Board of Directors' Meeting
13 October 2022

Agenda item	176/22			
Report	Fit and Proper Person Investigation Report – Ms Fiona Scolding KC			
Executive Lead	Trust Chair			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community		Safe	
	Our people		Effective	
	Our service delivery		Caring	
	Our partners		Responsive	
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	The initial draft report was presented to the Board of Directors at the October 2021 Board meeting held in private			
Dependent upon (if applicable)**:**	-			
Executive summary:	Following receipt of a letter by the Chief Executive from two complainants in July 2020 concerning Mr Ben Reid (the former Chair of the Trust), Ms Fiona Scolding KC was commissioned by the Trust to carry out an independent investigation with regard to whether or not the issues raised in that letter gave rise to matters which engage the Fit and Proper Persons Regulations (FPPR), such that Mr Reid's actions meant that he should no longer be considered to be a fit and proper person in accordance with the FPPR. Ms Scolding was asked to examine the actions and conduct of Mr Ben Reid, who was the Chair of the Trust between February 2018 and August 2020. Further, in commissioning the independent investigation, the Trust was conscious that the matters raised by the complainants in relation to Mr Reid in his role as Chair may also necessarily involve the Trust Board's actions and those of its Board Directors during the period in question. It is important to read Ms Scolding's full report in conjunction with this cover sheet and following Board paper. In her report, Ms Scolding concludes that the complaints against Mr Reid do not amount to matters which would be considered to			

	meet the test of "unfitness" set out in the FPPR. She concludes that mistakes were made and that, although the actions of Mr Reid were not always correct, they did not meet the threshold of "serious" mismanagement by way of deliberate activity or standards which fall significantly below the level of the competent Chair, (Paragraph 26). Following conference with counsel (ie Mr David Lock KC in Ms Scolding's absence), and prior to finalising her report, Ms Scolding, as author of the report, sent 'Salmon' letters to those directly and indirectly referenced in her draft report. Ms Scolding has received a number of responses to these letters and incorporated further information into her report. Ms Scolding's draft report was also shared with the complainants who made a number of observations such that further amendments were made to her report. The amended report was shared with Mr Reid as part of the 'Salmon' letter process. Given the importance of Ms Scolding's report and findings, a proposal for a Board Governance Review was received and approved at the July 2022 meeting of the Board of Directors held in private, whilst awaiting Ms Scolding's final report. Ms Scolding's final report was received by the Trust and complainants in August 2022. The Trust's position, based on Ms Scolding's final report, is set out in the summary and recommendation document, included as Appendix 1; Ms Scolding's full report is included as Appendix 2; a thematic summary of Ms Scolding's findings, with recommendations, is included as Appendix 3; and the proposal for a Board Governance Review, accepted at the July meeting of the Board of Directors held in private, is included as Appendix 4. The Board of Directors is asked to: • Read in full Ms Scolding's final report, noting the actions taken to address this complaint made against a previous Chair • Ratify the Trust's response to Ms Scolding's Report, as set out in this paper • Receive the thematic summary of Ms Scolding's findings, authored by the Chair • Review alignment between Board Governance Review and Ms Scolding's findings; and • Agree the associated assurance requirements.
Appendices	• Appendix 1: FPP Investigation Report: summary and recommendation document • Appendix 2: Ms Fiona Scolding's full and final report • Appendix 3: Thematic Summary of Findings • Appendix 4: Board Governance Review (accepted by the Board of Directors July 2022)
	

APPENDIX 1

FIT AND PROPER PERSON INVESTIGATION REPORT

SUMMARY AND RECOMMENDATIONS

October 2022

1. Background and Timeline

1.1 July 2020, the Trust received a letter of complaint pertaining to the actions and conduct of Mr Ben Reid during his tenure as Chair of The Shrewsbury and Telford Hospital NHS Trust. The letter raised a number of complaints which are enumerated in the Fit and Proper Person Report (paragraph 15, page 5) alleging that as such these amounted to serious mismanagement of the Trust, and that consequently Mr Reid's actions meant that he should be considered to be unfit to be a Director of an NHS body under the Fit and Proper Persons Regulations (FPPR).

1.2 August 2020, the Trust contacted NHSI, CQC and legal advisors for advice on how best to proceed, given Mr Reid had already declared his intent to step down from his role in August 2020.

1.3 September 2020, the Trust commissioned Ms. Fiona Scolding KC to carry out an independent review of the complaint. Details of her approach are included in her report.

1.4 February 2021, the Trust received Ms Scolding's draft report.

1.5 March 2021, following conference with counsel (ie Mr David Lock KC in Ms Fiona Scolding's absence) the Trust received further legal advice regarding the need to offer Board members, potentially affected by the comments made and conclusions reached in the report, the opportunity to review the report and offer factual correction prior to its finalisation by Ms Scolding.

1.6 May 2021, Ms Scolding was requested to send Salmon letters to all Board members potentially impacted by the report, past and present.

1.7 September 2021, Salmon letters sent via the Trust to all identified past and present Board members, highlighting the Trust's intent to publish the final report, including Mr Ben Reid.

1.8 September 2021, responses from Salmon letters received by Ms Scolding.

1.9 October 2021, the draft report was received by the Trust, and subsequently by the Trust Board at their November Board meeting, held in Private, whilst awaiting final report from Ms Scolding.

1.10 December 2021, Ms Scolding's final report was received by the Trust, with changes from draft report highlighted.

1.11 December 2021, the Trust shared Ms Scolding's report with the complainants and Mr Reid, informing them of the Trust's intent to discuss this report at a single-item Trust Board meeting, in Public, in January 2022 – called specifically for this purpose – and to include the full report within the Trust Board meeting pack. The report was also shared with all other recipients of Salmon letters, for their information.

1.12 January 2022, upon receipt of the draft report the complainants raised concerns about aspects of the report with Ms Scolding KC, following which Ms Scolding met with the complainants to consider the concerns which they raised, including further information which they provided to Ms Scolding. At the time, given the imminence of the publication of the final Ockenden Report (March 2020), Ms Scolding also took the opportunity to wait before submitting her report, to review the final Ockenden Report in so far as it related to her findings. She accordingly took this into account in her final report.

1.13 May 2022, Ms Scolding completed her considerations of the concerns raised by the complainants regarding aspects of her report, and the further information which the complainants provided and amended her report accordingly.

1.14 August 2022, following these amendments a Salmon letter was sent to Mr Reid by Ms Scolding, and Ms Scolding made her final report available to the Trust and the complainants.

1.15 September 2022, the final report received by the Board of Shrewsbury and Telford Hospital NHS Trust, and permission to publish the report in its full form was requested from the complainants.

1.16 October 2022, the final report is received by the Board of Shrewsbury and Telford Hospital NHS Trust, meeting in public, and the same is published with the Board papers.

2. Summary of Ms Scolding's report

2.1 There can be no substitute for reading and considering Ms Scolding's report in full. Her report suggests that it would be a wise lesson to be learnt to let such reports speak for themselves in order to avoid any suggestion of partiality when presenting a précised version.

2.2 It is important that this summary is therefore read in conjunction with the full report.

2.3 In summary, and for the purposes of this paper, in her report:

2.3.1 In considering the complaints, Ms Scolding concludes that Mr Reid made mistakes in relation to the publication of the RCOG report, finding that the report should have been published more quickly and that the publication was not balanced (paragraph 28 (d), page 12); that Mr Reid failed to interrogate adequately the delay in publishing the report and the approach of the Trust to the RCOG report and its recommendations, finding a lack of interrogation of the decisions and that the wrong decisions regarding publication were made (paragraph 28 (e), page 13); that mistakes were made in the handling of the complainant (Mr Stanton) in the Board meeting and in the e-mail exchange in January 2020 (paragraphs 28 (i) and (l), pages 14 and 15), the latter which has been accepted by Mr Reid. In relation to the complaint that the Trust's representatives continuously lied or obfuscated the truth, Ms Scolding concludes that there is no doubt that, in respect of the death of Ms Stanton Davies, there have been "obfuscations, difficulties and failures", and that whilst the mistakes relating to the publication of the report did not help, she does not consider that Mr Reid "lied" or acted unethically. He did what he thought was best for the Trust and acted on advice of others which was found to be wrong (paragraph 28 (j), page 14). Further, in relation to the complaint that the Trust has not dealt with Mr Stanton and Ms Davies in an open and honest way, Ms Scolding concludes that this is "undoubtedly true" but that this cannot be said for Mr Reid (paragraph 28 (k), page 15). Ms Scolding also highlighted the scope of Mr Reid's accountability, the lack of induction and training for Chairs in the NHS, the number of urgent issues that he was required to oversee during his tenure, and the perceived lack of guidance from NHSI regarding the need to publish the report.

2.3.2 With specific regard to Mr Reid, Ms Scolding concludes that the complaints against Mr Reid do not amount to matters which would be considered to meet the test of "unfitness" set out in the FPPR, whilst highlighting that this is a very high hurdle to overcome. She concludes that, on the balance of probabilities, mistakes were made and that although the actions of Mr Reid were not always correct, they did not meet the threshold of "serious" mismanagement by way of deliberate activity or standards which fall significantly below the level of a competent chair (paragraph 26, page 10).

2.3.3 Ms Scolding makes a number of criticisms of and comments about the Trust Board; in particular, in relation to the specific complaint that the

Trust has not dealt with Mr Stanton and Ms. Davies in an open and honest way, which Ms Scolding finds to be "undoubtedly true" paragraph 28 (k), page 15). She also concluded that, "on some occasions, [the Board] sought to prioritise the reputation of the organisation above transparency and candour" (paragraph 22 (a), page 8), and that the actions of the Trust "demonstrate[d] a culture of defensiveness" (paragraph 63, page 26). She highlighted that the publication of the RCOG report should not have been delayed, at least not without robust discussions at Board and consideration given as to whether the oversight proposed in response to the report was adequate or if alternative processes for scrutiny should have been implemented. She identified a number of issues with governance and management at Board, which are detailed in her report, highlighting that whatever is said in her report about the governance and management of the Trust should be considered against the full picture seen by Ms Ockenden, (Paragraph 7, page 2).

3. Trust Response

3.1 Given the fact that the majority of the current Trust Board members were in place during the period under review and are associated with the conclusions of Ms Scolding's report, the Chair initially met with Ms Karen Kneller, Non-Executive Director at University Hospitals Birmingham NHS Foundation Trust (UHB) and member of the Improvement Alliance Committees-in-Common, to discuss the report. Her role was specifically to provide critical challenge to assist the Chair. The Chair and Ms Kneller were supported by Ms Anna Milanec (Director of Governance and Communications, SaTH) and Mr Keith Haynes (Governance Consultant), neither of whom were employed by SaTH during Mr Reid's tenure.

3.2 The final review of the report and confirmation of the Trust's final position was carried out by the Chair and three recently appointed Non-Executive Directors, again with the support of Ms Anna Milanec (Director of Governance and Communications, SaTH) and Mr Keith Haynes (Governance Consultant).

3.3 The following comments reflect the discussions held between the Chair and Ms Kneller in October 2021 and the discussions held between the Chair and new Non-Executive Directors, and are the conclusions of those discussions.

3.4 Following review of Ms Scolding's report, the Trust accepts in full the conclusions of the review:

3.4.1 The Trust notes and accepts the conclusions in the report relating to the complaints made about Mr Reid (see paragraph 28(a) – (l), pages

12-15), and accepts that, on the balance of probabilities, mistakes were made and not everything was handled as it could or should have been. Furthermore, it notes and accepts Ms Scolding's finding that none of these actions amount to "serious mismanagement" such as to disqualify Mr Reid from holding office as someone who is unfit within the terms of the Fit & Proper Persons Regulations.

3.4.2 In relation to the findings relating to the complaint about Mr Reid, the Trust considers that no further specific action is required, or is possible, given that Mr Reid left the Trust in August 2020.

3.4.3 The Trust accepts in full the criticisms of and comments about the Trust Board.

3.4.4 In particular, the Trust accepts the finding made by Ms Scolding in response to the complaint that it is "undoubtedly true" that the Trust has not dealt with Mr Stanton and Ms Davies in an open and honest way. In the context of Ms Scolding's review, this relates to the Trust's mishandling of the publication of the RCOG report, which the Trust accepts as inappropriate and inadequate for the reasons set out by Ms Scolding. For this, the Trust offers an unreserved apology to Mr Stanton and Ms Davies.

3.5 Many of the issues and challenges identified by Ms Scolding relating to the Trust's governance and management are aligned with the findings of the NHSI report into the delayed publication of the RCOG report and the final Ockenden report. It is the Chair's initial view, to be confirmed, that most of the required actions are incorporated into the Trust's Getting to Good plan, the Trust's Quality Improvement Plan and/or the Trust's Maternity Improvement Plan (overseen, in part, by the Ockenden Report Assurance Committee, held in public).

3.6 As part of the "Salmon letter" process, the Trust signalled its intention to publish Ms Scolding's report in full once available, and no representations were made by recipients of Salmon letters requesting that the report should not be published. This is in keeping with one of the lessons of Ms Scolding's report, namely that if one seeks external advice from experts and commits to publishing it, then one must do so whatever the consequences. Further, this is also in keeping with the Trust's wish for ever greater openness and transparency in the face of criticisms, and in recognition that, based on the consideration of legal advice on the point, publication of this report is felt to be in the public interest.

4. Actions Taken

Following receipt of Ms Scolding's final report, the Trust has:

4.1 Shared a copy of the report with Mr Reid, highlighting the Trust's intent to put the report into the public domain.

4.2 Written to Ms Davies and Mr Stanton, highlighting the Trust's intent to put the report into the public domain. The final report had previously been shared with them by Ms Scolding.

4.3 Shared the report with members who sat on the Board during Mr Reid's tenure, for information.

4.4 Received the report at this Board Meeting to discuss the requirement for assurance regarding paragraph 3.4 above, to include, as a minimum:

4.4.1 The requirement for a Board Governance Review, to incorporate all relevant criticisms and findings from Ms Scolding's report, as highlighted in Appendix 3, with consideration of the draft recommendations for the Trust. This work to be overseen by the Audit and Risk Assurance Committee (ARAC), with progress reported to Board.

4.4.2 The requirement for a gap analysis to ensure that the recommendations made in previous reports, as referenced within Ms Scolding's report, have been, are being, or will be addressed by ongoing improvement plans; overseen by the Quality and Safety Assurance Committee (QSAC), with progress reported to Board.

5. Recommendation

5.1 The Board of Directors is asked to

5.1.1 Note the actions taken to address this complaint made against a previous Chair

5.1.2 Ratify the Trust's position as set out in this paper

5.2 The Board of Directors is asked to

5.2.1 Discuss the requirements for assurance, described in Paragraphs 4.4.1 and 4.4.2

Dr Catriona McMahon
Chair, Shrewsbury and Telford Hospital NHS Trust

APPENDIX 2

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

INVESTIGATION INTO THE COMPLAINTS MADE TO THE TRUST BY MR. STANTON AND MS. DAVIES CONCERNING MR. BEN REID: WHETHER THEY GIVE RISE TO MATTERS WHICH ENGAGE THE FIT AND PROPER PERSONS REGULATIONS – INVESTIGATION REPORT AUGUST 2022

Introduction

1. I am Fiona Scolding QC, a barrister in independent practice at Landmark Chambers, Fleet St, London. I have been commissioned by the Chair of The Shrewsbury and Telford Hospital NHS Trust ("The Chair" and "The Trust") to carry out an independent investigation as to whether or not the issues raised by Mr. Stanton and Ms. Davies in their letter to the Trust of 24 July 2020 give rise to matters which engage the fit and proper persons regulations ("FPPR").

