation roll out 29.06.20
- Safety Thermometer point prevalence audit to be re-instated monthly as from July

- An intensive support team will be introduced led by a quality matron and a mental health nurse supported by quality facilitators being recruited to the patient safety team.
  - This team will undertake targeted work on a ward by ward basis to both monitor and improve practice to ensure patient safety is paramount. They will also act as a rapid response team when incidents of a serious nature occur.
  - In the interim internal staff re focused to undertake this this work with support from the transformation team

CQC unannounced visit 9-10th June - Actions Taken

- Further additional resources have been requested to ensure individualised care for patients, This includes:
  - increasing funding in the safeguarding team to for a full-time adult safeguarding lead; seven day a week cover by matrons undertaking clinical oversight of patient care; and seven day per week from the Infection prevention and control team. Administrative support will be provided to the tissue viability nurses; falls nurses; nutrition team and dementia team/safeguarding to ensure the staff time is re-focused on the delivery and support of clinical care.

- In order to support the changes there is a need to implement the already agreed ward manager's development program for all band 7 nurses and midwives. This programme is planned to commence in September for 1 day per month for 12 months, it will cover:
  - insights, resilience, equality and diversity and quality improvements. Individual coaching will support this. We are exploring the launch of the programme through a conference focused on personal ownership, responsibility and accountability in July, supported by the NMC.

- The ward accreditation programme 'Exemplar' is currently being reviewed and updated to ensure that the RAG system demonstrates a true representation of the findings in clinical areas.
  - This will then link to a revised dashboard that will cross-reference clinical indicators on the ward, competencies; complaints and incidents. Monthly reviews will then occur with the Chief Nurse

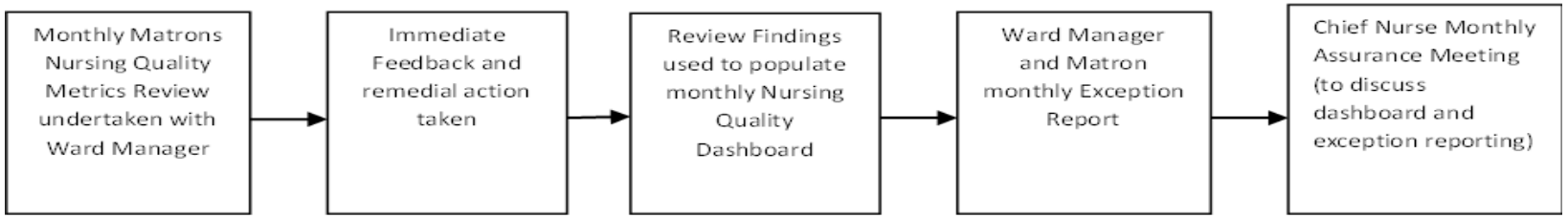
Quality of Care on Wards and Ward Leadership

Nursing Assessment and Documentation:

- New Nursing Risk assessments and documentation
- Online user guide for new documentation and Practice Educators “floor walking”
- Development of care planning drop in sessions for nurses by the Nurse Education Team
- Spot checks by Ward managers
- Ongoing education in the clinical areas from specialist nurses/AHPs
- Staff Documentation stamps ordered for all registrants.
- Letter from Chief Nurse to all registrants in relation to professional standards for documentation

Nursing Assurance and Accountability for Quality of Care:

- New monthly Matrons Nursing Quality Assurance Metric Audits Framework
- Monthly Nursing Quality Assurance Meetings with Ward manager and Matron to review Ward Dashboards/Quality KPIs, chaired by the Chief Nurse
- Twice monthly matrons development session with Chief Nurse started



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Falls and Bed Rails- Review of Incidents and Learning

Review of Incidents involving falls with bed rail involvement between April 2019 and June 2020 and Falls Improvement Work

Number of Incidents	Type of incident	Level of harm	Learning
11	Fall with bed rail involved	• 7 Near miss/no harm • 3 Minimal harm minor treatment • 1 Death (bariatric bed incident and entrapment)	Risk of falls identified in 10 of the cases.
Key Falls Improvement Actions	• Improvement in nursing risk assessment in relation to falls and bed rails • Implementation of revised Falls Prevention Care Plan and Patient Prevention of Falls Booklet • Falls Training by Falls Practitioner on 'high risk' wards • New nursing documentation with improved falls and bed rail assessment rolled out on 29th June 2020 • Enhanced Patient Supervision (EPS) Policy and improved use of cohort bays and 'bay tagging' • Monthly audit of nursing documentation in place to include completion of falls risk assessments and use of bed rails • Unreported falls audit planned for August 2020 • Information cascade from Falls SIs via Patient Safety Newsletters and Safety Huddles • Immediate actions, learning and action plan in place with regard to the fall and entrapment from the bariatric bed incident		

Developing our Senior Nurse/Midwifery Workforce Leadership Programme commencing September 2020

50 senior nursing staff in 2 cohorts, attending 1 day a month across the Trust commencing September 2020 for 12 months

Aims:

- To equip Band 7 nurse leaders with the skills and techniques to support them in effectively managing their working environment, keeping the patient at the centre of all they do.
- To develop a community of practice to support and empower the frontline nursing leadership teams.

Delivery Methods:

- **Workshops:** Interactive facilitated workshops using reflection and work based experiences
- **Coaching:** A person-centred coaching style utilising the coaching network
- **Action learning Sets:** Group support to discuss the outcomes and impact of learning in practice
- **Individual reflection:** Supported through Personal Portfolios

Additionally:

Retired Chief Nurse x2 days a week working with Ward Managers to develop their leadership capacity to improve patient centred care

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Leadership- Medical Staff

Medical Leadership:

- 3 out of 4 CGMDs appointed
- Funding secured for all leadership and corporate functions
- NHSI regional asked for help with SCMD position
- 6 new CDs / site leads appointed in USC
- New CD in Radiology; ICU / Anaesthetics
- CCIO interview – 6 candidates
- Mortality leads out to advert
- Leadership programme re-launch 8/20

Governance

As at 8th July 2020, 42 actions out of 51 (84%) have been completed to improve Governance in the Trust. Summary of key highlights below:

- Review of Trust Governance structure and processes have taken place and Action plan developed, including development of performance management framework.
- Independent review carried out of entire Risk management system and strategy for Trust.
- Review of ED Governance framework and processes, including implementation of Weekly ED assurance meeting, and review of ED Oversight Group to ensure oversight and assurance of department. ED Dashboard developed to improve oversight of performance.
- Establishment of Maternity Quality Group to provide assurance and oversight across the department. Development of overarching Maternity Improvement Plan.
- Reminders to staff of key responsibilities, for example, secure storage of patient records, and maintenance of accurate and complete patient records.
- Introduction of standard work to ensure regular spot checks and audits in clinical areas to ensure compliance with policies and standards, including reporting of findings and actions through governance framework.
- Nursing Documentation updated and to aid consistent completion of patient records.
- Review of SOPs to ensure up to date and relevant, including dissemination and communication.

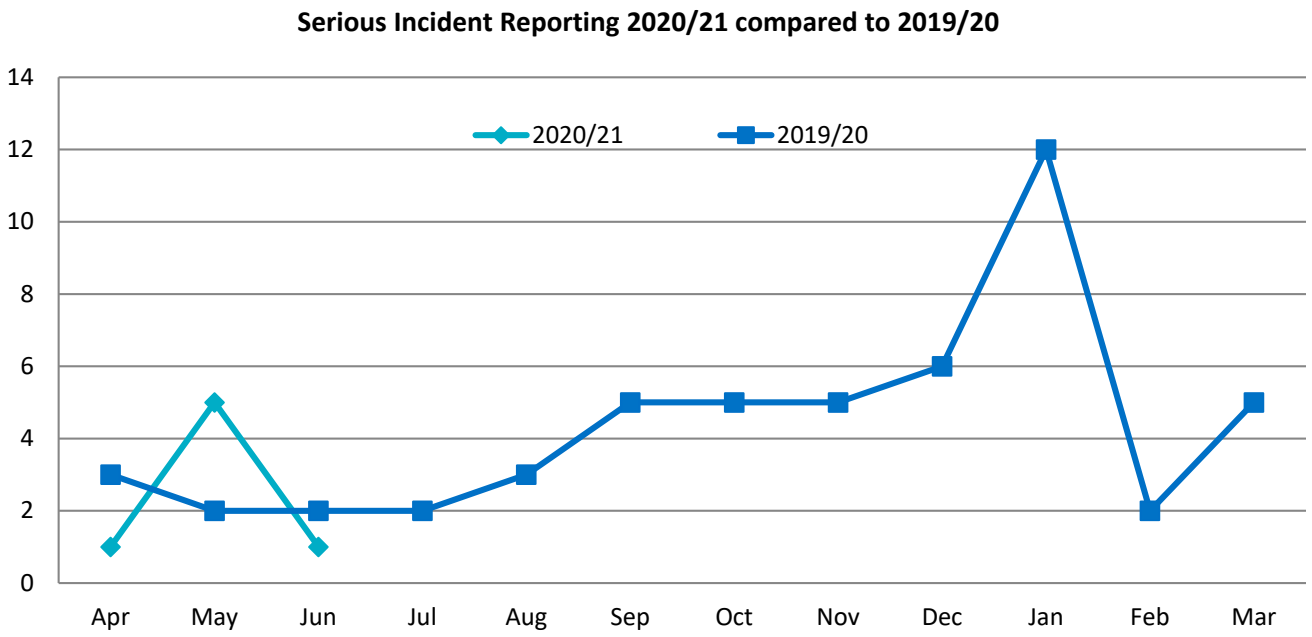
- Deputy Director from Sherwood Forest appointed to support CQC improvement work

Improving SATH's Culture

- People strategy
- Dedicated clinical leadership programmes
- Focus on fundamentals of care, behaviour and outcomes
- Strengthening HR processes and capabilities
- Targeted programme with dysfunctional teams – strengthening challenge and team resilience
- Leadership and followership changes
- Improved funding , seniority and hours for FTSU team
- Comprehensive support and wellbeing programme

Serious Incidents – June 2020

Serious incident reporting 2020/21 compared to 2019/20



NB: Since October 2019, all falls resulting in Head Injury or '#NOF are automatically reported as SIs

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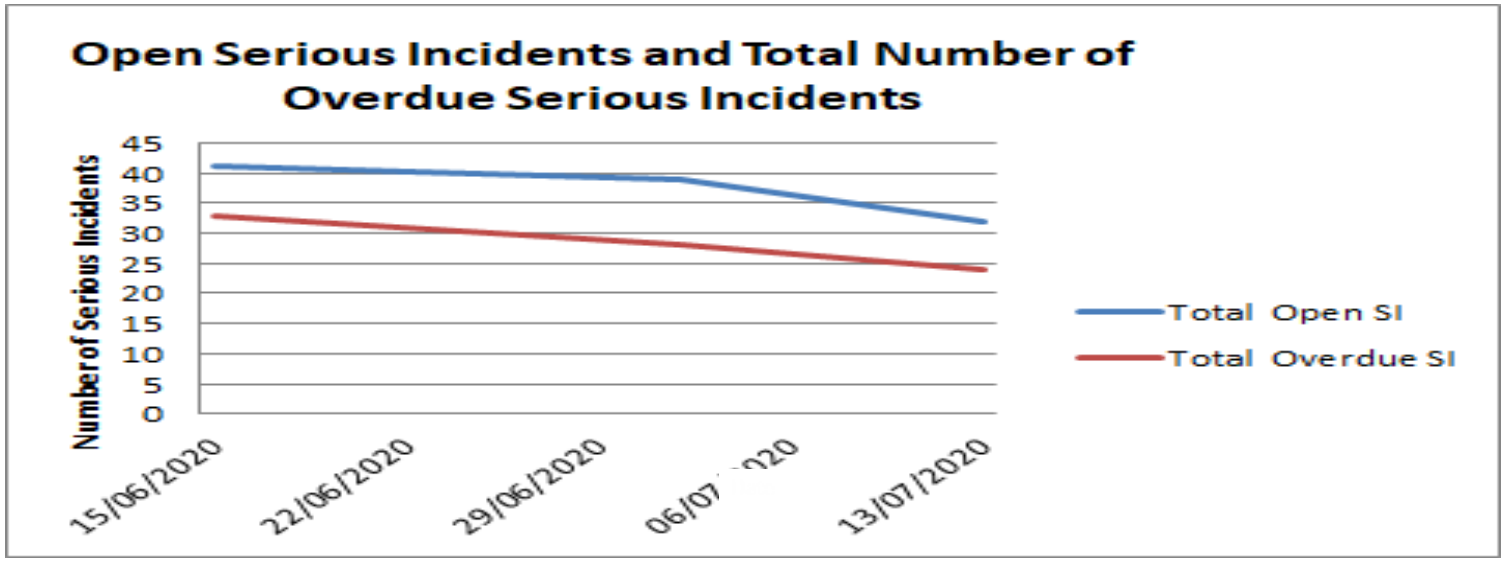
Serious Incidents Open and Progress with Overdue Investigations