2. I apologise for the delay in providing this report. I have had an extended period of ill health which delayed its production.

3. I am asked to examine the actions and conduct of Mr. Ben Reid, who was the Chair of the Trust between February 2018 and August 2020. Mr. Reid is only one member of the Executive and Non-Executive team, all of whom have responsibilities as I outline below in terms of governance and oversight.

4. I confirm that I do not know any of the individuals involved or mentioned in the investigation. I have previously compiled an investigation report into complaints made about other executives of the Trust between 2013 – 2019. This was in relation to another matter unrelated to any concerns or complaints about maternity care or the actions of the Board about any such concerns. It did not involve Mr. Reid.

5. I start by paying tribute to Ms. Davies and Mr. Stanton. Their tenacity and commitment to improving patient safety is laudable. Their daughter died – as a result of failures of the Trust. The Trust should have acted with transparency and

with compassion and care – but they, as the findings of the Ockenden review (amongst others) indicate, did not. Their continued efforts have led or will lead, hopefully, to fundamental changes in the provision of maternity care not just in Shrewsbury, Telford and Wrekin, but across England. This complaint is viewed by them as part and parcel of their concern that there was complacency and a failure to take serious concerns about maternity care on board, or to change practices and processes already established as unacceptably poor.

6. The Ockenden review published its initial (first) report on 10 December 2020 and its final report in March 2022. I have read the reports but have not seen all the underlying documentation upon which Ms. Ockenden relies.[1]

7. Whatever is said in this report about the governance and management of the Trust should be considered against the full picture seen by Ms. Ockenden.

8. In undertaking this investigation, I have examined the following documents. In particular, I have had sight of the following:

   (a) Complaint letter from Mr. Stanton and Ms. Davies, 24 July 2020.

   (b) RCOG report into the Trust of October 2017 and addendum report of April 2018.

   (c) Executive Summary provided to the Trust Board in July 2018 by the Trust about the RCOG report.

   (d) Ockenden review initial report dated December 2020 and the final Ockenden review report dated March 2022.

   (e) NHS Improvement (NHSI) report into the handling of the RCOG report, July 2020.

   (f) Board minutes 2018 – August 2020 which deal with maternity issues, including, inter alia, for example, the Maternity Dashboard sent on 29 January 2019 onwards.

[1] Save where that may have also been provided to me.

(g) Maternity Oversight Committee ("MOC") summaries March 2019 – August 2020 (with some but not all accompanying papers).

(h) Maternity Services Open Book Data Review December 2018 (NHSI).

(i) Improvement Alliance press release 2020.

(j) Terms of Reference for Internal Audit review by Deloitte in respect of maternity, set out to examine the Trust's declarations to the maternity incentive scheme review run by the Clinical Negligence Scheme for Trusts. Undated but sometime in early 2020.

(k) Information about maternity CNST Incentivisation Scheme 2019/2020.

(l) Women and Children Care Group Maternity Learning slides (undated but some point in late 2019/2020) presented by Maternity Clinical Director Mr. Adam Gornall.

(m) Details of Maternity Improvement Plan (in as much as they were provided to the Board).

(n) Maternity Clinical Dashboard 2018/2019.

(o) Quality and Safety Meetings January 2020 – June 2020 including agenda, minutes, and relevant enclosed reports.

(p) Review by Deloitte about the maternity incentivisation scheme.

9. I conducted a video meeting lasting approximately one hour on 1 October 2020 to clarify the nature of the complaints and concerns that Ms. Davies and Mr. Stanton had. I provided a copy of the notes I made from this meeting which I sent to Ms. Davies and Mr. Stanton for their record and to ensure that it accurately reflected their concerns. I offered to interview Mr. Reid, but he declined. He provided me with a written response to the complaint on 14 October 2020. I have no power as part of this review to compel Mr. Reid to engage or be interviewed by me. I did not interview any of the other non- executive or executive personnel given the nature of the complaint made.

10. After having received the information from Mr. Reid, I asked the Trust for further material because of the nature of the concerns and issues raised by both parties. In the light of that material, whilst I had considered speaking further to Ms. Davies and Mr. Stanton, I determined that there was no clarification that was needed from them. Mr. Reid provided his answers without access to paperwork as he was no longer the Chair or a non-executive of the Trust.

11. Following on from delivery of the draft report, I asked the NHS Trust to send a draft copy of the report to those members of the Board in post during the times in question as the report is critical of them – known as a "Salmon" letter process. I received 9/10 responses, including one from Mr. Reid. Four of those responses asked that the responses were not provided to the Trust by myself. I acceded to their request as I considered that it was important that I received relevant information which could assist me with the report, and I wanted any responses to be candid and frank. I have taken the comments into account when finalising the report.

12. Representations were also made by Ms. Davies and Mr. Stanton in February 2022 about aspects of the report. As a result of that, further amendments have been made to reflect the issues they raised but also the final Ockenden report of March 2022.

13. I have not sought any documents subject to legal professional privilege. The Trust cannot be compelled to provide this information and I have not considered it necessary for them to consider the waiver of privilege in order to reach my conclusions in this matter. Had I considered that sight of this information was required, I would have asked for them to consider the waiver of this privilege.

14. I have also examined the Regulations and guidance issued by the Care Quality Commission (CQC) to provide advice to Trusts and others about what the Regulations mean and how they should be interpreted by the CQC and others. I

have also considered the findings and recommendations of the Kark Review[2] on issues where relevant.

The complaint

15. The complaint of Mr. Stanton and Ms. Davies is, in summary form, that:

    (a) Mr. Reid failed to take adequate steps to improve patient safety and/or to ensure that patient safety was his most important priority in his approach to handling the RCOG report.

    (b) The Maternity Oversight Committee ("MOC") set up and chaired by Mr. Reid from March 2019 failed to take sufficient steps to improve maternity care, and in fact contributed to its decline in patient safety.

    (c) Mr. Reid failed to take steps to ensure that the RCOG report was published quickly after it had been received and/or that information around its publication was sufficiently balanced.

    (d) Mr. Reid failed to interrogate adequately (a) the delay in publishing the RCOG report (b) the approach of the Trust to the RCOG report and its recommendations – what Mr. Stanton and Ms. Davies call "softening" (a term used by Mr. Reid at a public meeting).

    (e) As Chair of the Trust, Mr. Reid failed to have sufficient oversight and to perform sufficient scrutiny about both maternity care during Board meetings or answer questions posed by the public about such, and failed to interrogate adequately information provided to him by others in the Executive team and to the Board.

    (f) Mr. Reid behaved in an aggressive and intimidatory manner to Mr. Stanton at a Board meeting held in public in October 2018 by speaking over Mr. Stanton when he asked a question and then switching off his microphone.

    (g) The Trust's representatives have continuously lied or obfuscated the truth.

[2] I shall explain this below.

(h) The Trust has not dealt with Mr. Stanton and Ms. Davies in an open and honest way.

(i) Mr. Reid sent an e-mail to Mr. Stanton in January 2020 which was overly friendly in tone, and unprofessional.

16. Many of these concerns are directed at Mr. Reid but Mr. Stanton and Ms. Davies' complaints are wider than that. In effect, this complaint challenges the governance and management of the Board over a long period of time, and also ultimately NHSI which was responsible for oversight of the Board.

17. My remit is only to examine the actions of Mr. Reid – not the governance of the Trust or management more widely, over a longer period of time. The Ockenden review has examined wider aspects relating to culture and organisation. Where relevant, I have relied upon these conclusions which were based upon much wider evidence and material than I have seen. The Trust has accepted in full the report.

Wider background and concerns in respect of the Trust

18. The Ockenden review focused upon how governance, management and leadership at the Trust operated during the period 2000 – 2020, and how it dealt with concerns and complaints about maternity care. As identified by the Ockenden review, during that period there had been a significant turnover in Executive and Non-Executive Board members. The period between 2018 – 2020 had seen considerable turnover in those in Executive and Non-Executive positions within the Board, often at the behest of NHSI, under the auspices of creating improvements. This level of turnover can lead to the following results:

(a) Organisations have no or limited institutional memory for what may have happened in the past. In a case like that of Ms. Davies and Mr. Stanton, this can lead to them being told the same thing will happen on several occasions by different people, or individuals not having an understanding of the past circumstances and situation. It will also mean that Ms. Davies and Mr. Stanton will have had to disclose their concerns on a number of

occasions. As the Ockenden review says, [3] having the Board in a constant state of churn and change meant that it failed to foster a positive environment to support service improvement.

(b) Turnover means that plans may be put into place which are not then followed through and/or seek to replicate what has already been tried and not succeeded.

(c) Rapid turnover can lead to inconsistency of approaches and lack of continuous oversight of actions and plans.

(d) Limited accountability for the actions of previous administrations which can be seen as the "past."

(e) Turnover leads to a Trust Board which did not have an oversight of full understanding and issues relating to the maternity services, resulting in a lack of strategic direction and change, and a lack of development of plans which could be implemented and for which people could be accountable.[4]

19. It is also extremely difficult for new members of a Board, such as a Chair, where there are long term issues which arose long before his tenure, to have a good understanding of what may have been happened in the past and to understand why it did or did not work. The absence of effective handover or briefing did not assist.

20. From the information written in minutes, in the various reports I have seen and in information sent to me in writing by various Board members, there seems to be widespread acknowledgement that whilst there was a recognition that there needed to be changes in maternity services (and the CQC rating went from inadequate in 2018 to requires improvement in 2019 overall), there was still much more to be done to improve services during that time.

21. The Trust throughout this time was dealing with a fundamental and systemic problem which would also have led to insuperable difficulties in improving

[3] Page x of the executive summary
[4] Ockenden review, final report, executive summary, Pages x - xi

patient safety and culture – which is the number of staff and the reliance on temporary staff. Every Trust has to manage this problem – and so it is not unique, but the levels of absence, sickness and turnover do not assist in building a resilient workforce.

22. Many of the issues raised by Ms. Stanton and Mr. Davies more broadly, and which are reflected in their concerns about Mr. Reid, concern the culture of the Trust. By culture, I mean the values, systems and beliefs of the organisation. As an observation, from having examined the papers alone and without interviewing relevant staff members, this was an organisation which:

    (a) When it felt under threat, it sought, on some occasions, to prioritise the reputation of the organisation above transparency and candour. Whilst there are understandable reasons why, particularly in respect of staff retention, keeping the reputation of an institution may help to ensure better patient care - as a poor reputation means staff leave, are unmotivated, and it can be difficult to get new staff of sufficient calibre - if one goes down the path of external advice from experts and commit to publishing it, then one must do so whatever the consequences.

    (b) Was not making connections sufficiently between the past and the present – in particular in respect of governance, oversight and approaches in maternity care. If one traces the concerns raised by various reviews about the Trust over time, the same concerns and issues are raised. To give an example, in 2013 concerns were raised about a failure to investigate serious incidents in maternity care and learn lessons from them: that was still seen to be the case in more recent CQC reports (from 2018). The Ockenden review echoes my concerns in this regard, identifying that those lessons were not learned because of a failure to carry out investigations to an appropriate standard for the time resulting in a failure to identify the underlying systemic failings together with a lack of

oversight into investigatory practice; consequently, some incident investigations therefore made the same mistakes in 2018/19 as in 2008/9.[5]

(c) Was struggling to manage several serious problems, with patient care and safety. The inevitable consequence of this was both the Board and senior team having to constantly "firefight" and deal with several problems at once.

(d) Had serious problems with staff morale which then contributed to poor standards of care and outcomes because of both sickness and lack of staff. This appears to have become a cycle.

(e) Had individuals who had suffered harm as a result of maternity care who needed to be engaged with and brought on board. In circumstances where individuals have been badly let down by authority, and then subject to further trauma in the responses to the original incident, without having the authority recognising and acknowledging their mistakes, those individuals need and deserve responses which recognise their trauma, which make decisions and take actions informed by the trauma, and which seek to be sensitive. Specialist thought and advice should have been sought as to how to engage with these individuals to seek their views, but also to see if co-production could take place. Engaging in this way is a difficult, sensitive and time-consuming task, and I do not underestimate the difficulties in such, but I see little evidence of that sort of nuanced and long-term engagement informed by expert advice and support in the actions of the Trust during the time period I am examining. Certain individuals within the Trust did seek to engage and did so in a way which individuals appreciated, but this was person dependent and not consistent across a number of years. People do not want things done "to them" but "with them," and their views should have been used as a way for the Trust to develop strong and accountable policies and practices to improve maternity care.

[5] Executive Summary, Page xi.

23. Board members from 2019 described the Trust as the "most difficult and challenging" organisation that had ever been encountered during the course of their career. Other Board members described an executive team that was unstable and that was unhappy with each other. Some suggested that the culture of the Trust was that staff knew best, and did not welcome challenge or external scrutiny. Every Board member who has written to me has indicated that Mr. Reid was focussed, in their view, on improving patient safety. He may not have got everything right, but in their view, he was trying to do his best, and would take on board differing views.

24. My conclusions here (written before my reading of the final Ockenden report) have been reaffirmed by its findings. I cannot possibly do justice to the breadth and depth of that investigation. What stands out is the Trust is not alone in having these issues - that the very significant workforce challenges require a radical injection of resource and there needs to be significant change in the "whole system" underpinning maternity services, so that the concerns and issues raised in this report are likely to be replicated across a number of Trusts. That is sobering but also makes it essential for there to be radical and substantive change to improve patient safety.

25. But that should not and does not excuse the failings at the Trust - failings which led to avoidable deaths and injury.

Executive Summary

26. As I have set out, I am asked to decide if any of Mr. Reid's actions meant that he is, or should be, considered to be unfit to be a Director of an NHS body under the Fit and Proper Persons Regulations ("FPPR"). This is a high bar. It is designed to incorporate activities which are criminal, but also "serious" mismanagement by way of deliberate activity or standards which fall significantly below the level of a competent Chair. I find, on the balance of probabilities, that mistakes were made – and that not everything was handled as it could and should have been. I do not find however that any of these actions amount to "serious mismanagement" in the context set out in the FPPR in the

context of Mr. Reid. That does not mean that everything he did was right, or not the subject of criticism. But given when he arrived in post, what he had to deal with and the very many structural problems inherent within the Trust, it would not be appropriate to find that his acts amounted to "serious mismanagement." The problems rightly brought to the attention of the Trust by Mr. Stanton and Ms Davies were not dealt with adequately - over a very long period of time. It is undoubtedly the case that the Trust as a whole, including its board of management, failed systemically at a number of levels over a number of years. That is different to an individual case of "serious mismanagement."

27. I am particularly struck by the depressing conclusion of the Ockenden review that the issues highlighted in their report have been highlighted in a number of other local and national reports. As the Chair of a Trust, there are only so many levers that can be operated in isolation if there is a system which is broken. I set out here what is said in the Executive Summary of Ockenden.

"*It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This is why the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.*

It is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years. This has already been highlighted on a number of occasions but is essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave. Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England. "

28. In particular, in relation to the specific complaints which have been made (and which appear below in italics), I consider that:

(a) It was a mistake and wrong not to publish the RCOG report when it was first finalised, and the supplementary report should not have been published "on top", but I do not find that the responsibility for that lies solely with Mr. Reid, who was relatively new in post. I also do not consider that the failure to publish the reports together amounts to serious mismanagement by Mr. Reid as is intended by the Regulations. It was a failure, however.

(b) *Mr. Reid failed to take adequate steps to improve patient safety and/or to ensure that patient safety was his most important priority in his approach to handling the RCOG report*. The evidence shows that Mr. Reid did take steps to seek to improve patient safety. The difficulty was trying to make such improvements when not given the relevant information to make a strategic difference and in the context of an organisation which was broken. He did not succeed but he did try within the confines of his expertise and understanding.

(c) *The Maternity Oversight Committee ("MOC") set up and chaired by Mr. Reid from March 2019 failed to take sufficient steps to improve maternity care, and in fact contributed to its decline in patient safety*. The CQC report shows some improvements in maternity care in 2019 . Whilst the report shows that the Trust did not make as much progress as may have been possible and did not do everything, the evidence and information does not show that this in and of itself was "serious mismanagement". Given the context, changes in culture and improvements would be long term projects which would take some time.

(d) *Mr. Reid failed to take steps to ensure that the RCOG report was published quickly after it had been received and/or that information around its publication was sufficiently balanced*. I agree that the RCOG report should have been published more quickly and that the publication was not sufficiently

balanced. For the reasons I give, I do not consider that this amounts to "serious mismanagement"

(e) *Mr. Reid failed to interrogate adequately (a) the delay in publishing the RCOG report (b) the approach of the Trust to the RCOG report and its recommendations – what Mr. Stanton and Ms. Davies call "softening" (a term used by Mr. Reid at a Board meeting in public).* I agree that there was a lack of interrogation of those decisions and the decisions made were the wrong ones.

(f) *As Chair of the Trust, Mr. Reid failed to have sufficient oversight and to perform sufficient scrutiny about both maternity care during Board meetings or answer questions posed by the public about such, and failed to interrogate adequately information provided to him by others in the Executive team and to the Board.* As I identify below, how far the Board, as opposed to Committees should have scrutinised matters, there could have been further scrutiny prior to March 2019 and the governance issue of referring matters to "committees" for assurance may need to be revisited. As Ockenden identifies, the Board did not have sufficient understanding of the difficulties with the service to be able to implement change. Responsibility for that failure lies in part with the Board as a whole, but also with a service which did not provide the information required.

(g) I also note that the Ockenden review found that some of the findings from various external reviews gave "false reassurance about maternity services at the Trust"[6], and that external reviews of maternity services between 2013 - 2017 gave the overall message that this was a "safe maternity" service (paragraph 5.86 of the Ockenden review). This must be a relevant factor which Mr. Reid would have been told after starting at the Trust. Furthermore, Ockenden found that external, independent and internal reports were not "critical of the clinical leadership at the Trust" - something which she and her team criticise.

[6] Ockenden executive summary , page xi.

(h) The Ockenden report does go on to state (at paragraph 5.89 of the report) there was no account of "who was accountable for implementation" of recommendations or who was responsible for oversight - thus there being no effective strategy for meaningful change. This is a broad statement which I assume relates to the entire period examined by the report, only a small part of which related to Mr. Reid's time on the Board. However, it is my view that during Mr. Reid's period as chair, it was only really with the institution of the MOC that something like the level of oversight which Ms. Ockenden recommends began to be put in place, and as the NHSI report has identified and as I have seen in the minutes provided to me, it is difficult to divine how far that body "drilled down" into the evidence, although it certainly from its meeting minutes was covering relevant topics.

(i) *Mr. Reid behaved in an aggressive and intimidatory manner to Mr. Stanton at a Board meeting held in public in October 2018 by speaking over Mr. Stanton when he asked a question and then switching off his microphone.* Mr. Reid has provided an explanation for this. It was plainly a stressful occasion for Mr. Reid but that was not because of Mr. Stanton's actions - Mr. Reid has, I find on the balance of probabilities, misidentified Mr. Stanton with other individuals who may have been present at that meeting. With the benefit of hindsight the Board meeting was not well handled. But in all the circumstances, I do not consider that this in and of itself could amount to serious mismanagement. Mr. Stanton should not have been spoken over and his microphone should not have been switched off.

(j) *The Trust's representatives have continuously lied or obfuscated the truth.* There is no doubt that in respect of the death of Ms. Stanton Davies, there have been obfuscations, difficulties, and failures. The publication of the RCOG report did not help, but I do not consider that Mr. Reid "lied" or acted unethically. He did what he thought was best for the Trust on the advice of others. That advice was not correct – but I do not think that means that his failures in this respect amount to "serious mismanagement". There

were widespread failures of management at this Trust, which took place over a long period of time. There was undoubted mismanagement. But I do not think that Mr. Reid's actions in and of themselves, and viewed in isolation as I must, would amount to "serious mismanagement".

(k) *The Trust has not dealt with Mr. Stanton and Ms. Davies in an open and honest way*. That is undoubtedly true, but I do not think that can be said in respect of Mr. Reid more than others, and in some ways Mr. Reid was more open than others.

(l) *Mr. Reid sent an e-mail to Mr. Stanton in January 2020 which was overly friendly in tone, and unprofessional*. That has been accepted - but is not serious mismanagement.

Wider background and Trust failures more broadly

29. I have been greatly assisted by the NHSI report published in 2020 concerning the actions of Mr. Reid and others. As the body responsible for appointing Non-Executive persons, they have significant day to day knowledge and understanding of how Trusts should operate. From my own independent reading of Board minutes, I would agree with their analysis in its entirety. This was a Trust in crisis between 2018 to date. It was operating poor care in a number of areas (as the CQC reports show) and was facing enforcement action about its Accident and Emergency provision. The financial position of the Trust was precarious. It was also finding it difficult to fill vacancies for appropriately qualified and experienced clinical staff and staff morale was very poor. It had also had a number of years of financial underinvestment and a set of strict financial controls which meant that staff felt that "nothing would ever change". Poor morale reinforced lack of recruitment. The Ockenden report also talks of bullying of some staff by others, which obviously does not help morale but will be interrelated to staff absences and morale.

30. The Executive team, as recognised by both the NHSI report and the Ockenden review, had changed several times, and this constant turnover meant that there was no consistency of leadership, nor a chance for people to ensure that actions were followed through.

31. Mr. Reid in February 2018 arrived to have to deal with several serious and significant issues all at once. He did not have any briefings. He chaired his first Board meeting on 5 February 2018 but had no involvement in preparing the agenda or any underlying papers for that.[7]

32. My conclusions are that there is no doubt there were a number of pressing and urgent matters which had to be grappled with immediately upon Mr Reid's appointment. It is comprehensible that he chose to focus initially upon resolving the problems with Accident and Emergency as it was at that time the most imminent problem with the threat of regulatory action by the CQC hanging over the Trust. The Trust had a history of underinvestment: there were very significant and serious staff shortages in A and E, leading to very serious concerns about patient safety. In that situation, there was a clear and compelling case to seek to resolve this problem.

33. This is a typical reaction when organisations are in "crisis management" mode. They prioritise the most important thing directly in front of them, but then leave other issues dormant until they too become crises.

34. The role of a Chair is part time: in a situation like this, with executive turnover, and a Trust that was struggling, it is understandable why it would have taken some time to have found out and identified the full range of concerns without extensive briefing at the start of his office (which did not happen). At least at first in any role, it is acceptable to rely upon the Executive team and other Non-Executives to provide details of what is most pressing.

35. Staff were buckling under pressure. The NHSI report of 2020, in particular, identifies there being high levels of sickness related to stress and anxiety, and

[7] Ref: Response from Ben Reid to draft report supplied September 2021.

negative morale. When deciding upon how to deal with the RCOG report, such concerns would have to be considered. Maternity care would not improve if there were high levels of sickness.

36. The RCOG report was an attempt by the Trust to seek to improve itself, and it did promise to publish it, knowing that this may well lead to yet further scrutiny. The Report was published in full, as was the addendum, and an action plan was put into place.

37. Mr. Reid did take steps to resolve concerns when he found out that staffing levels were not adequate in early 2019 (although this should have been known and such information provided to the Board throughout the time that he was chair), and set up a Maternity Oversight Committee. This was a start in seeking to provide formal oversight at Board level. From the minutes I have seen of those meetings (which are summary in nature), they involved reviewing perinatal mortality and reporting upon it on a monthly basis[8] and discussion of the staffing of the obstetric service.[9] They did not involve, other than on irregular occasions, discussions of the action plan from the RCOG report. The fact that the CQC improved the rating for maternity services in 2019 from inadequate to "requires improvement" in the "safe and effective" domains also suggests that he, along with others, had taken steps to improve scrutiny of maternity services which had led to some improvements in safety.

38. This Trust needed an extremely strong and capable Chair operating on a full-time basis to make an effective difference to this situation. A part time individual would never have been able to provide effective time for adequate oversight given the number of challenges that this Trust faced. Other Board members describe Mr. Reid's leadership as "thoughtful" and that he sought to change the culture by taking on responsibility for the MOC. It would seem to me that given the number and nature of difficulties faced by this Trust, it would be impossible for any Chair to have materially altered the culture during a two-year period.

[8] Summary from Maternity Oversight Committee of 11 November 2019.
[9] Summary 9 September 2019.

39. Non-Executives rely very heavily on the Executive team telling them the full facts. They rarely have the time to "dig down" to examine what is happening on the ground. This demonstrates the need for a team who can effectively scrutinise Executive assurances and undoubtedly in this Trust, as in many others, require further training and expertise to do so effectively.

40. The problems at Shrewsbury and Telford Hospital NHS Trust, at least in part, demonstrate the systemic weakness of governance and management of NHS Trusts. This is referred to extensively in the *Kark* review. The ability of the Board to give effective oversight and assurance of all aspects of the care of a Trust can be very limited unless you have individuals who have the relevant expertise and experience to be able to scrutinise relevant material and to "dig down", and act as a critical friend to the Executive team, and who can commit significant amounts of time to really exploring the issues. Until very recently, there has been very limited training for Trust Boards in how to manage and govern. Moreover, it is always easy for non-clinicians to defer, sometimes inappropriately, to clinicians who are seen as understanding the clinical complexities if the concerns raised have a clinical element. It is therefore, extremely hard for non-executives with a very limited understanding of sometimes complex clinical situations to be able to effectively challenge clinicians. This is particularly the case where the clinicians hold all the relevant information, and the Non-Executive members of the Board are only given limited or partial information.

41. The Board can and should set the tone in terms of the culture it expects to be followed within the organisation. The Ockenden review of March 2022 has identified the multiple research into the need for team working, and how this improves patient safety when it works well (cited at paragraph 5.62 - 5.5.67 of the Ockenden review and the footnotes set out within those passages). The research Civility Saves Lives (cited in Ockenden at paragraph 5.66 and published in 2017) articulates how rudeness and bullying results in a decrease in a clinician's performance but also their cognitive ability and impacts upon bystanders, patients, and the wider team in healthcare settings. This is something which the Board could have assisted in by "setting the tone" and

inculcating a culture where bullying is seen as wrong, even when there are significant shortages. But limited staffing and crisis situations can often lead to such bullying or negative behaviours surfacing, which then leads to yet poorer morale and fewer staff . You need the staff, the training, and the culture to all be working. Given the concerns raised by staff about being bullied and being worried about reprisals for passing on information which may cast the Trust in a negative light and the some staff told the Ockenden review of a bullying culture within the leadership team (paragraph 5.76 - 5.85 of her report), it seems essential that the Board now use those positive behaviour strategies to improve the working environment for staff - for example, as recommended by Ockenden (at paragraph 5.74) , the Workplace behaviour toolkit produced by the RCOG, and the Civility Toolkit produced by the HEE in 2021. Both of these toolkits were not available when Mr. Reid was in post.

(1) Delay in and publication of the RCOG report and addendum.

42. The RCOG report should not have been delayed, and should have been published in late 2017, and not in the middle of 2018. The reasons given for delaying publication had nothing to do with transparency or patient safety. Mr. Reid was appointed in February 2018. By that stage, the RCOG had agreed to return to carry out an updated formal discussion with the Trust, who were unhappy about the contents of the report and felt that they had improved. Given this, whilst it was an incorrect decision to delay publication of the main report, it was understandable from Mr. Reid's perspective as a new member of the Board to wait for the addendum, in particular as NHSI were not advising its publication despite being involved in providing advice to the Trust about how to communicate the report to the public. It may be that others on the Board, who were aware of the background, should have advised that the report should be published as soon as possible or raised this at Board meetings.

43. The way in which the report was published was unhelpful and sought undoubtedly to try and "spin" the findings of the RCOG. This should not have

happened. In as much as Mr. Reid was aware of this and approved of this approach, it was wrong but again there was no advice that I have seen from any external communications professionals to the Trust who pointed this out at the time. It is clear that there were discussions between the clinical team and Executive team about what should be published and when, and there was disagreement. Much of this would have predated Mr. Reid's appointment.

44. Again, the approach taken to the publication of this report shows the difficulties in leading a Trust. On the one hand, one has a role of oversight over staff members, and to ensure that their needs are taken into account and that the welfare of clinical staff is seen as relevant. Furthermore, in this situation, staff shortages meant that to keep any form of service running it was imperative to maintain staff and to keep them at work, and not off on sick leave. On the other hand, one's role as a Chair is to act as a critical friend and speak truth to the Executive team. When it comes to questions of patient safety, the priority must always be the patient and the quality of care given to them. In this case, the quality of current care may have been compromised by further staff resignations or further absence because of the publication of the report. However, in a culture of learning from lessons, avoiding the creation of "blame" environments and one of continuous improvements, it should have been possible to have published the report promptly whilst ensuring that staff were aware that the critical lesson to learn was to improve care.

45. Mr. Reid would have received the report forwarded to the Board. It is my view that this report should have been progressed more quickly, in line with the conclusions of the NHSI review, and put to the Board in the summer of 2018. I also consider that the Chair, as the person with ultimate oversight and scrutiny of Executive action, and the Board, should have published the report unvarnished, and not waited for the supplementary report.

46. The supplementary report should not have been published "on top" of the original report. It was not a report designed to, and could not, show an appropriate degree of assurance that the position had changed in respect of

maternity care at the Trust. It portrayed an unduly rosy picture. That was wrong. The cover paper published alongside the reports was also unduly optimistic about the issues which the Trust faced. It may have been wrong, but it is a relatively common practice in the NHS (as NHSI identify).