Date	Total Open	Total Overdue	Overdue on-going investigation	Sent to CSU/CCG With further actions for SATH to complete	Sent to CSU/CCG Awaiting decisions regarding closure	Stopped Clock
15/6/20	41	33	17	8	8	4
02/7/20	39	28	15	9	4	4
13/7/20	32	24	13	7	4	4

The Shrewsbury and Telford Hospital NHS
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Review of the handling of the Royal College of Obstetricians and Gynaecologists report by NHS Improvement

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RCOG Report Handling Review

- Following a complaint from a family in November an investigation on was launched by NHSI into the handling of the invited review of the maternity service
- John Lester was appointed to do this and concluded his report that was published on 21.07.20
- The trust has accepted the key findings of the report in that it could have taken the original report through governance processes more quickly
- Additionally, it is noted that candour was applied and the nothing was hidden from the public
- There are three recommendations included in the report which the Trust has responded to and are included in the report which is attached as Appendix 1

The Shrewsbury and Telford Hospital NHS
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Independent Maternity Review

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Independent Maternity Review

- An independent review, led by experienced midwife, Donna Ockenden, is looking into cases involving families from our communities. On 21.07.20, it was announced that the total number of families whose cases are being reviewed is 1,862.

- The Chief Executive wrote an open letter to the community, explaining the position and acknowledging that the announcement will be concerning, both for those families and everyone in our communities, who depend on the Trust for their care. It was also noted that an apology is not enough and that families need to see evidence of real improvement at the Trust.

- The Trust continues to work with the Ockenden review team to help families get the answers they need and in turn we will make the necessary further improvements.

- The Trust has established a dedicated email address for any family not included in the review can come to us at any time to share their experiences or raise any concerns.

Embargoed until 11am Tuesday 21 July

NHS Improvement

Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust

July 2020

Contents

Introduction

Background

On 29 November 2019 a letter of complaint was sent to the National Medical Director by some families affected by the issues covered by the Donna Ockenden review of maternity services at The Shrewsbury and Telford Hospital NHS trust (the trust).

The letter set out concerns in relation to a report by the Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at the trust, based on a visit carried out from 12-14 July 2017.

The letter alleges that the RCOG report was withheld from the trust board for 12 months. Furthermore, it alleges that trust management sought to 'water down' the RCOG report by requesting a further document (the 'addendum') to be produced by RCOG acknowledging improvements that had apparently been made, following representations made to RCOG by a trust delegation in April 2018. This document was then added to the original report before being presented to the trust board in July 2018.

In response to this letter, NHS Improvement's Investigation Team, with independent advice and scrutiny from Heather Tierney-Moore (see below), has looked into this complaint to establish the facts relating to the allegations. The review was independent of the trust and all other relevant parties.

Scope

The overall objective of the review was to determine whether members of trust management acted in accordance with acceptable standards of governance, specifically to address concerns within the complaint that staff at the trust attempted to (a) 'cover-up and water down the significant concerns contained in the RCOG July 2017 report' and b) deliberately suppress that report to avoid accountability, and scrutiny of the maternity services by the Board.

In places, this report goes beyond the above scope in order to provide further relevant context which may help to explain motivations and decision making at the

time. The review has focused on the actions of the trust and its staff rather than RCOG, although it has been necessary to comment on RCOG's role in the process to an extent to provide context for the trust's actions.

Approach

The review consisted of meetings with a number of current and former trust staff and RCOG representatives, as well as with one of the families raising the concerns. Multiple documents, including board and committee papers and relevant emails, were reviewed.

In this report, the term 'maternity management' refers to the senior clinical and administrative leadership of the maternity service and Women and Children's Care Group, one of four clinical groups at the trust.

Some of the events described in this report occurred almost three years prior to interviews with individuals. Memories of key events, meetings, decisions and thought processes are understandably diminished and it has been necessary to rely on documentary evidence, including emails, as well as interviews to create as full a picture as possible.

The trust (and relevant former employees) and RCOG have been given the opportunity to comment on factual accuracy in relation to the draft report.

We are aware of another investigation having been carried out by a third party, which touches on some of the issues in this report but is distinct in terms of subject matter. We have intentionally not had sight of the outcomes of this separate investigation as part of this review.

Independent reviewer

An external reviewer, Heather Tierney-Moore, has provided independent advice and scrutiny to the review. This has included review of all evidence, identification and resolution of potential further lines of enquiry, discussion and refinement of judgements and conclusions, and joint development of the recommendations.

Ms Tierney-Moore is the former Chief Executive of Lancashire Care NHS Foundation Trust and has held Director of Nursing and Quality roles in the NHS.

She does not have any prior connection with The Shrewsbury and Telford Hospital NHS trust or its current and former employees relevant to this review.

Executive summary

The trust commissioned a review from RCOG in 2017 to seek assurance regarding its maternity service. Terms of reference were agreed upfront, although the purpose was described varyingly by interviewees as the improvement of services and reassurance of the local population and media. The trust committed upfront to publishing the report.

Twelve months elapsed between RCOG's site visit and the report being presented to the trust's public board. The first five months of this period was for the production and finalisation of the report. The process of getting agreement to the revised report and subsequent follow up visit took up a significant further proportion of the overall timescale.