47. One of the roles of Chair is to be a "critical friend" to the organisation and to probe what is going on, rather than simply rely upon the assurances of the Executive team. Mr. Reid, being new in post, seems to have relied entirely on the Executive team as to the importance of the report and how it should be presented. A rationale has been given of not having been party to previous discussions about the RCOG report (which I accept was a valid rationale) and of the need to maintain or start with a good relationship with clinical staff who wanted the report and supplementary report to be put together. Not just Mr. Reid, but the entire Board should have sought to see the report, not least because of the degree of consternation it was causing in the Executive team. They should not have acceded to the wishes of the Executive team without interrogating the reasons for such.

48. Given the very high profile of maternity failings at the Trust, which I have set out below, the Board should have scrutinised the report earlier and published it earlier. Mr. Reid accepts that this decision was wrong, and that the addendum report was sought to "soften" the criticisms. The entire report was published, and there was no suppression of it. In these circumstances, whilst I consider that it was not acceptable, I do not consider that it amounts to serious mismanagement. I do consider that a Chair in these circumstances should not have automatically acceded to the views of the senior clinicians – in particular as it was in their interests to delay publication – and for that reason, the rationale given by Mr. Reid can only partly excuse his actions. In all the circumstances, I consider that the Board should have published the report and it was wrong to wait for the addendum. That is said with the benefit of hindsight – and I note that no-one in NHSI at the time (from the records I have) sought to advise the Trust of this.

49. As far as the Board meeting of July 2018 is concerned, at which the RCOG report and its addendum was discussed, the paper presented to the Board was partial and not candid. Mr. Reid was not responsible for that paper. I would have considered, however, that the underlying reports should have been read by all Board members.

50. The issues raised here are common to many Trusts in respect of how much is delegated to Committees and how much is dealt with at the Board. In this case, the Trust Board operated a system of "assurance" whereby Committees – in this case the Quality and Safety Assurance Committee (QSAC) – "assured" the report so that the Board could receive it. My view is that for key reports – such as this one – the use of "sub -Boards" can be unhelpful as it can lead to an excessive emphasis upon delegation. There needs to be an understanding that this level of "assurance" should not replace scrutiny by the main Board in the case of key reports on patient safety.

51. Even if only the executive summary of the main report had been read by the Chair this would have alerted him to higher-than-average perinatal mortality rates, and continuing failures in the investigative process for serious incidents. This stands in some contrast with the covering Board paper which mentions nothing about the original report in any depth, save for identifying three areas where there are "some issues". The covering letter presented to the Board does summarise what is said to be the addendum report and is positive in tone. As was identified by NHSI in their report, the information given to the RCOG from the team and the limited oversight of the RCOG team of what was happening on the ground, led to the addendum report which was not extensive enough to provide a level of assurance, which the Trust then relied upon.

52. I consider, in all the circumstances, that the Board should have investigated how much assurance could be garnered from the conclusions of the Addendum report as it largely relied upon the Trust's own information rather than providing independent assurance. Mr. Reid should have asked probing questions.

53. Without an underlying knowledge of history, Mr. Reid may not have been as aware as he should have been that the RCOG report demonstrated a continuation of the same problems and concerns that had been occurring over a lengthy period of time. Moreover, the Ockenden review, established in 2017, was set up to look at serious incidents in respect of maternity care which took place between 2000 – 2017: a reasonable Chair should have been part of a process within the Trust of identifying in what ways the RCOG report reflected previous concerns, and how those issues could be addressed swiftly. Mr. Reid identified that both the Medical Director and Director of Nursing considered that the original and addendum RCOG report should be presented as a complete picture and advised him of such – he says that as this was an issue of clinical performance in a high-profile area, to insist on presenting the report to the Board against their views would have "severely damaged" the chances of developing a positive relationship with them.[10] Whilst this may be a true assertion, it once again throws up the difficulty of being able to be a "critical" friend as Chair of a Trust.

54. In the light of even a cursory reading of the underlying report, I would have anticipated some questioning at any Board meeting of the "candour" of the accompanying paper, which seemed to suggest that the vast majority of concerns had been addressed. The failure to appropriately scrutinise the candour of the accompanying paper and the "glossing over" of serious concerns should have led to the Board seeking to take decisive action to (a) ensure that executives took action and (b) that there was no further "glossing over" of the report.

55. The Board should have been particularly concerned by the RCOG's finding of a lack of planning and resulting changes of practice after serious incidents. The RCOG report identified that the process of investigating serious incidents was still manifestly deficient, and that there was "no culture of shared learning" and no drawing out of lessons to see if systemic changes needed to be made. In the light of this, I would have anticipated that any action plan should have been focussed upon learning what systematic issues arose and seek to make

[10] Mr Reid response September 2021.

improvements not just in respect of each individual case, but system wide. [11](The Ockenden review does, however, reflect that there was improvement in the quality of some serious incident investigations, and cites an example from 2017). [12]

56. Again, that was a continuing failure. Even if Board members were not fully conversant with all the past reviews, the fact of the existence of the Ockenden review should have alerted Mr Reid and the other Board members to undertake a forensic analysis of the report.

57. The fact of the delay in the production of the RCOG report to the main Board should have been the subject of discussion at the Board meeting. There should also have been consideration of whether the mechanism of oversight proposed by the Trust's Executives was adequate, or if alternative processes for scrutiny and oversight should have been implemented. Whilst there was some discussion, this did not happen to a sufficient degree to satisfy NHSI in their report.

58. Moreover, as the NHSI report finds, whilst work was done to implement actions, there was limited scrutiny and oversight of the Trust's plan by the Board, with the Board only examining it once in July 2019. In the light of all the circumstances, the issue of the action plan following on from the RCOG findings should have been the subject of an update at every Board meeting and at relevant sub-committee meetings. There should have been questions asked to ensure that the action plan (a) was being implemented and that (b) this was leading to changes and (c) substantive changes were being made to processes and practices.

59. Mr. Reid in his written evidence indicates that he was not provided with full information by all of the Executive team – he also identifies that as he only came into post in February 2018, he had no knowledge and awareness of concerns about the report prior to that time.[13] Mr. Reid, as the Chair, is unlikely to have

[11] This is reflected in the Ockenden final review paragraph 4.19.
[12] Paragraph 4.24 of the Final Ockenden review report.
[13] Response from Mr. Reid to draft report, September 2021.

day-to-day knowledge of the level of staff shortages. But members of the Executive team, who would have had such information, should have provided this information to the Board.

60. Inadequate staffing levels inevitably (and particularly in maternity cases where swift and decisive action is often needed on an emergency basis) lead to lower levels of patient safety. Whilst I would not expect the Board to know all details of all staffing vacancies and/or concerns, I would expect them to know or be told about such staffing shortages that would or could have a significant impact upon the provision of patient care and safety. Ms. Ockenden's report also observes that it was only in 2022 that the Trust appointed a consultant midwife post, despite the RCOG having made recommendations from 2007 on standardising an approach to clinical leadership roles . The Review finds (paragraph 5.31) that had such a role been developed prior to 2022 by the Trust it could have provided the balance of professional and effective clinical leadership to ensure improvement of safety and quality. It seems to me that this was a failure by a series of Trust Boards in not considering this prior to 2022.

61. Another example of problems within Mr. Reid's time in office is identified by the workings of and assessment of the auditing practices of the Trust in respect of the Clinical Negligence Scheme for Trusts (an explanation of which is set out in full at paragraphs 4.96 - 4.106 of the Ockenden review of March 2022). Whilst much of the criticism in that review concerns matters before Mr. Reid was in office, in 2019 there is evidence from a staff member that the "maternity scheme training requirements" were signed off by both the Executive team and the Board - such requirements being necessary for the Trust to receive a rebate of monies paid under the scheme without underlying evidence being shared by or requested by them (paragraph 4.105). Whilst it may not be usual for a Board to require the underlying evidence in all circumstances, given the questions raised about "assurance" of this scheme, as a "critical friend", it may have been expected that the Board would have wanted to have seen this material to satisfy themselves given the position. Whilst I cannot say that not asking for the material was serious mismanagement, good practice should have at least

questioned the evidence base upon which the assertion was made by the MOC or other board members, or questioning the executive about such. I note that the Ockenden review indicates that this was evidence from an individual, and I am not clear if that was raised by the review team in their discussions with any Board members in post at the time.

62. This unwillingness to share unwelcome information or information which did not present a positive picture, demonstrates a culture within the organisation of defensiveness. Whilst a degree of defensiveness is understandable in an organisation which had extremely low staff morale, the role of a Chair is to lead and seek to inculcate a culture which seeks to change such approaches, and which has an open and honest approach to failings. This is not something which can be solved overnight, but in the context of all the facts, it was the only sound approach to adopt.

63. The NHSI report also concludes that the Board did not adequately follow up on the review undertaken by the Board in July 2019 of the actions following the RCOG reports. The Board should have been given updates at every Board meeting as to the progress and whether (a) changes were taking place and (b) the efficacy of those changes. This level of oversight was initiated from March 2019, when the MOC was set up but should have been initiated from the date of receipt of the RCOG report.

64. The Ockenden review identifies (paragraph 5.2-5.4) that the Board of the Trust "did not know what was needed in maternity services.". It is not clear at what time this remark relates to in the review's timescales (which were from 2000 – 2019) but this chimes with the views expressed in a number of other reports about relative lack of board oversight of what was happening strategically and operationally within maternity services.

65. From the date that the MOC was set up, the agenda and minutes that I have seen do show that the concerns around risk management, patient safety and current actions were being examined on a monthly basis by this Committee. This

included, for example, gap analysis actions. The CQC identified in its reports in 2018/2019 that leadership at Board level was not adequate (overall).

66. The Ockenden review has provided actions in respect of the leadership of the Trust (at paragraphs 4.131-4.133). The Trust has accepted all of Ms. Ockenden's recommendations. This requires the Trust Board to review the progress of maternity improvement and transformation plan every month, with the senior leadership team completing the National Maternity Self Assessment Tool to benchmark their governance against national standards, and should share their report, and any remedial plans with the Trust board. But such review by the Board must examine what is happening, and not just examine the headline figures. The self assessment tool [14] should assist the Board in doing this, and it is a shame that such a tool was not available prior to July 2021.

(2) Dealing with Mr. Stanton and Ms. Davies at various meetings and in correspondence.

67. Mr. Stanton and Ms. Davies have been involved in seeking improvements to patient safety for over a decade. Until at least 2015, it would appear that they had to take vigorous steps, including legal action and formal complaints, to have acknowledgment of the failings of the Trust. They therefore had to spend 6 years with figures of authority within a Trust either not accepting what was being said by them, or seeking to avoid any investigations.

68. Moreover, as both the Ockenden report and NHSI report identifies, there does appear to have been a mindset amongst Executives and others that the problems with the maternity unit were in the "past", when the CQC reports and the RCOG report show that this is not the case. To a degree, the problems at this Trust reflect wider concerns about maternity units and patient safety highlighted by NHS England in their 2016 and 2019 reports on maternity care and repeated in the Ockenden review. But if Mr. Stanton and Ms. Davies had been told that their

[14] https://www.england.nhs.uk/publication/maternity-self-assessment-tool

issues were "*in the past*" or concerns about maternity care were "*legacy*" issues, then that would have done a disservice to their bereavement, and also failed to grapple with the issues which caused the death of Ms. Stanton Davies, which were still present.

69. Mr. Reid describes situations in meetings at which he felt personally uncomfortable and concerned at the nature of the approach taken by Mr. Stanton. It was undoubtedly the case that Mr. Stanton was clear about the need for the Board to recognise the need for significant improvements in patient care. He was not familiar with the process of board meetings, which in the case of a Trust, can take all day. He wanted to have his point of view put across. Mr. Reid describes a noisy protest on that day, with TV and press present. Mr. Stanton indicated to me in 2022 that he was not part of the "noisy protest" and it seems to me that Mr. Reid may well have , over the fog of time, forgotten that there were a number of individuals present at that meeting and confused Mr. Stanton with another individual or set of individuals. I do not consider that Mr. Stanton's actions on the day of the board meeting could justify being spoken over or contributed to the "stress " which Mr. Reid felt. I consider that there were plainly others who may have been contributing to the concerns of the Board, but that Mr. Stanton was not the cause of the "conflict".

70. It is also the case that both Mr. Reid and Ms. Clarke made a personal apology to both Mr. Stanton and Ms. Davies at a Board meeting in November 2019 on behalf of the Board for the way that they had been treated. Apologies are always difficult when time has passed – as it is often hard to accept that an apology is genuine and that it is not just a chance to be "seen" to be doing the right thing.

71. There appears to have been miscommunication between Mr. Reid, as the Board Chair, on at least one occasion when Mr. Stanton considered that he was made to wait too lengthy a period before being able to make his point. He therefore sought to politely indicate what he wanted to say. There were other people in the room and around at this meeting and others (but not with Mr. Stanton) who had caused what Mr. Reid considered to be discord at the meeting. It was plainly

a high stress situation for Mr. Reid. Mr. Reid did apologise afterwards to Mr. Stanton. I do not consider that it can be "serious mismanagement" or "misconduct" to deal inappropriately and wrongly with a group of individuals in the way described. Mr. Stanton was undoubtedly spoken over, which was discourteous. Mr. Reid was trying to keep the meeting on track. A better way to deal with such issues is often to let groups speak first and have their concerns heard at the outset of the meeting, but this is said with the benefit of hindsight. I understand that following on from this meeting, and prior to the onset of the COVID-19 pandemic, the Board had "public interest" items which were considered first, with the meeting then being "paused" so that questions could be taken by ~~from~~ the Board.

72. Again, as I have indicated elsewhere, the fact that Mr. Stanton only felt able to be "heard" by attending a Board meeting held in public points out that the relationship between the Trust and Mr. Stanton had broken down. Mr. Stanton should have had a direct conduit of communication whom they could trust and to whom they could go to make their point.

73. As to Mr. Reid's broader relationship with Mr. Stanton, he did seek to build rapport when he first joined the Trust and to "re-set" the relationship, which was appropriate. That did not work. In order to really create a positive relationship, there would need to be the time and understanding spent over a number of months to develop and build a relationship of trust and mutual understanding. Mr. Reid did not have that time.

74. Boards do not routinely have training in mediation and conflict management. They also rarely have training in developing and maintaining rapport and reflective listening. In as much as Mr. Reid failed, this is symbolic of wider failure within NHS Trusts and the current structure of Non-Executive Director training. Furthermore, as was seen with the Ockenden review (where such provision was made available), there is a need for therapeutic assistance to be offered to families when dealing with these issues - they cannot be expected to be able to cope alone - and those engaging in dialogue and discussion also need

to have sufficient training and understanding of trauma to adopt a trauma informed approach. That was not the case here - and I have no doubt the offer or provision of such support could have provided much needed assistance.

75. More widely, however, this case reflects the continuing problems that Boards, and hospitals can have in engaging with patients when things have gone wrong. Various organisations have indicated that families should be actively involved in investigations (as identified in the Ockenden review at paragraph 4.44). The Ockenden review also indicates that there is not current complaint handling training available across the board for those undertaking such complaints (paragraph 4.146) and there is currently going to be development of an involvement guide for trusts in respect of seeking active involvement of women and families in investigations (paragraph 4.148). The fact that these two pieces of work are being done demonstrates that there is a current gap in the guidance and advice available to Trusts in this respect.

(3) Emails between Mr. Reid and Mr. Stanton

76. The last issue relates to inappropriately informal e-mails from Mr. Reid to Mr. Stanton – for example sending them from his phone, rather than from a computer and referring to him by his first name. Whilst small, understanding how individuals wish to be referred to is important, as it helps to build trust and confidence. In most organisations, however, there is routine informality and an expectation that such is acceptable. Whilst I consider that further care should have been taken by Mr. Reid in the communications he sent, which would have been perceived as overly informal, I do not consider that this can amount to "serious mismanagement" or "misconduct". It reflected how most communication in organisations takes place. The e-mail concerned the suspension of board meetings due to the pandemic, but identified that if Mr. Stanton had any issues then Mr Reid would facilitate the raising of these – and was trying to be helpful. But the "small stuff" does matter: as a matter of good

practice, there should always be checking of how individuals wish to be addressed.

77. Given the conflict which appears to have been engendered, it may be that as a Board or Trust there could have been steps taken to seek some form of conflict management/resolution. This could have recognised and reflected upon the needs of Ms. Davies and Mr. Stanton and to do more than simply acknowledge them – to engage, reflect upon their experiences, and seek to have them as co-partners in changing patient care and safety. I consider that Mr. Reid's approaches were clumsy but not meant maliciously or to cause harm. They do not amount to serious misconduct.

78. Mr. Reid indicates in his response to the draft report that he had always orally called Mr. Stanton by his first name and had seen other correspondence with the first name of Ms. Davies.

General conclusions about the Trust

79. Mr. Reid inherited a Trust which was institutionally defensive about maternity care, and which was seriously dysfunctional. The response to the RCOG report by clinicians and Executives shows an organisation which was not capable of reflection and which (possibly because it felt under siege) therefore reacted in a defensive manner. Mr. Reid, as the Chair, should have sought to take steps to (a) understand that this was the case and then (b) sought to have taken steps to address this fundamental problem. He did take some steps when he found these concerns. Ultimately, changes in these cultures require all the senior team to model this behaviour and a largescale overhaul of all practices, policies, and procedures, all of which takes time.

80. Responsibility does just not lie with Mr. Reid, however. Members of the Board in post prior to February 2018 and who were aware of the issues that had taken place between November 2017 – April 2018 should have asked about the report and requested that it be provided. Furthermore, there should have been

someone on the Board with express responsibility for oversight of maternity care – other than the Director of Nursing, Midwifery and Quality who was the person with responsibility, as given their relationship with staff there was a possibility of a potential conflict of interest - and any action plans and development, given that the Ockenden review had been commissioned in 2017. With the benefit of hindsight, someone like the Chair should have taken control of this issue from the date of commissioning of the Ockenden review.

81. Furthermore, as Mr. Reid identifies, the Chair of a Board in an NHS Trust has no powers to direct operations or to drive change other than by influence and leadership – and that the Board is there to provide assurance, and not to manage. There is a difficult line between governance and management – and it is not always clear where the boundaries lie. My view is that the Boards of Trusts, particularly in this situation, need to, in some cases, take a more direct role to "assure" themselves. But this is both unusual in a Board, and not something that most Board members who were Non-Executives may have been comfortable grasping. This case reflects a wider problem of how, in cases of crisis, a Board can and should act – what are the limits of their powers? How can they make change?

82. Moreover, the CCG as commissioner has been found wanting in its review process by the Ockenden review team. The CCG carried out a report in 2013 which found openness and transparency in reporting at the Trust , and a robust approach to risk management, clinical governance and learning from incidents which were not borne out by the findings of Ms. Ockenden. She found (paragraph 4.43 of the March 2022 Ockenden report) a lack of incident reporting: low levels of serious incidents being declared: poor quality RCA's and investigations where lessons are not learnt. She identifies that this poses the question as to the suitability of the CCG review process in 2013.

83. There was a MOC set up in March 2019 chaired by Mr. Reid, which does seem to have sought to grapple with matters, and does show that Mr. Reid wanted, and did seek, to take responsibility for actions. Its success or otherwise is not entirely

within Mr. Reid's hands but, from the information I have seen, it was examining patient safety and sought to do something.

84. How much assistance should come from NHSI or other central bodies in this situation? Some of the Executives have identified that they would have welcomed further support from NHSI during this time. There is a very difficult balance to strike given the operational independence of Trusts as to how far NHSI can and should be involved, and what support it can and should give – something which should be the subject of a national discussion.

The role of Chair of an NHS Trust and his responsibilities.

85. Mr. Reid became Chair of the Trust in February 2018. He left the Trust in August 2020.

86. As the Chair of the Board of the Trust, he has a Non-Executive role. This means that he is not an employee, but an office holder. The Secretary of State for Health is responsible for the appointment of the Chairman of the Board of Directors of an NHS Trust *(Schedule 4, paragraph 3 of the NHS Act 2006*). In practice, the Secretary of State for Health and Social Care has delegated his powers to make an appointment to NHSI, which, since 1 April 2019, works as a single organisation with NHS England.

87. NHSI is responsible for overseeing all NHS Trusts, including appointments of Non-Executive directors to all Trusts, save for NHS Foundation Trusts.

88. Three things should be noted about the Chairs of NHS Trusts:

    (a) The role is not full time: it is a part time role.

    (b) The role has very many requirements (set out below) and it can often be difficult to match those requirements with the time that someone can realistically give to it.

    (c) Chairs will have different skill sets and strengths: not everyone will be skilled at engaging with those who have been let down by their Trust and

with the "public facing" element of the role. Chairs of NHS Trusts come from varying backgrounds. The *Kark* review has criticized the training of Chairs and other non-executives. Whilst training has been put in place now, this is still a work in progress.

NHS Principles and Values

89. The NHS has seven key principles and a set of core values. These are the overarching principles that should guide all decision making. The principles include:

    - an aspiration to the highest standards of excellence and professionalism:
    - that the patient is at the heart of everything that it does:
    - that it should be accountable to patients and the community it serves, as well as the public.

90. The core values include, inter alia, compassion, respect and dignity, a commitment to a quality of care and improving lives.

91. The role of an NHS Trust Board in delivering those principles is to govern effectively and in doing so to build confidence that their health and care needs will be safely and effectively met.

Regulations to appoint a Chair

92. The relevant regulations – the *NHS Trusts (Membership and Procedure) Regulations 1990* set out the basis for the appointment and tenure of both Non-Executive and Executive directors of the Trust. NHSI has issued information about the appointment of Chairs of NHS Trusts (*version revised in April 2015*). It provides, inter alia that as a Chair, one has to serve the Trust to the best of their ability and use their best endeavours to promote the welfare of the Trust and follow the terms of the job description.

93. NHSI expected all members of a Board to commit to the Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England. This document was produced in November 2013 by the *Professional Standards* organisation (another governmental body which produces standards, publications and advice for health and social care bodies). This sets out a number of principles, which include, inter alia:

(a) The requirement to treat patients with dignity and respect.

(b) To be accountable for the work undertaken by the Board and for the staff and services for which he is responsible.

(c) To be open about the reasoning, reasons and processes for decisions taken.

(d) To have relevant knowledge and skills and that this is reflected upon and gaps are filled.

(e) To lead by example in promoting the Standards and use them to create a positive culture.

(f) To act consistently and fairly and raise concerns if harmful behaviour or misconduct by others is seen.

(g) Put the safety of patients and the quality of care first.

(h) Understand roles and powers and the legal and regulatory frameworks.

(i) Work collaboratively and constructively with others, contributing to discussions, challenging decisions and raising concerns effectively.

(j) Think strategically and developmentally

(k) Competently use data and patient complaints to improve the quality of care.

(l) Reflect on personal, Board and organisational performance and on how behaviour impacts on others and support colleagues to do the same.

(m) Listen to patients their families and carers, community colleagues and staff so that people are involved in decision which affect them.

(n) Communicate clear, consistently and honestly with patients and services users to ensure messages have been understood.

(o) To take responsibility for ensuring that any harmful behaviour, misconduct or systems weaknesses are addressed and learnt from, and taking action to raise concerns as identified.

(p) Ensure effective incident reporting and whistleblowing procedures are in place.

(q) To extinguish any practices that could inhibit the report of concerns by anyone about standards of care.

(r) Provide high quality care in a listening, supportive and learning environment.

(s) Seek assurance that risk management frameworks are sound, effective and are properly used, and that the values in these Standards are put into action in the design and delivery of services.

(t) Work in partnership and co-operating with local and national bodies.

(u) Ensure that the organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

94. NHSI provides a "*Provider Chair competency*" framework.[15] This provides for competencies in five areas. Relevant areas for this report are:

(a) Strategic, which includes:

- Leading the Board to setting a deliverable strategy
- Taking account of internal and external factors to guidance decision making for the benefits of patients.
- Provokes and acquires new insights and encourages innovation.
- Evaluates evidence, risks and options for improvement objectively.
- Builds organisation and system resilience.

[15] Published November 2019 and available on www.improvement.nhs.uk.

(b) People, which includes:

- Creates a compassionate, caring and inclusive environment welcoming change and challenge.
- Builds an effective, representative and sustainable team focused upon patients.
- Ensures all voices are heard and views are respected, using influence to build consensus and manage change effectively.
- Supports, counsels and acts as a critical friend to directors, including the chief executive.
- Develops a Board that is genuinely connects the staff and patient experience.

(c) Professional acumen, including:

- Owns governance, including openness, transparency, probity and accountability.
- Understands and communicates the trusts regulatory and compliance context.
- Leverages known experience to build a modern, sustainable Board.

(c) Outcomes focused, including:

- Creating an environment in which clinical and operational excellence is sustained.
- Embedding a culture of continuous improvement.
- Prioritising issues to support service improvement for the benefit of the population.
- Measuring performance against institutional and CQC led standards.

Guide to Development of NHS Chairs.

95. NHSI provided guidance to NHS Trusts in November 2019 setting out the "*Role of the NHS Provider Chair: A development framework*". The guidance prior to this date and the development framework for Chairs were not as clearly laid out, and the NHS has recognised that it has provided relatively little professional development for Chairs and other Non-Executives despite their significant role within public life. I note that this was only produced over halfway through Mr. Reid's term of office. He would not have had sight of it prior to his induction as Chair.

96. NHSI's framework sets out (in brief) what they consider to be the main functions of the Chair of the Trust. This is to lead effective governance and securing a long-term vision and strategy for the organisation. It says:

"*Fundamentally, the chair is responsible for the effective leadership of the Board …. They are pivotal in creating the conditions necessary for overall Board and individual director effectiveness*."

97. They identify five key responsibilities for a Chair:

(1) Strategic: ensuring that the Board sets the Trust's long-term vision and holding the Chief Executive to account for achieving the Trust's strategy. This is to include:[16]

- Ensuring that the whole Board of Directors play a full part in developing and determining the vision, values, strategy and objectives to deliver the purpose.
- Ensuring the strategy aligns with NHS values
- Ensuring that the Board identifies the key risks in implementing any strategy and provides effective oversight of those risks.
- Ensuring that there are prudent controls to manage risk.
- Holding the Chief Executive to account for delivering the strategy and performance.

[16] P10 role description of Chair from NHS improvement Framework for Chairs.

(2) People: creating the right tone at the top, encouraging diversity, change and innovation and shaping an inclusive, compassionate, and patient centred culture in the organisation. This includes:

- Providing visible leadership in developing a health, open and transparent patient centred culture for the organisation where all staff have equality of opportunity to progress, to speak up and ensuring that the culture is reflected and modelled in their own and in the board's behaviour and decision making.
- Leading and supporting a constructive dynamic with the board, enabling grounded debate with contributions from all directors.
- Promoting high standards of ethics, integrity, probity and corporate governance throughout the organisation and in particular the board.
- Demonstrating visible ethical, compassionate and inclusive personal leadership by modelling the highest standards of personal behaviour and ensuring the Board follows this example.
- Ensuring that constructive relationships based on candour, trust and mutual trust exist between Executive and Non-Executive directors.
- Developing effective working relationships with all Board Directors, in particularly the Chief Executive to provide advice, support and guidance.
- Ensuring the Board has the right balance of skills, knowledge and perspectives.
- Considering the suitability of Non-Executive members who lead sub-committees.
- Advising on removal of Non-Executive directors.
- Ensuring annual evaluation of the performance of the Board.
- Taking account of their own development needs.

- Developing a Board that is genuinely connected to staff and patient experience.

(3) Professional acumen: leading the Board, both in terms of governance and managing relationships internally and externally. This includes:

- Making sure that the Board operates effectively and understands its own accountability and compliance with its procedures
- Doing the right thing ethically, and demonstrating the same behaviour to the Board.
- Leading the Board in establishing effective and ethical decision-making processes
- Setting an integrated Board agenda taking account of important strategic issues and key risks.
- Ensuring that the Board receives accurate, timely, high quality and clear information – that the relevant assurance systems are fit for purpose and that there is a good flow of information between the Board, its Committees and senior management
- Ensuring Board Committees are properly constituted and effective.
- During Board meetings, facilitating agile debate which considers the big picture
- Ensuring that the Board both collectively and individually provides sufficient challenge

(4) Outcomes focus: achieving the best sustainable outcomes for patients/service users by encouraging continuous improvement, clinical excellence and value for money.

(5) Building systems partnerships and collaboration (largely to do with integrated care plans under the NHS Long Term Plan which is not relevant to my report).

Relationship between Chair and Chief Executive

98. The guidance identifies that the relationship between the Chair and the Chief Executive of the Trust is "*key*" to the success of the role, to cultivate an effective working relationship. In reality, the Board cannot discharge its duties without the Executive and it is seen as vital in the guidance for the Chair and Chief Executive to be clear about their individual and shared roles and who is responsible for what. The Chair leads the Board and is responsible for the effectiveness of the Non-Executive directors and the Board as a whole.

99. This is a long list, and one which involves skills in several overlapping areas, but also a detailed knowledge of (a) the workings of the Trust (b) the expectations of NHSI or NHS England (c) how clinical and patient safety works within the Trust (d) understanding the interrelationships between the various forms of oversight and governance are essential. One then has to translate that understanding into being able to oversee improvements, act as a "critical friend" and test information given to the Board.

100. Any office holder in public services also has to reflect the Seven Principles of Public Life (often known as the "Nolan" standards) of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. These are, in effect included in the detailed set of "outcomes" provided in NHS Guidance.

101. Regulation 9 of the *NHS Trusts (Membership and Procedure) Regulations 1990* sets out the grounds upon which the appointment can be terminated with immediate effect, which include if "*it is considered that it is not in the interests of the health service that you should continue to hold office*" or if one becomes disqualified for appointment. The guidance upon what is considered to be contrary to the interests of the health service includes:

    (a) A finding that someone is an unfit person

    (b) If the confidence of the Board, public, community or NHS improvement has been lost.

    (c) If the Board does not monitor the performance of the Trust effectively.

(d) If there is a breakdown in essential relationships.

(e) If you fail to apply the principles which have been set out.

(f) If an internal investigation of wrong-doing results in a finding against you.

102. In this case, the appointment was terminated by way of resignation so these issues did not arise, but it shows that there is a wide measure of discretion for termination.