A number of trust staff were unhappy with the draft report when it was received three months after RCOG's site visit, feeling it was not an accurate representation of the service. The trust gave a lengthy factual accuracy response a month later.

RCOG made only minor changes to their original draft and clearly intended to stand by their initial assessment, which they said was based on the totality of evidence available, including staff views. Some trust staff were dissatisfied with this stance and the CEO, in part guided by staff feedback, initially would not accept the report. While we believe there were some genuinely held concerns about the report's accuracy, it seems that the trust's response at this stage was driven primarily by concerns about the impact of publishing the report in its current form. In particular, the trust was worried about the potential public and media reaction and resultant effect on both staff morale, which was already low following periods of intense scrutiny on the maternity service, and public confidence.

Following further discussions with RCOG, the trust did then accept the report in early January 2018 but remained concerned about its tone and context, particularly in relation to the executive summary. The trust made representations to RCOG to address this, and also proposed a follow up exercise to evidence improvements the trust felt it had made. RCOG declined to make any further changes to the report, but did agree to a follow up exercise, to be conducted as a 'progress review meeting' at RCOG's premises.

Our view is that it was reasonable for the trust to request a follow up if it genuinely believed improvements had been made; it was appropriate to seek external assurance about the changes made and right that the public should get the most accurate and up to date account of the service. The action plan prepared in response to the RCOG report seemed to support the assertion that changes had been made in an attempt to address the concerns raised, although it was focussed more on process than outcomes. However, a single off-site meeting could only ever provide a limited degree of assurance, particularly in relation to issues of culture which cannot easily be assessed from a distance.

Again, our view is that the primary purpose of the follow up exercise from the trust's perspective was to mitigate the perceived adverse impact of publishing the initial report. We can understand why the trust would have been motivated to pursue such an exercise, given what we have heard about how some staff have been affected by intense media and public scrutiny.

An addendum was produced by RCOG summarising the findings of the follow up exercise, which the letter of complaint from families describes as having 'softened' the initial report. It is fair to say that the addendum, and particularly the covering paper prepared by management for the board, does reduce the impact of the initial report. This in itself is not of concern if the improvements were evidenced. However, as above, the degree of assurance from a single remote meeting could only be limited, and no such caveats were highlighted to the board or public. The covering paper to the board was overwhelmingly positive in tone, with its twelve-point summary reflecting only the most complimentary aspects of the addendum itself. The overall result was a document that gave the impression that issues in the maternity service had been largely resolved, when in fact there was significant further work to do.

The report was not withheld from the board. It went in full to the Quality and Safety Committee (QSC) before the addendum was produced, and to the board after it was produced. However, our view is that the report should have gone to both forums sooner than it did. The trust wanted to wait for the addendum before publishing, but this should not have delayed internal scrutiny; QSC and the board should have had an earlier opportunity to scrutinise the actions being taken by the care group.

We can understand why the trust wanted to publish the report alongside assurances of improvements made, but it would have been more transparent to publish sooner, along with a clear statement of how the issues would be addressed. All board members were kept informed of the report's progress and could have challenged the approach or timelines, but did not.

Governance arrangements at the service and care group level were not operating effectively in relation to the report and associated action plan, with the report itself not coming to the care group board until July 2018.

Although a lot of work was initially done to implement actions and keep the action plan updated, there has been very limited ongoing scrutiny of the plan by local or corporate governance forums. This is concerning given the severity of some of the issues identified in RCOG's report.

It is important to acknowledge that the trust was not obligated to commission the RCOG review but chose to do so and committed from the start to publish the results, knowing that this would open itself up to further scrutiny. However, when the outcome was less favourable than hoped for, the primary trust focus seemed to shift towards the perceived public reaction to the report, rather than getting the right internal assurance and scrutiny to ensure the improvement of services.

Detailed findings

Context

It is important to understand the context in which the trust was operating over the period in question (c. March 2017 to July 2018), as this helps to explain some of the decisions that were made in relation to the RCOG review. These points of context will be referred to throughout this report.

1. In response to concerns about the quality of maternity services, the trust has been under significant scrutiny from regulators, its local population and the media over a long period. The trust has been subject to a number of external reviews, including most notably the ongoing Ockenden review commissioned by the Secretary of State for Health and Social Care in April 2017. At the time of the RCOG visit, the trust expected the Ockenden review would be finalised in early 2018. It is clear that this scrutiny has put significant pressure on staff and negatively affected morale. We have heard reports of staff being reluctant to go shopping for fear of being confronted, and of high levels of sickness related to stress and anxiety amongst midwives. We are not suggesting that this level of scrutiny is not required or justified, but that its impact should be noted. We believe the degree of scrutiny has influenced behaviours and decision-making over the period in question.

2. The trust was challenged in a number of respects. In addition to concerns about maternity services, A&E performance was very poor, particularly over the winter of 2017/18, and the trust was dealing with the potential closure of the A&E at Telford. At the same time, the trust and commissioners were in the process of reconfiguring the midwife-led units (MLUs) in response to safety concerns. The board therefore had several priority areas to consider and executives were under pressure on multiple fronts.

3. The Chair, having joined the trust in February 2018, was still working to understand the trust's issues and build relationships at the time the RCOG report was being finalised.

4. A number of individuals have described a culture of defensiveness, denial and/or lack of openness that existed at the time in the maternity service and

trust more generally. While such a culture clearly does not excuse any actions or behaviours, it may help to explain them.

Commissioning the review

Discussions began in relation to commissioning an invited review from RCOG in March 2017, with the primary trigger being concerns raised about the trust's maternity services and associated national press interest. The suggestion of the review was made by the then Medical Director at NHS Improvement, during a call with the then trust Medical Director.

At this stage, involvement from the trust was primarily among the trust Medical Director and Care Group Medical Director (Women and Children's Services), with the former CEO reviewing and signing off the terms of reference. The designated lead for the review was determined as the Director of Nursing, Midwifery and Quality (DNMQ), who had recently joined the trust and has since left.

A formal request was sent to RCOG at the end of March 2017, with RCOG accepting the request shortly afterwards. The document included a request that two further visits be conducted by the reviewing team in order to monitor actions and progress. Such a follow up exercise did not form part of RCOG's standard invited review process[1] and did not form part of the initially agreed approach. Terms of reference were agreed in May, with the site visit by RCOG planned for 12-14 July.