FPPR- Regulations and Guidance

103. Prior to April 2015, there was no obligation upon an NHS or social care body, when employing or appointing individuals as Directors, of trustees of such organisations, to assess their fitness and competence for these roles. The Government determined[17] that Directors of health and adult social care organisations play a crucial role in determining the safety and quality of care provided by the organisation through the decisions that they take, and the culture that they set. The policy objective behind the Regulations was to ensure that bodies take proper steps to ensure that their Directors are fit and proper for their role. Providers must undertake appropriate checks to ensure that their Directors (and equivalent) exhibit the correct types of personal behaviour, technical competence and business practices required for their role. The checks should take place at the point of recruitment and as part of on-going monitoring of existing Directors to ensure that they remain fit and proper for their role.

104. Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936* (as amended by the 2015 Regulations) set out the requirements to be used by a provider when assessing the question of fitness for office.

[17] Information taken here from Impact Assessment of Fit and Proper Requirement for Directors published with the 2014 Regulations on 29 April 2014. The policy emerged from the report of Sir Robert Francis into the Mid Staffordshire Inquiry and the Governmental Response to the events at Winterbourne View Hospital.

105. The Regulations[18] state that a provider must not appoint someone as a Director, unless they meet the requirements set out in Regulation 5(3). These are that someone:

(a) Is of good character. This is not defined, but the CQC guidance (see below) identifies that good character involves both convictions, decisions made by regulators to censure the individual evidence of investigations or proceedings by a professional or regulatory body, evidence of breaches of the Nolan principles of public life, and evidence of breaches of the Companies Act and also any other relevant information in respect of disciplinary action taken by an employer.

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office and position or the work for which they are employed. I have taken this to mean that someone is registered with and accredited by their relevant professional body relevant to their role: has a track record[19] of undertaking the same or comparable work: satisfies the objectives set out in the job specification: and can demonstrate the relevant competencies for the role.

(c) The individual is able by reason of their health, after reasonable adjustments are made, or properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed. This is self-explanatory but would be a question of judgment in each case.

(d) The individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity or

[18] Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936

[19] In LB Wandsworth ex parte M [1998] ELR 150, the court held that "experience" meant a "significant track record" . Whilst in a different context, I consider that the Regulations are meant to connote that someone has a significant track record in what the role for which they are applying or undertaking.

providing a service which, if provided in England, would be a regulated activity.

(e) Is not an un-discharged bankrupt (Part 1 of Schedule 4) or subject to a bankruptcy order.

(f) Is not someone with an un-discharged arrangement with creditors (commonly known as an IVA).

(g) Is not someone included on any barring list preventing them from working with children and vulnerable adults

(h) Is not someone prohibited by law from holding a trustee or director position because of disqualification either under the Companies Act: The Charities Act or under professional regulation.

Misconduct or mismanagement – CQC Guidance

106. The CQC provides guidance as to its understanding of what is misconduct or serious mismanagement.[20] It identifies misconduct as conduct which is in breach of a legal or contractual obligation, or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence. Mismanagement is identified in being involved in either the quality of decision making or actions which fall below any reasonable standard of competent management. Misconduct can be a single incident: however, an isolated incident is unlikely to be mismanagement unless it calls into question the confidence of the organisation and the public over time and so is more likely to be established by a course of conduct over time. This is to include:

(a) Transmitting to another public body information which was inaccurate without checking its accuracy.

[20] Guidance issued January 2018: Regulation 5: FPPR

(b) Suppressing reports where this may be compromising for the organisation.

(c) Failing to learn from incidents, mistakes, complaints, or failing to have an adequate whistleblowing system in place.

(d) Failing to model and promote standards and behaviour expected of those in public life, including protecting one's own reputation over the interests of those who use or are employed to provide the service.

107. Serious is defined by the ordinary dictionary definition which is:

"*Important, grave, having (potentially) important consequences, giving cause for concern or significant degree, amount, worthy of consideration.*

108. Not all misconduct or mismanagement will be deemed to be serious. The guidance provides some examples of misconduct or mismanagement that should be seen as serious and would usually amount to serious misconduct (absent exceptional circumstances) which includes fraud, assault, sexual harassment, bullying, victimisation. The CQC also identifies the following can amount to serious misconduct or mismanagement:

(a) Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.

(b) Failure to make full and timely reports to the Board of significant issues or incidents, including clinical or financial issues.

(c) Failure to promote good practice, leading to departure from recognised standards, policies, or accepted practices.

(d) Continued failure to develop and manage "business".

109. The CQC does not identify within its guidance specific examples of when someone would be considered to have been responsible for, privy to, contributed or facilitated any serious misconduct or mismanagement. The guidance (see below) recognises that context is all, and that providers should examine the

services which the organisation provides, the role of the employee and the adverse impact either on the provider, or upon the public services that it provides. The nature of the conduct, whether the action (or omission) of the Director was central or peripheral, or any mitigating factors have to be considered. The Guidance does identify that Directors should be asked in interview or during recruitments processes whether or not they have been involved with or been responsible for serious misconduct and show with appropriate records that they have asked those questions.

110. The guidance identifies that 'responsible for' means that they were one of the decision makers that took decisions which led to the serious misconduct: contributed to it : or took some significant steps or steps which assisted those that undertook the misconduct: facilitated any misconduct: that steps were either taken or failed to be taken which enabled those to undertake misconduct, or privy to them in that they were aware that it was happening and failed to respond to this appropriate. Someone is privy to it if they had sufficient details of the misconduct/mismanagement or ought to have known of them to require appropriate action. Given the wide nature of the drafting of this guidance, I would suggest that context is all, and that it is important to carefully examine the nature of the misconduct carefully alongside the steps which should (but were not) taken and in particular, when someone was privy to such mismanagement, that it would have been reasonable and/or appropriate for a response to have been taken and a clear understanding of what steps should have been taken, but were not.

111. The CQC has produced guidance to provide assistance to organisations and individuals about how they can comply with these Regulations. This provides, inter alia, that when implementing the Regulation, the CQC expects to see:

    (a) Evidence that appropriate systems and processes are in place to ensure that all new and existing directors are and continue to be fit.

(b) That the appointment of existing Directors shall be secured through robust and thorough appointments processes.

(c) That the provider has asked the right questions and asked for relevant information.

(d) If new information comes to light, that the organisation has examined matters in the light of this.

112. I also identify that the CQC is only responsible for regulating activities which are "Regulated" within the meaning of the Health and Social Care Act 2008 and Regulation 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Commissioning care does not include the delivery of care and other clinical services as identified, simply the arrangement of such. Given this, there is ambiguity as to how far actions undertaken outside of a regulated activity can be regulated by the CQC. It is not clear from the drafting of the regulations whether or not Regulation 5 is intended to deal with fit and proper behaviour in the context of regulated activity alone – at least in respect of serious misconduct or mismanagement, or is meant to reflect any serious misconduct or mismanagement. Obviously, some of the other requirements (for example a clean DBS check and /or not being bankrupt) are not dependent upon someone engaging in or having been undertaken a regulated activity when the bankruptcy and/or offending occurred. However, given that the purpose of the relevant Regulations was about creating a culture of integrity and ethics in the context of regulated activity, there may be an argument that it is only conduct when undertaking a regulated activity which is relevant.

113. The Government has published the "Kark Review" [21] in 2018. In it, Mr. Kark QC identifies the limits of the FPPR, identifying that the scheme created in 2014 did not create a "barring" mechanism to stop Directors moving as the Department of Health had envisaged , and the CQC has in fact no direct power over individual

[21] A review of the Fit and Proper Persons Test: by Tom Kark QC and Jane Russell: published 6 February 2019 .

regulations and would not be able to effectively regulate them given its role. The Kark review therefore found that the CQC could not fulfil the Government's policy.

114. The review also correctly (in my view) identifies that the responsibility for assessing the quality and culture of the management team of any Trust should be assessed by the Board of that Trust rather than by an external body, at least at first instance. Mr. Kark also concludes that there has been a systematic failure of the NHS to provide adequate, quality training as to what a Board is, how it works, what good "*looks like*" and independent analysis, support and training of Boards.[22]

115. The Kark review makes seven recommendations including the provision of detailed core competencies to be met by all Board members and relevant training. It also recommends introducing a power to disbar Directors by way of the introduction of a new regulatory body. The Kark review stresses the importance of respect for whistleblowers and recommends that where Directors are involved in deliberate suppression of whistleblowing or the deliberate targeting of a whistleblower, then this should amount to serious misconduct.[23] I cannot find any formal governmental response to this review but have taken Mr. Kark's views into account when reaching my conclusions.

Factual background

116. Mr. Stanton and Ms. Davies rely in particular on the NHSI report published in July 2020. This report was commissioned by NHSI following on from complaints which Mr. Stanton and Ms. Davies (amongst others) made about the Trust's handling of the RCOG report published in 2017.

117. I have no doubt that the Ockenden review would have been relied upon by them had it been published at that point.

[22] See paragraphs 16 – 19 of the Kark review.
[23] Paragraph 10.24 of the Kark review

118. Maternity services at the Trust have been the subject of considerable concern for a long period of time (at least since 2009), which has culminated in the Secretary of State for Health and Social Care commissioning the Ockenden review which reported initial findings in December 2020 and its final conclusions in March 2022.

119. The backdrop to the problems at Shrewsbury and Telford Hospital NHS Trust and the concerns raised there in some ways echo the investigation into the failure in maternity care at Morecambe Bay, which was only published in March 2015, but which covered concerns about Midwifery at that Trust between January 2004 – June 2013.[24] As in Shrewsbury and Telford Hospital NHS Trust, Dr. Kirkup (the author of the Morecambe Bay review) found that the reason for avoidable deaths and poor care was the dysfunctional services at the hospital. There was substandard clinical competence, with a deficiency in skills. Working relationships between obstetricians, paediatricians and midwives were very poor, and there was a move amongst midwives to pursue normal childbirth "at any cost".

120. There was then a failure of governance to notice these problems, and to do anything about them, and a culture of defensiveness, rather than openness.

121. The National Maternity Review of 2016 – Better Births[25] - identifies improvements in the rate of stillbirth and neonatal deaths in maternity care across England, but also that there is not real choice in the services that women can access, and changes in staffing were too common. Moreover, NHS England recognised the variation in quality across maternity services – identifying that often staff in this area do not work well across professional divides. It also identified that when things went wrong, fear of litigation can prevent staff from being open about their mistakes and learning from them.

122. This context demonstrates that:

[24] Available from www.gov.uk website: An Investigation into failings in Maternity Care at Morecambe Bay Hospital, 2015.
[25] Available from the NHS England website , www.england.nhs.uk

(a) All Trusts should have been alive to the possibility of substandard care in maternity services.

(b) The culture of defensiveness and of a failure to work across clinical barriers was well known in obstetrics.

(c) Many maternity services have found it difficult to learn lessons or to undertake adequate internal investigations and so can act "defensively".

Mr. Stanton and Ms. Davies

123. Mr. Stanton and Ms. Davies lost their daughter Kate Seren Stanton Davies on 1 March 2009, six hours after her birth, and sought answers as to why she had died. The Trust did not raise Kate's death as a serious incident and did not undertake a root cause analysis into the standard of care and treatment provided by the Trust in 2009. Following her death, formal complaints were made to the Trust by Kate's parents but were not upheld.

124. The family sought judicial review to obtain an inquest which took place in 2012. This confirmed that Kate's death had been avoidable – because Ms. Davies should not have been permitted to give birth to Kate at the Ludlow Midwife Led Unit given the high risks that were posed to both Kate and her mother, and that allowing Ms. Davies to do so caused or contributed more than trivially or minimally to the death of Kate.

125. An investigation by the Parliamentary and Health Service Ombudsman in 2013 concluded that the death of Kate had been the result of serious failings in care, and criticised the internal investigation undertaken by the hospital.

126. An investigation by West Mercia Police in 2013 did not lead to any charges of manslaughter or corporate manslaughter against the Trust in relation to Kate's birth at that time. There are currently ongoing investigations by the Police into a significant number of neonatal or maternity deaths within the Trust.

127. As a result of concerns raised by Mr. Stanton and Ms. Davies, the CCG which commissioned care from the Trust, stated at its first meeting in April 2013, that it

was concerned about midwifery staffing levels.[26] In May 2013, concern was expressed by both CCG's which commissioned maternity services from the Trust as to the maternity services model which it operated. This included concern about the number of serious incidents which had taken place in midwifery care. In July 2013, a CCG review of the Trust stated that there needed to be an external review of maternity services because of concerns. A report was published by the CCGs in October 2013.[27] This was broadly positive about safety and the level of care provided between 2012 – 2013, whilst finding a shortage of midwives and consultant obstetricians.[28] The Ockenden reports comments that given the failings in the lack of incident reporting, low levels of SI being declared (all SI's should be examined by CCGs), poor quality RCAs and investigations where lessons were not learnt, it "begs the question as to whether the CCG review process was fit for purpose". [29]

128. In March 2014, the Trust was reviewed by the NHS Litigation Authority and awarded Level 3, its highest standard under the Clinical Negligence Scheme for Trusts - being benchmarked against the need to demonstrate good leadership and an open culture, which again would not have suggested to the Board given this that there were significant problems[30]- but there was some suggestion that the board were told in 2014/15 that the information provided and sent to the NHS Litigation Authority was not evidence based (paragraph 5.8 - 5.9 of the Ockenden review). Given this, a board may have wanted to have been on "high alert" to ensure that all further information was correct and that the evidence base was appropriately checked.

[26] Taken from Telford and Wrekin CCG, Minutes of Governing Board Meeting 090413, p4: https://www.telfordccg.nhs/uk/who-we-are/publications/ccg-governance-board/governance-board-papers 2013/may-3/444-03-ccg-board-minutes-9-April-2013-v1/file.
[27] https://shropshireccg.nhs.uk/media/1197/maternity-services-review-mar-report-281013.pdf.
[28] P5 – 6 of the 2013 report.
[29] Paragraph 4.42 of the March 2022 Ockenden review.
[30] Information about this taken from paragraph 5.8 of the March 2022 Ockenden review).

129. Mr. Stanton and Ms. Davies, following two unsuccessful complaints made as set out above in 2009 and 2012 about Kate's birth, complained again to the Trust in 2015. In 2015, The Trust:

(a) Apologised unreservedly for the failings identified in the Health Service Ombudsman investigation.

(b) Acknowledged service failures

(c) Acknowledged failings in the complaints handling process of the Trust.

In the same year, NHS England found that the original investigation carried out by the Trust into Kate's death was not fit for purpose. This was material as from Kate's birth until that point, the Trust had used the findings of the original investigation to respond to complaints and concerns by the family – and so had been opposing or refusing to accept failings on the basis of a report which was deficient. The original investigation report was palpably inadequate and was used as a defence of the care provided – when it should not have been. This provided the backdrop for the relationship between the Trust and Ms. Davies and Mr. Stanton when they were, in reality, not listened to and the wider Trust considering that the findings of the review had been independently validated, when the report, was not, in fact, independent. This was not the only inadequate investigation report - the Ockenden review notes a substantial number and finds that inadequate serious incident reports and failing to undertake such reports were a persistent and critical problem at the Trust.

130. Following these critical reports, an independent review was published by Debbie Graham, an independent reviewer, in November 2015. This was commissioned by the Trust Chair, and the report was then published by the Board, even though it was very critical of the Trust. Ms. Graham found that:

(a) The Trust failed to fulfil its responsibility to establish the facts of the case, abdicating its responsibility to a supervisory authority which was not accountable to the Trust.

(b) There was a disconnect between clinical governance processes as published and what happened on the ground which "*prevented clinical governance activity from being embedded into the culture of the organisation*".[31] This led to a failure to carry out sufficient independent and rigorous analysis of the death of Kate, and so, until 2015, no staff were held accountable for the standard of care and treatment provided by the Trust.

(c) The responses to the letters of complaint showed a Trust which did not put Kate or her family at the centre of their response, did not address the issues raised by the family and contained factual inaccuracies.

(d) There was a failure furthermore to co-ordinate between the different organisations involved with the case.

(e) The failure to carry out an adequate investigation in 2009 meant that lessons were not learnt appropriately, and it was only with the 2015 review that further concerns came to light.

(f) Nine recommendations were made about changes to the Trust's policies and practices, but also about the conduct of a particular midwife.

131. The report of Ms. Graham identifies that in 2015, there had been considerable improvements in the provision of maternity services and the strengthening of the clinical governance and complaints processes, in particular the development of advocacy roles.

132. The midwife involved in Kate's care was barred from practice by the Nursing and Midwifery Council in 2018.

133. Further media interest and the discovery of further concerns around a significant number of births at the Trust led to the commissioning of the Ockenden Review by the Secretary of State for Health and Social Care in 2017. The emerging findings of this review, based upon an assessment of 250 cases was published on 10 December 2020 and its final report published on 30 March 2022. I summarise its concerns as far as they touch upon governance or oversight below. There are

[31] Conclusions of Debbie Graham, p3/4 of her report November 2015.

approximately 1,862 cases being examined by the review – the largest review of maternity care ever undertaken.

Review of Maternity Services by the Trust

134. In June 2017, the Trust conducted an internal review of maternity services between 20017 – 2017.[32] The report concluded, inter alia, that all patient safety actions should be in one plan, there was a need for the Trust to create a co-ordinated approach to the maternity safety improvement plan: and that safety in maternity must be protected by the efforts of the staff and supported by leaders.[33] The Ockenden review notes that despite this internal review indicating that the maternity service should "create a coordinated approach to the maternity safety improvement plan" , no plan had ever been provided by the Trust to the review team or seen any evidence of its existence. [34]

The RCOG review – 2017, the Addendum Report and The NHS Improvement Report of 2020.

(1) Background to the commission of the report and surrounding circumstances.

135. The RCOG review was commissioned by the Trust and started in March 2017. Its remit was to examine the current adequacy of its maternity service. It was undertaken, at least in part, in order to reassure the local population and media that services were of an acceptable standard.[35] The suggestion for the review was made by the Medical Directors of the Trust with the approval of NHSI. It does not appear that there was any Board oversight of this suggestion at the time from Non-Executive Directors or the Chair – but the Medical Director was involved as was the Chief Executive. There was no common agreement as to what it was meant to achieve:

[32] https://www.sath.nhs.uk/wp-content/uplads/2019/12/170629-08-Safety-of-Maternity-Services-2007-17-final-version-June-17-pdf.
[33] 2017 report, p28.
[34] Paragraph 4.26 of the Ockenden final report, March 2020.
[35] Taken from Executive Summary of NHSI report, July 2020, p5.

(a) Some saw it as a chance to get a professional view as to what the Trust was doing.

(b) Some saw it as a chance to learn (this was the view of the then Medical Director at NHSI).

(c) Some viewed it as a chance to publish information to show that the Trust's services had improved.[36]

136. The NHS Improvement report of 2020 ("NHSI") notes that at the time of the RCOG visit and report, staff felt that they were under significant pressure – with high levels of sickness relating to stress – which the NHSI report stated further that "*the degree of scrutiny has influenced behaviours and decision making over the period in question.*"

137. The visit of the RCOG also coincided with very poor Accident and Emergency performance during the winter of 2016/17 and a proposal to close Accident and Emergency at Telford. Alongside this, the Trust was engaged in a long-term process (still ongoing) alongside the CCGs to restructure the Midwife Led Units given concerns raised about their safety. NHSI describes the Board as having "*several priority areas to consider*" with "*executives under pressure on multiple fronts*".[37]

138. A culture of "*defensiveness, denial and/or lack of openness within the maternity services*" was described by NHSI about a number of individuals during 2017.[38]

139. The visit of the RCOG happened in July 2017, and a draft report for comment on any factual inaccuracies was sent on 9 October 2017 to the Trust. Members of the maternity management team were unhappy with elements of the draft report, considering that criticisms were not supported by evidence or were internally inconsistent – leading to a response to the report by the Trust of some 17 pages. This response was described as "*counterproductive*" by NHSI in their report of July 2020. However, NHSI considered that the concerns raised were "*genuinely*

[36] NHSI report, p9.
[37] NHI report, p8
[38] NHSI report, p8.

held" and the concerns expressed were not an attempt to delay the publication of criticism or to create a negative impression.

140. The RCOG responded on 12 December, revising some minor aspects of the report, but standing by its initial assessment, which it says was based upon evidence of staff concerning serious incident investigations and a failure to learn lessons from such.[39]

141. NHSI in their report found that it was reasonable for the Trust to respond in the way that they did until December 2017. The Trust had genuinely held concerns about the balance and language of the report, given the level of media scrutiny which the Trust was under.[40]

142. However, it finds that the actions of the Chief Executive and senior maternity management was wrong, and that they should not have said that they "*could not accept*" the document as a final version. The report also criticises the view expressed from December 2017 by the Trust that the RCOG had not dealt with the concerns about accuracy: they had done so but decided not to make changes. There were telephone calls between the RCOG and the Trust in January 2018 where the Trust indicated that they would not sign off the report. The RCOG made it clear that this report was completed, and their expectation was that it should be reported to the Board.[41]

143. Following on from this, the Trust's position altered so that it accepted the content of the report, although they had concerns with its context and tone. A face-to-face meeting was held with the Director of Nursing, the Care Group Medical Director and the RCOG to set out their concerns. RCOG rejected any changes.

144. The NHSI report did not find that the Trust exerted excessive pressure on the RCOG or asked them to remove facts. However, these requests for changes led to delay in scrutinising the report.[42]

---

[39] NHSI report, July 2020, p10
[40] NHSI report, p11
[41] NHSI report p11.
[42] NHSI report, July 2020, p12.

145. I have been given context by Board members that between January – June 2018 there were concerns about unpleasant behaviours towards members of staff outside the workplace by individuals, which had made them worried and frightened. Some Executives had received threatening messages. There were a number of people off work with work related stress.

(2) Context for Mr. Reid.

146. Mr. Reid has provided me with some information which he considers to be relevant to the context of the complaints. In particular, he says:

(a) He was appointed in February 2018 as a part time Chair, without any executive authority.

(b) He was not given any briefing on the main issues he would face.

(c) He had no knowledge of, and was given no advance warning as to, the quality of the Executive and Non-Executive team.

(d) Upon his arrival he found a Trust in crisis. As is noted in the NHSI report of July 2020, immediately upon Mr. Reid's arrival the Trust was rated extremely poorly for Accident and Emergency (Mr. Reid says the worst Trust in the country). They had half the doctors necessary to staff the Accident and Emergency Department and 200 nursing vacancies. Eight of the most experienced nurses resigned in March/April 2018 as a result of the pressure they were under. The CQC placed an enforcement notice on the Trust. He says that this was only one of several critical issues that had to be faced during his first few months of leadership. The serious safety issues in Accident and Emergency would have required an immediate response and it was a "real challenge" according to Mr. Reid to grasp these issues.

(e) Whilst he did know of the RCOG report, he considered that as it was a report commissioned by the Trust for itself, and that it did not come from a regulator, then there was no concern with it progressing through the

governance system at the pace at which it did. He says that the report has been used to drive forward improvements. He says that:

> *"It is hard to see how, with the fundamental issues that I was facing from day one, any newly appointed chair would have acted any differently."*

147. Mr. Reid identifies a number of actions that he says he took to "challenge" and to seek to change the culture at the Trust. He acknowledges that the Trust needed to change the culture. This included:

(a) Recognising that there needed to be a complete shift in culture at the Trust, and that he sought to meet all senior clinicians to seek to establish what could be done to achieve real change – he says that these meetings took place informally and "off the record" given the poor staff morale at the time.

(b) That he sought to address the culture in services in the Trust by taking steps to review the current senior Executives, and worked with and engaged NHSI to change some of the Executive members of the Board to seek to change the culture. This process takes time but was seen by Mr. Reid to be changing by the time that he left the Trust.

(c) He worked with the then Chief Executive to create a new Vision and Values in 2020.

(d) He sought to seek to have reinvestment and to prioritise patient safety over finance – but this would take time. He was responsible for the recruitment of more midwives and the recruitment of more staff generally.

(e) He sought to amend the culture of the Trust more broadly by creating a Workforce Committee and appointed a Non-Executive Director to chair this who was an academic expert in the field.

(f) He took on the Board role of "Freedom to Speak Up" – and sought to have individuals charged with performing that role to go into the maternity service so that those issues could be discussed.

(g) Contacted the Chair of the Morecambe Bay Trust to learn from their experiences – which led to the setting up of an External Expert Advisory Panel to provide oversight of the Maternity Improvement Plan – and which has been useful to provide adequate governance. This External Panel had other leading experts in maternity services, including the NHS England Deputy Chief Midwife. The rationale for this panel was to ensure that any improvements were subject to external scrutiny and to provide assurance to everyone.

(h) He chaired the MOC so that there could be "direct" assurance with the Board. He accepts that it made a "slow start" as he struggled to get senior clinicians to prioritise attendance – but he sought as the Chair to use his leadership to ensure that this happened, and progress "started to be made".

(i) The RCOG report was not ignored, but the MOC recognised that the positive progress reported by the Maternity team was not materialising and that a "more holistic" approach was needed – hence the creation of a Maternity Action Plan. This therefore meant that the issues raised by the RCOG were subsumed into the Maternity Action Plan – which may well mean that the work taking place does not look as "visible" in notes and minutes of meetings.

(j) As Chair, he asked for NHSI to carry out a "deep dive" into clinical governance processes within maternity. This resulted in a report written by an individual within NHSI dated October 2018 which identified considerable work to do. As a result of this, there was scrutiny of serious incidents including a weekly executive meeting to discuss scrutiny and feedback with the maternity team.

(k) He insisted on recruiting 18 further midwives despite the poor financial performance of the Trust, and as a result of understanding that the actual staffing levels were too low.

(l) Led and ran the wide debate around the shape of the Maternity Service and whether Midwife Led Units should exist. This may not have been labelled as something directly arising from the RCOG report, but the debates and discussions were linked to the quality of service – and the Midwife Led Units were closed so that the service could be strengthened. This was a direct action to seek to improve patient safety.

Other Board members have written to indicate that they found Mr. Reid to be "thoughtful", decisive and committed to turning around the Trust.

(3) The role of NHS Improvement

148. Mr. Reid and other members of the Board have alerted me to the role of NHSI during this period of time, something which does not necessarily come across very clearly in the NHSI report. My understanding from Mr. Reid and others is that NHSI were involved in working with the Trust during this period of time. There were two NHSI Improvement Directors attached to the Trust, at least during 2019 and into 2020.

149. The Trust was working with NHSI about how to best communicate the RCOG report and taking advice from them about how to publish the report. Taking advice about this from NHSI would be routine if they were already involved with the Trust, and would also be necessary given that there was a national focus upon this Trust and maternity services. Mr. Reid identifies that NHSI did not mention during 2018 that the original report should be published immediately, nor did they suggest this as an action. The NHSI Improvement Director, and NHS England were involved in discussions between January – March 2018 about publication of the report, and none of them suggested that the report should be published earlier than March 2018.

150. Mr. Reid also remembers (as do other Board members) that in 2018 they were invited to speak with NHSI and discussed all the key issues facing the Trust – and there was no criticism of how the Trust handled the report at that time.

151. Several of the Board members during the 2018 – 2020 period noted that whilst NHSI was involved, there was a view that they could have provided more support and to have had people from NHSI directly involved to "do" rather than just to "monitor". There was a feeling that insufficient support was given from the centre.

(4) The Addendum RCOG report

152. The Trust wanted the RCOG to undertake further work and have a follow up exercise to demonstrate improvement in their services. The RCOG agreed in April 2018, to a meeting between Trust senior staff and the RCOG. Trust staff set out what they had done to comply with the concerns raised by the report. An action plan devised by the Trust setting out how concerns were being addressed was provided to the RCOG.

153. The RCOG told NHSI that "*The Trust had done a lot of work, put in a significant effort and made genuine improvements. Trust attendees felt that verbal feedback was positive, and acknowledged material improvements.*"[43]

154. The original intention of the Trust was for RCOG to carry out an ongoing monitoring role at the Trust. The RCOG did not wish to undertake this work. The rationale, according to NHSI, for any supplemental report from RCOG from the perspective of the Trust 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*."

155. A letter was provided by the RCOG to the Trust summarising the conclusions of the meeting held between them. This was very positive in tone. An addendum report was then provided by RCOG on 20 June 2018 (some 2 months after the meeting). The final version was received (following Trust comments put in quickly and according to NHSI none of which were "inappropriate") on 28 June 2018 and the document was presented to the Trust Board meeting held in public on 5 July 2018.

[43] NHSI report, July 2020, p13.

156. NHSI[44] considered that the following were concerns about the way that the RCOG report was presented to the public.

(a) The report was only published seven months after the final report was sent to the Trust. The reasons given by various individuals to NHSI for not publishing either did not stand up to scrutiny or were that staff morale was poor so that publication of the main report before the addendum was seen as being damaging to them.

(b) The addendum, report (which could not have provided sufficient assurance that the service had altered significantly) was placed before the main report.

(c) The cover paper which accompanied the RCOG report was written in a way to reassure the reader, rather than to provide a balanced picture of positives and negatives, and the key findings summarised from the addendum presented only the favourable conclusions.

(d) The transparency of the full picture should not have been compromised by a cover paper which was not balanced.

(e) The need for candour is heightened when a Trust is under particular scrutiny.

157. NHSI concluded that the RCOG report was not changed, and so the issues were set out in it. The inclusion of the addendum "*certainly reduces the impact of the initial repor*t" but finds that it was "*relatively common practice for an update demonstrating genuine improvements to be added*."

158. Its conclusion as to the delay was that it was a "*finely balanced judgement*". The NHSI indicate 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.

Board oversight as set out in the NHS Improvement report.

[44] NHSI report, July 2020, p22.