The primary aim of requesting the review has been described varyingly by different individuals. Many described it as an opportunity to shine a light on the trust's practice and get a professional and independent view. Some saw it an opportunity to receive (and publish) assurances either that the service was sound or that it had demonstrated signs of improvement. The former Medical Director at NHS Improvement is clear that the purpose as she proposed it was solely as a learning exercise.

[1] The standard process at the time was for RCOG to contact trusts three to six months after the final report had been issued to discuss the outcome of the review and whether the suggested recommendations had been implemented.

Site visit and draft report

RCOG's site visit happened as planned in mid-July, with verbal feedback provided to the maternity management team at the end of the visit. A summary of this feedback to a wider staff group demonstrated that, in addition to some positive points, there were a number of concerns relayed at that time, for example relating to staff morale, staffing levels and serious incident investigations. At this point the trust expected the draft report to be received at the end of September.

RCOG sent the draft report to the trust on 9 October. RCOG has indicated that production of the report was in line with normal timescales for such reviews. When sending the report, RCOG asked for any factual inaccuracies to be communicated by 30 October.

It is clear from trust email correspondence at the time, and from interviews, that members of the maternity management team were unhappy with elements of the draft report and felt that some criticisms were not supported by evidence or were internally inconsistent. Comments were collated by the Care Group Medical Director and sent back to RCOG on 10 November. This was later than the requested timescale, but not significantly so given the number of individuals providing feedback.

The list of comments extended to 17 pages. RCOG commented that the trust's response was longer than they would normally expect, and that many of the issues raised were not actually points of factual accuracy. We do think it is reasonable for the trust to have provided broader comments, for example in relation to tone, internal consistency or offering further clarity. However, the sheer size of the trust's response potentially rendered it counterproductive and may have been indicative of an overly defensive attitude.

Nevertheless, our view is that the trust's concerns with the report – whether supported by evidence or not – were genuinely held. In other words, the articulated concerns were not an underhand attempt to create a falsely positive report or to delay its publication.

RCOG considered the trust feedback and responded on 12 December, with a revised report and covering letter. Few of the trust's comments resulted in changes to the report, and those changes that were made were relatively minor, not altering the overall tone of the report. The letter, from the then Vice President, Clinical

Quality at RCOG, explained in broad terms their response to the trust's comments. In essence, RCOG stood by its initial assessment, which was based on evidence available at the time and on information gleaned from interviews. In particular, RCOG provided a robust defence of its criticisms of the trust's approach to serious incident investigations and of its culture in relation to learning from incidents. The letter made it clear that further details of process provided by the trust were not sufficient to change the conclusions which were, it seems, strongly supported by staff statements.

Residual trust concerns

Following receipt of the revised report, internal trust communications demonstrate disappointment with RCOG's stance. The former CEO, in part guided by the comments emanating from maternity management, stated in an email to colleagues that he 'cannot accept' the document as a final version given the perceived residual inaccuracies and inconsistency between the executive summary and body of the report. He also referred to RCOG 'refusing to recognise the factual accuracy exercise'. We do not believe RCOG refused to recognise the factual accuracy process; rather they considered the trust's comments and elected not to make changes in respect of most of them given the overall balance of evidence.

The trust arranged a call with RCOG to relay its concerns, which was scheduled for 4 January 2018 and was attended by the Care Group Medical Director. During this call, the trust's outstanding concerns were raised, as was their unwillingness to sign off the report at that time. RCOG representatives state that they were clear that the report was complete and that their expectation was that it should be reported to the board.

The trust's stated position changed shortly afterwards, with the former CEO and DNMQ agreeing that the trust needed to accept the content of the report, albeit they still had concerns with its context and tone, particularly in relation to the executive summary. This was set out in email communications with RCOG, alongside a request for a follow up review.

A face to face meeting between the trust and RCOG was arranged for 23 February. This was attended by the DNMQ and Care Group Medical Director from the trust side, with RCOG attendance including the Vice President for Clinical Quality. During this meeting the trust outlined the context of their concerns, namely staff

morale and media interest and the fear that the press would disproportionately focus on the negative aspects of the report and that this would be damaging. RCOG rejected the idea of any material changes to the report, saying that they considered it to be the final version.

The other purpose of the meeting was for the trust to demonstrate that it had taken action to improve services since the time of the review in July 2017. The trust states that it was already in the process of making improvements at the time of the site visit, and an action plan was developed specifically in response to the RCOG report, which the trust brought to this meeting. The trust felt that, at this time, improvements had been made and that they should be recognised. The trust was maintaining a repository of evidence supporting completion of actions, and the action plan referenced the evidence base for each item. The result of the ensuing discussion was agreement to undertake a progress review meeting at RCOG to review the improvements the trust said it had made. This meeting was subsequently scheduled for April 2018, which was the earliest date that RCOG representatives were available.

Our view is that it was reasonable for the trust to initially respond to the draft report in a comprehensive way. While the trust did want changes to be made to the report, this was predominantly in relation to the tone of the executive summary, which was felt to be inconsistent with the rest of the report in terms of its balance. Any attempt to change the report at this stage was, in our view, based on genuinely held concerns about the report's balance and language, and on the resultant media scrutiny and staff impact should the report be published in its current form. In the context of the initial response to the draft report, it is not unreasonable that the trust tried to address perceived inaccuracies and inconsistencies, particularly given the intense media scrutiny that would likely follow publication.

However, RCOG's response made it clear in December 2017 that the report would not be changed and that there was a clear evidence base for its conclusions, so it is difficult to understand the rationale for the trust not accepting the report at this point. Further requests for changes simply delayed proper internal scrutiny of the report (this is discussed below). That being said, we have seen no evidence that the trust exerted excessive pressure on RCOG to make changes (and in any case no significant changes were made), or that the trust requested RCOG to remove factual elements from their report.

Follow up exercise and report addendum

RCOG stated that they did not wish to undertake another site visit at this stage, and that a return visit to the trust would have meant further scrutiny of staff already feeling under pressure.

Such a follow up exercise was unprecedented according to RCOG, although that in itself does not make it wrong. Indeed it is good practice to carry out a follow up process to a review that has made recommendations. However, conducting this as a progress review meeting was clearly not going to provide the same degree of assurance in relation the actions taken than revisiting the trust would have done; this is particularly the case for those criticisms in the report around 'softer' factors such as culture, which are difficult to measure without direct access to a range of staff. This is discussed further below under 'Report governance' (Publication).

Some at RCOG had reservations about agreeing to a follow up exercise, as they had not undertaken such a process before. We believe however that they did so in good faith, wanting to help a trust that was struggling and under pressure as part of their role to support the system.

RCOG advised the trust that those working on the action plan should be present at the meeting on 27 April 2018, to present the work they had undertaken. A group of seven individuals from the trust attended the meeting. RCOG requested additional documentation in advance, such as recent serious incident reports, which the trust provided.

Both trust representatives and RCOG report that the meeting was relatively formal, structured and professional in tone, with the trust presenting on the action taken and the areas requiring further work and RCOG members providing challenge on what they heard. RCOG had a copy of the trust's action plan, referenced to documents that they felt evidenced completion. RCOG representatives' view of the meeting is that it seemed that the trust had done a lot of work, put in significant effort and made genuine improvements. Trust attendees feel that verbal feedback from RCOG at the end of the meeting was positive and acknowledged material improvements, while noting areas requiring further action.

The RCOG Vice President for Clinical Quality wrote to the trust shortly after the meeting summarising the conclusions. Overall these were very positive, albeit the need for further work in areas was acknowledged. The letter stated that an

addendum to the original report would be prepared to reflect the current status. This seems to be an appropriate output from the follow up process and one that would have been necessary to provide assurance (either positive or negative) to trust maternity management, the board and public.

The draft addendum was received by the trust on 20 June 2018, approximately two months after the follow up meeting. RCOG report that the time taken was due to the availability of required individuals and the necessary drafting and quality assurance steps. The trust provided some comments on the draft five days later, with the final version received a further two days later. Some minor changes were made in response to the trust's comments, with other comments being disregarded by RCOG as they reportedly related to further action taken since the follow up meeting. We have not seen anything inappropriate in the response provided by the trust to the draft addendum.

Following receipt of the final addendum on 27 June, the document – along with the original report – was taken to the trust public board on 5 July 2018. This is discussed further below.

It is relevant to note that the trust had requested an ongoing relationship with RCOG – 'to monitor actions and progress' - from the initial commissioning of the review. The follow up process was therefore consistent with the trust's desire from the start to seek independent assurance on any actions taken. However, the evidence from interviews and documents indicates that the eventual primary purpose of the follow up exercise from the trust's perspective was to mitigate the potential negative media scrutiny that could have arisen from the original report, rather than to seek assurance for themselves that they had made the necessary changes.

In relation to the complaint's allegation that the report was watered down or softened, it is important to note that RCOG's initial report was materially unchanged from the first draft and was included in full in the public board papers. The issues highlighted within were clear to see and were not watered down. The inclusion of the addendum alongside the initial report certainly reduces the impact of the initial report and could therefore be described as having softened it. However, it is relatively common practice for an update demonstrating genuine improvements in care to be added to a report.

Report governance and publication

Care group governance

The Women and Children's Care Group is governed by its own board, in line with other care groups at the trust. Four service-level forums in the care group report to this Care Group Board (CGB), one of which is the Maternity Governance meeting (MGM).

We have seen no evidence that either the draft or final RCOG reports were presented to either CGB or MGM until after they were received by the board in July 2018. Some interviewees commented that governance processes were not operating effectively at the time. We note that the April 2018 CGB was stood down, and the trust could not locate minutes from the May meeting. One interviewee commented that, as the report was commissioned by the board rather than care group, it could not go to the CGB before the trust board. We do not agree with this; the report should have progressed through the governance chain, being scrutinised locally initially by those best placed to address the issues, and then to QSC for oversight of proposed actions. It is important to note however that maternity management did see the report outside of governance forums and were working to address the recommendations.

Furthermore, knowledge of the report's consideration by the trust board or committees was very limited among most members of the maternity management team. While we would not expect routine attendance at either of these forums from members of this group, we would have expected senior managers to be more cognisant of how a report highly relevant to them was being scrutinised by the board and its committees.

Board governance

The board was informed in April 2017 that RCOG had been commissioned to review maternity services. In June 2017 the board was told that the report would come to the public board, and it was therefore clear at this point that the trust intended to publish it. The QSC was also informed at a similar time about the review.

The next update went to private board in November 2017, at which the former CEO explained that the draft report had been received and accuracy comments sent

back to RCOG. During this meeting, the Medical Director expressed concern that readers of the report may only refer to the executive summary and that therefore they needed to ensure this summary was a fair reflection. At this point a publication date in January or February 2018 was anticipated, and the expectation at this time was that this would coincide with the publication of the Ockenden review. We are surprised that, notwithstanding the report still being in draft, the minutes do not show the board enquiring as to the key findings of the review and any immediate action that was required as a result. The report raised patient safety concerns, but these were not recorded as having been discussed. The focus appeared instead to be on how the report should be handled and the potential media and public interest.

Further updates were received in private board sessions in both February and March 2018, with reference to the 'final draft' report having been received, the meeting with RCOG on 23 February and, later, the further planned meeting with RCOG on 27 April. The RCOG report itself was not presented to the board in either of these meetings.

QSC received the report in April 2018 (prior to the addendum being produced), alongside an action plan. The minutes demonstrate a reasonable level of questioning and challenge in relation to the findings and proposed actions. The evidence therefore refutes the notion of any attempt to conceal the report from the board prior to positive assurances being received from RCOG in respect of progress made.

We do not think it was acceptable that QSC did not receive the report until April 2018, given that it had been received by the trust four months prior. The December 2017 QSC meeting was cancelled, but the report could have come to the January 2018 meeting. Management had accepted the contents of the report at this point, even if there were outstanding concerns regarding tone and there was therefore no good reason for QSC not to review it at that time.

While this gap of three months was not particularly significant in the context of the whole report's timeline, it was nevertheless a delay in the non-executive scrutiny that a report of this nature clearly required. Trust representatives have noted that maternity improvement was not hinged solely on the RCOG review; the review was just one strand of several programmes of work to improve services, an action plan in response to the RCOG report was already in development, and there were multiple other sources of assurance for QSC and the board in relation to the quality

of services. While there is no indication that maternity services in general were not an area of high priority and intense focus for the committee, we do not think the other strands of work adequately justify the delay to reporting. If there was value in commissioning the RCOG review, there was also value in it being reported through the governance chain at the earliest opportunity.

The QSC Chair prepares a monthly summary report from its meetings for the board. The summary from the April 2018 meeting, which went to the May 2018 public board, did not make any reference to the RCOG report or the associated action plan that it had discussed, although it did refer to related maternity issues such as training for serious incident investigations. Nor was there any reference to QSC's discussion in the private board, where the RCOG report status was discussed, including receipt of a letter from RCOG following the follow up exercise. We think the discussion held at QSC was worthy of escalation to the board at this time, given the criticisms in the RCOG report and the degree of scrutiny already on the maternity service.

It is clear that the board was kept well informed of progress with the review and next steps. Board members could have challenged the approach being taken or the proposed timelines for receipt of the report by the board, had they been concerned by this, but they did not. Responsibility for the delays described here and below does not therefore fall to one individual. The situation was not helped by the fact that the Chair only started in post in February 2018 and did not yet have the full context or details of the RCOG review. In further mitigation, it should also be acknowledged that the board had other areas of significant focus at the time, including configuration of the MLUs and A&E performance, and we cannot therefore expect that the RCOG report would have been the trust's only consideration at this time.

Action plan

The trust created an action plan in response to the RCOG report. This process began in January 2018, although several staff reported that some actions were taken earlier than this, in response to the draft report of October 2017. The plan had input from a range of clinical and non clinical staff including the DNMQ, as it went through several iterations throughout January and February.

The plan included a record of evidence required for each action, which was collated and stored by the care group as actions were completed. Meetings were held regularly at first, and then approximately monthly until May 2019, to update the action plan with progress made.

The action plan was presented to the April 2018 MGM meeting for information, but was not sent to the CGB in full at any point. The CGB received only a summary report of action progress, but this did not elaborate on the actions that were not complete and did not highlight risks or mitigations as we would have expected. The trust has not been able to provide evidence that the action plan was scrutinised again by either forum until June 2019. This does not represent an acceptable level of quality of governance. As of June 2019 there were ten actions that were 'not on track', including several relating to the MLU operating model which was (and still is at the time of writing) the subject of a public consultation led by the CCG, and the trust is unable to progress a new model of care until this process is complete.

The action plan went to QSC alongside the initial report in April 2018. There were a number of outstanding actions at this point, all of which were categorised as 'on track to deliver'. Given these outstanding items, we would have expected the action plan to go back to QSC regularly for ongoing scrutiny, but this did not happen. We have not seen evidence of any further review until the Maternity Oversight Group (MOG), which was set up in March 2019 as a board committee and is chaired by the trust Chairman, received a brief summary update in June 2019 at the Chair's request. Ten actions were described as 'not on track' at this time, and the Chair asked for details of any obstacles to completion to be brought to the following meeting. However no action was recorded in relation to this, and there was no update at future meetings.

The plan itself noted that it would only be reported to QSC by exception. 'By exception' is not defined, but our view is that the number of overdue actions a year later was indicative of exceptions that should have been escalated either to QSC or MOG much earlier than June 2019. We are concerned by the apparent lack of ongoing scrutiny of the actions designed to address RCOG's recommendations, particularly given that they referenced patient safety issues in their report.

It is outside of the scope of this review to assess the extent to which issues raised in the RCOG report were addressed. However, it should be noted that a CQC report, based on an inspection undertaken in August and September 2018,

identified some issues that overlapped with RCOG's findings from over a year earlier. This included concerns that there was poor evidence of learning from serious incidents, issues with governance, and risk management and staffing concerns that followed similar themes to RCOG's findings. RCOG also noted that 'action plans developed following external reviews were not fully embedded in practice', although it is unclear which plans they were referring to specifically. It therefore seems that, despite the fact that a number of actions were taken, some of them did not have the intended impact. One possible reason for this could be the evidence for completion consisting predominantly of process - rather than outcome - measures.

We requested the latest version of the action plan in April 2020 but did not receive it. In June the trust informed us that the Women and Children's Care Group had undertaken an internal review in May of the action plan and associated governance. We have summarised the findings below from the trust's output of this review, which was authored by the Care Group Director and Director of Midwifery:

- Some of the actions would not have properly addressed the associated RCOG recommendation, even if fully implemented.
- The evidence files kept by the trust relating to the recommendations did not always contain relevant evidence to either the actions or the recommendation.
- The trust has assessed that, out of 37 actions, the current status is that 22 have been addressed, 11 are only partially achieved and 4 are not achieved.
- Care group governance for the action plan was not robust, including the sign off process for actions being recorded as 'delivered'.
- The full action plan was not actively monitored in any formal meeting and it is therefore unclear how the board or any other governance forum were assured of its status.

The trust has set out actions it now intends to take to update and monitor the plan; we have allowed management to respond fully in the Recommendations section below.

Publication

On 5 July 2018 the RCOG report was presented to the public board, with a link also provided from the trust's website. The addendum produced by RCOG was attached to the front of the original report, and there was an accompanying cover paper. RCOG expressed surprise that the addendum was attached to the front of the original report rather than the back and we agree that this is unusual.

It appears that the cover paper was written in such a way to reassure the reader, rather than to present the balance of positive and negative assurances provided in the original RCOG report and its addendum. The addendum, based as it was on a single off-site progress review meeting, could only provide a limited degree of assurance that improvements had been made, but no such caveat was highlighted in the cover paper. The 12 'key findings' summarised from the addendum represented only the favourable conclusions and did not reflect the outstanding concerns outlined by RCOG after the follow up exercise. The full report was of course attached and none of the serious initial findings was therefore concealed from the board or public, but nor were they emphasised in the cover paper as they should have been. Although we understand the sensitivities around expected media interest that may have driven this style of narrative, transparency is crucial and should not have been compromised. The need for candour is heightened when a trust is under intense scrutiny as was the case here.

The report and addendum were published almost seven months after RCOG sent their final report to the trust. In January and February 2018 the trust was liaising with RCOG regarding their concerns about the tone and balance of the report, but it was clear by the end of February (and arguably when the revised report was sent in December 2017) that RCOG would not be making any further changes to the report, and at this point it was therefore a final document. The trust chose not to publish at this point, and interviewees have cited various reasons for this, including that the report first needed to progress through sub-board level governance (this is not substantiated by evidence, as it went to QSC in April and appears to have bypassed care group level governance processes), and that publication prior to receiving anticipated assurances from the follow up exercise would result in negative publicity, with a resultant impact on staff morale. The evidence suggests that the latter was the predominant factor in the trust's decision to wait until July to publish.

Whether such a delay to publication was appropriate is a finely balanced judgement. On the one hand, the trust had a duty to be open and transparent with the general public, particularly in the face of significant concerns about the maternity service. It could have published the initial report, or a summary of it, alongside a description the work that had been done to address the concerns, rather than waiting for an addendum from RCOG. On the other hand, the trust believed it had made material improvements to the service since the RCOG review and it was reasonable to want to demonstrate that to the public through an externally assured update. It was also conscious of a further impact on staff morale of publishing a critical report. On balance, our assessment is that it would have been better for the trust to publish the report sooner, and that the scrutiny it was under at the time necessitated a more transparent and candid approach than was taken.

Recommendations

No.	Recommendation	Trust response
1	The board should satisfy itself that the governance issues identified in this review have been addressed. This should include the flow of information from local to corporate governance forums, and the ongoing oversight of action plans.	The Board is implementing a revised governance process throughout the organisation to ensure that governance is strengthened. This includes a review and revision of the assurance committees. A leadership committee has been established to strengthen decision making and a transformation committee. As part of this change an Executive Led Maternity Quality Committee to review and challenge delivery of quality actions prior to the consideration at the assurance committee, has been established. The oversight and assurance processes have been strengthened with clear lines of accountability, supported by the introduction of a new performance management framework. The importance of the appropriate management, storage and dissemination of evidence for assurance has also been addressed. The process for governance in Care Groups is currently being reviewed and strengthened as part of the overall trust approach to governance by the new Chief Executive. There is a new leadership team in the Care Group who have been in place since November 2019.

		This includes a new Director of Midwifery. Changes at Clinical Director level have also been made. The maternity improvement plan (MIP) has been developed and will continue to develop – it will incorporate all action plans from local and national reports and reviews as they are published. Monitoring is via the service, care group and corporate committees, as described above.
2	The board should satisfy itself that the actions arising from the RCOG report are complete or have been superseded, and have had the intended outcome.	The Board reviews the RCOG actions as part of the Maternity Improvement Plan at its assurance committee. The actions that were not on track have been reviewed for current relevance and amended or updated as appropriate, and are subject to ongoing monthly monitoring. The overall improvements to the service have been evidenced through the improved domain ratings in the most recent CQC inspection.
3	The trust should ensure that, particularly where a number of action plans exist from different reviews, management takes a step back from the detail and considers the overall themes. The trust should ensure that plans also include recommendations from national guidance so that quality can be sustained as well as improved	As advised the maternity improvement plan has been devised using the CQC core assessment framework and therefore the key lines of enquiry and 5 domains. All actions from a variety of reports are included within this plan and mapping undertaken to address any duplication or potential omissions, to enable oversight in one place. In addition, in line with the NHSI Improvement Programme, the Trust is progressing the development of a more formal transformation programme with 6 work streams, similar to Morecambe Bay and each action contained within the MIP will be assigned to the relevant work stream enabling thematic review and approach to be taken.

	reactively following external reviews. The success of actions should be measured by looking at outcomes, not just the completion of process.	This will support an outcomes based approach and ensure the service is able to embed changes in practice where required. Oversight continues to be provided by an external Maternity Advisor as part of the on-going national support programme.

Appendices

1. Timeline of key events

Date	Event
30 March 2017	Review request sent by trust to RCOG
6 April 2017	Request agreed by RCOG
12-14 July 2017	RCOG site visit to review maternity services
28 July 2017	Summary of verbal feedback emailed to senior maternity staff
9 October 2017	Draft report sent to trust
10 November 2017	Trust factual accuracy response sent to RCOG
12 December 2017	RCOG sends updated report and covering letter
13 December 2017	Trust CEO says cannot accept report as final and that RCOG meeting is required
21 December 2017	DNMQ sends RCOG a letter requesting meeting
4 January 2018	Call between trust and RCOG to discussed concerns
10 January 2018	DNMQ emails RCOG saying the report contents are accepted but residual concerns with tone. Suggests a follow up exercise.
23 February 2018	Trust/RCOG meeting in London to discuss report. No material changes made. Follow up exercise agreed as next step.
27 April 2018	Care Group visit to RCOG for progress review meeting
30 April 2018	Letter from RCOG to trust summarising visit
20 June 2018	Draft addendum received from RCOG
25 June 2018	Trust responses to addendum sent to RCOG
27 June 2018	Final addendum received from RCOG
5 July 2018	RCOG report and addendum presented at public board

2. Interviewees

We have spoken with the following individuals as part of this review and would like to thank them for their contributions:

Families

Individual representing the families

SaTH board

Chair [from February 2018]

Non Executive Director

Non Executive Director, Chair of QSC

Former Medical Director

Former Chief Executive [September 2015 - June 2019]

Former Director of Nursing, Midwifery and Quality [May 2017 - April 2019]

Women and Children's Care Group, SaTH

Consultant in Fetomaternal Medicine & Gynaecology (former CD for Maternity)

Consultant Obstetrician Gynaecologist, CG Medical Director (ended role May 2020)

Consultant Neonatologist, Clinical Director for Neonatal Governance

Quality Improvement & Governance Manager

Officer, Quality Improvement and Governance

Former Director, Women and Children's Care Group [left November 2019]

Former Head of Midwifery [left March 2019]

RCOG

President (former Vice President, Clinical Quality)

Executive Director of External Affairs

Senior Director, Clinical Quality

NHS Improvement

Former Medical Director