159. The NHSI report sets out in some detail the chain of events concerning oversight and governance leading to the report being presented to the Board in July 2018. Their concerns and criticisms are:

(a) The Women and Children's Care group was governed by its own Board (there were four clinical care groups which made up the organisational structure of the Trust at the time). One of the governance fora that fed into the Care Group Board was called the Maternity Governance meeting. Neither the draft nor final reports were presented to either of these fora until after they were received by the Board in July 2018. Members of the Women and Children's Care Group Board and Maternity Governance meeting did see the report and were working to address the recommendations – but NHSI states that the report should have been examined by them, before going to the Quality and Safety Committee of the Trust.

(b) The maternity management team had only very limited awareness of how the Trust Board or relevant Committees were looking at the report. NHSI stated that they would have expected senior managers to be more aware of how a report highly relevant to them was being scrutinised by the Board and its committees.

160. In respect of the Board, NHSI makes the following points:

2017

(a) The Board was informed in April 2017 that the RCOG had been commissioned to review maternity services and that the report would come to a Board meeting held in public. The Quality and Safety Committee (a committee of the Board) was also informed of the review.

(b) In November 2017, a private Board meeting heard an update. That update identified that the draft report had been received: and comments had been sent to the RCOG. The Medical Director identified that the Executive

Summary needed to be changed (from the Trust's perspective) as it was not a fair reflection of the report.

(c) NHSI identify that at that time, the minutes do not show the Board asking as to:

- The key findings of the review or
- What action needed to be taken as a result.
- No patient safety concerns as outlined in the report were discussed.

The focus was upon how the report was to be handled and dealt with in respect of the public and the media.[45]

February – March 2018

(d) The Board received further updates about the report in February and March 2018 with reference to a "final draft" having been received, and there was discussion of the planned meeting with the RCOG in April 2018. The report was not presented to the Board in either of those meetings.

April 2018

(e) The Quality and Safety Assurance Committee (QSAC) received the report at its meeting in April 2018, in advance of the addendum report. This was alongside an action plan. The minutes, (according to NHSI and with which I agree), show a reasonable level of questioning and challenge in relation to the findings and the proposed actions. NHSI concludes that the evidence refutes the notion of any attempt to conceal the report from the Board prior to positive assurances being received from the RCOG in respect of the progress made.

(f) NHSI did criticize the failure to place the RCOG report before the Quality and Safety Assurance Committee before April and identified that the report could have come to the January 2018 meeting. It describes it (p16 of the NHSI report) as a "*delay in the Non-Executive scrutiny that a report of*

[45] NHSI report, July 2020, p16.

this nature clearly required." It also identifies that although other strands of work were ongoing to improve services, NHSI considered that this work did not objectively justify the delay.

(g) It also identifies that there was no reference in the May 2018 Board minutes to the RCOG report or the associated action plan although it did refer to related maternity issues, and there was no discussion of the RCOG report in the Board meetings in private or public, or in the summary which goes from the QSAC Chair to the full Board, which is meant to be a summary of the discussions of the April 2018 meeting.

(h) There was no discussion in May 2018 at the main Board meeting about the detail of the report or the discussions held in the Quality and Safety Assurance Committee, despite there being discussion of the RCOG report and the follow up letter. NHSI identify that the discussion held at QSAC was worthy of escalation to the Board <u>at this time</u>, given the criticisms in the RCOG report and the degree of scrutiny already on the maternity service.

(i) Board members did not challenge the approach taken, nor the timelines of receipt by the Board. NHSI identifies certain mitigating features, namely that:

- The Chair had only started in post in February 2018 and did not have the full context or details of the RCOG review.
- The Board had other areas of significant focus, including configuration of the Midwifery Units and the performance of Accident and Emergency.

161. The NHSI report also raises concerns about the timing and consultation about the Action Plan produced by the Trust in response to the RCOG report. It identifies that from October 2017 onwards some actions were taken (shortly after receipt of the report) and an action plan was formally devised from January 2018 onwards. These were collated and stored by the Care Group as actions were

completed. There were meetings more frequently than monthly[46] from January 2018 – May 2019.

162. The action plan was presented to the Maternity Group Meeting in April 2018, but was not sent to the main Board in full at any point – the Care Group Board received only a summary report of action progress, but this did not:

(a) set out which actions were complete

(b) highlight risks or mitigation as NHSI would have expected.

163. The action plan did go to the Quality and Safety Assurance Committee in April 2018. The plan showed a number of outstanding actions at this point, all of which were set out as "on track to deliver". Despite this, the plan did not go back to the Committee for regular scrutiny to see if the action plan had been implemented.

164. The action plan was not scrutinised again by either (a) The Maternity Group or (b) the main Board until June 2019. The NHSI report says that this "*was not an acceptable level of quality of governance*".

165. Furthermore, as of June 2019, there were ten actions which were said on the action plan to be "*not on track*" which included those relating to the Midwife Led Units and its operating model – something which is still ongoing.

166. The plan devised in response to the RCOG report identified that it would only be reported to the Quality and Safety Assurance Committee, "*by exception*". This was not defined. NHSI says that given that there were overdue actions between 2018 – 19, these should have returned to the QSAC or referred by them. NHSI were concerned about the lack of ongoing scrutiny of the actions designed to address RCOG's recommendations, particularly given that they referenced patient safety issues in their report.[47]

[46] The minutes I have seen show at least monthly meetings

[47] NHSI report, July 2020, p18.

Report of NHS Improvement, October 2018

167. A report was produced for the Trust by NHSI in October 2018 following a request by the Chair, Mr. Reid, to undertake a "deep dive" into the clinical governance procedures at the Trust. Not all aspects were reviewed: once "areas of concern" were identified, then there was a "move to improvement". The reviewer found areas of good practice, and improvements being made in respect of governance by this stage. A detailed set of findings were made which identifies both strengths and areas for improvement, and which then sought to identify overall "trends" which could then be worked upon. These "trends identified" included:

(a) No robust implementation of Datix management guidelines, or those of the Trust.

(b) Action plans not Smart.

(c) Poor recording of meetings discussing incidents.

(d) Poor senior attendance at Care Group and Executive meetings.

(e) Use of risk register poor.

(f) Grip on action plans poor

(g) Poor audit process implemented which will not support clinical engagement.

(h) Lack of professional curiosity during review of incidents.

168. There were a series of positive actions also seen during this time.

169. It should be noted that a number of the deficiencies identified in this report , which dealt with clinical governance at the Trust as a whole, are reflected by Ms. Ockenden in her view of the sample of maternity cases she reviewed from 2018/2019 from the Trust to demonstrate improvement in their

investigation processes. [48]In that case, she still found that local investigative processes and governance needed to improved by :

(a) Consistent staff groups and senior staff attending rapid review meetings to decide on whether a SI was required:

(b) Lack of oversight or accountability from the Director of Midwifery and Clinical Director of Obstetrics or lead on "risk"

(c) Reluctant to declare a serious incident and undertake that investigation.

(d) Actions did not always correlate with the findings of organisations.

(e) No evidence that action plans were reviewed by the senior leadership team (although they were by the quality improvement midwife) with some concerns about the expertise of those who were responsible for quality improvement at the Trust.

(f) Significant delays in completing cases in 2019.

(g) Families not actively involved or empowered to contribute to investigations.

CQC report 2018

170. The CQC reported in November 2018, following visits in July and August 2018.[49] They noted continuing issues and concerns which had been reflected in the RCOG findings from the report of October 2017 namely:

(a) Poor evidence of learning from serious incidents

(b) Issues with governance.

(c) The Trust's rating for leadership was inadequate for a number of reasons. Many of these reflect the concerns expressed by Mr. Stanton and Ms. Davies and others. This included:

[48] Paragraph 4.44 of the Ockenden review, March 2022.
[49] Found at www.api.cqc.org.uk/public/reports/2dc4410-3977-4fdf-bf2b-8362acc2040d2021011506033

- Not all the Trust leaders had the right skills and abilities to run a service providing high quality sustainable care.
- Leaders were not visible and did not work together as a cohesive team.
- Trust staff did not have confidence in all members of the Executive team.
- The strategy and plans focussed upon the long term, rather than the short term with a lack of clinical strategy that engaged services across the Trust.
- Whilst there was a policy in respect of Fit and Proper Persons checks, to ensure compliance, there were gaps in all the seven Board member files that were reviewed.
- There was a culture of defensiveness from the Executive team.
- Governance systems were ineffective to ensure that quality services were provided.
- The Board assurance framework lacked clarity and coherence. There was a lack of accountability and ownership of patient safety agenda at Board level.
- The disjointed approach of the leadership team and ineffectiveness of systems meant that the Trust did not maximise opportunities to learn and improve.

171. The overall rating for the Trust for the leadership of services was seen as inadequate, as was safety. The effectiveness and responsiveness of the Trust was seen as requiring improvement. In respect of leadership, two services at Royal Shrewsbury Hospital (RSH) and two at the Princess Royal Hospital (PRH) were rated as inadequate for leadership and many were rated as required improvement.[50] The CQC did note that there had been a demonstrable and

[50] CQC report Nov 2018, p4

sustained drive to improve the sensitivity of delivery of care. The Trust was in particular asked to (in respect of issues of governance and management):

(a) Ensure compliance with the requirements of the fit and proper persons regulations (FPPR - Regulation 5).

(b) Ensure the effectiveness of governance arrangements and that the Board is "*consistently informed of*" and sighted on "*risks*".

(c) Take account of the RCOG review of current practice when released and formulate action plans to improve maternity services. It is not clear why this is drafted in this way as the 2017 report had been provided by the time of the CQC inspection in August 2018.

(d) In maternity, the following actions were to be taken:

(a) Ensure that there is proper assessment of need for patients using a midwifery unit and that they give birth in the correct area according to their assessment of risk.

(b) Ensuring mandatory training in various areas – including CTG training

(c) Ensure handovers are completed regularly and that high-risk women in labour are reviewed by medical staff, and that they are reviewed by the correct number of staff.

(d) Make sure that the correct number of anaesthetists are employed

(e) Ensure that community midwives are carrying the correct equipment.

(f) Ensure that grading of incidents reflects the level of harm.

(g) Ensure that the Head of Midwifery has direct access to the Board in line with "Better Births 2016".

(h) For the PRH, ensure that staff are aware and can explain learning from serious incidents and complaints.

(i) For the PRH, ensuring that the Executive team are visible and supportive during challenging times.

(j) For the PRH, ensure that all risks within the maternity services are added to the risk register.

172. Maternity services at the RSH were rated as required improvement for effectiveness and responsiveness, but at the PRH were rated as good. The CQC did find some examples of outstanding practice in maternity care at the PRH.[51]

173. Despite these extensive concerns, the CQC still found that the Trust collected and analysed information. It was committed to improving services. It engaged with patients to plan services, and the Chair and some of the Executive Directors acknowledged that "*work was required urgently to address the Trust culture and there was a vision for where the Trust wanted to be*". The CQC also identified that the Trust had appointed a maternity safety champion in line with the national recommendation following Better Births. Maternity issues were discussed in Board meetings, although not by the Head of Midwifery but with representation by the Director of Nursing.

174. NHSI identify that[52] one reason why the actions did not have impact was because the evidence of completion was judged to have taken place when a process had been put into place, rather than by measuring the outcomes of those processes.

The Open Book Review – 2018.

175. This was a review undertaken by the Trust with support by NHSI and NHS England into a review of electronic and paper records of stillbirths, neonatal deaths, issues of hypoxia in birth and maternal deaths. An electronic review took place in October 2018. I have seen this review. A further review took place in July 2020 including looking at the paper records – which included referral by the Trust of 750 incidents of poor outcomes between 2000 – 2018, which were then referred to the Ockenden review.

[51] CQC report, Nov 2018, P6.
[52] CQC report, P19

Other views about management and governance of the Trust 2019

176. Other Board members have provided information to indicate that the Executive Team (meaning the Chief Executive and other Directors) produced a report in November 2019 about making changes including making the actions of the Trust more transparent and candid – and that this was shared with the full Board and NHSI at a "risk summit" which took place in November 2019.

177. Those in positions of executive responsibility in charge of Nursing on an Interim basis in 2019 identified that they took steps to try and secure sustainable solutions to the staffing crisis through work with NHSI, Unions, the Royal College of Nursing, the Nursing and Midwifery Council, the CCG and others, and that steps were taken to have monthly open meetings with nursing staff to enable them to share views and concerns (although the Ockenden report [53] said that it was not clear that all staff were enabled and encouraged to attend).

Maternity Oversight Committee

178. The Maternity Oversight Committee was set up in March 2019 as a Board Committee, which met monthly. It was chaired by Mr. Reid. This Committee was created, says Mr. Reid, to make sure that relevant plans were being followed up. The Group was set up because of concerns by him that actions were not being implemented to improve the service adequately.[54] He says that when he became aware of staff shortages, he took steps to change them.

179. So, to give an example, he visited the maternity unit in early 2019. Midwives working on the unit said that the reports did not reflect the reality of the levels of staffing or the service they could provide. Mr. Reid says that he was not aware that 18 midwife posts had been frozen to balance the Nursing budget.[55] As a result of this, he raised recruitment with the Chief Executive, and then the additional recruitment was agreed by the Board. He considered that the

[53] At paragraph 4.43)
[54] E-mail from Mr. Reid, 15 October 2020.
[55] E-mail from Mr. Reid, 15 October 2020.

fundamental weakness in the position had not been fully disclosed to the Board. It was this that prompted him to set up the MOC so that there could be direct scrutiny of what was happening.

180. Mr. Reid further says that when he set up the MOC:

(a) He had to get a thorough understanding of what the problems were and the scale of them.

(b) They uncovered a series of previous issues that they had been "unsighted" on and that this could create the impression that things were getting worse.

(c) He says that this was not the case, but that there needed to be development of a base line against which to assess progress.

(d) He says that real progress had been made, with a complete change in both clinical and general Management.

(e) The Key Performance Indicators of the Care Group showed that there is appropriate supporting evidence to demonstrate improvement.

(f) The Board were hopeful that the rating by the CQC would be "good".

(g) The MOC, he says, has made a significant difference to the performance of the care team.

181. From some of these meetings, it would appear, at least at the start of the MOC, there had been a lack of attendance and a failure to provide papers.[56]

182. I have seen some summaries of the MOC meetings from 2019 and 2020. The summaries simply identify the overall nature of the issues which were discussed, rather than providing a detailed nature of the discussion.

183. The overall summaries suggest that the Committee:

(a) Looked at risk reports.

(b) Examined projects concerning maternity services.

[56] Maternity Oversight Committee Meeting, 11 March 2019.

(c) Examined perinatal mortality.

(d) Examined patient safety

(e) Examined the provision of additional staffing.

(f) Looked at how and if culture improvement measures within the maternity units had taken place.

184. Discussions were held, on at least some occasions, about the problems with staffing, the need for cultural change and the need for senior leadership in Midwifery as several individuals left the Trust in early 2019 (Head of Midwifery, Director of Nursing and the Deputy Director of Nursing).[57]

185. The RCOG report is only discussed in the June 2019 meeting where it was noted that an updated RCOG paper had been received with approved actions which were completed.[58] Other issues related to patient safety were discussed at meetings, but there appears to have been no "standing" agenda item to look at the RCOG report actions and comment upon their updates or elsewhere. Some of those issues would have been covered when discussing, for example, staffing of the obstetric service.[59]

186. It is impossible from these summaries to divine the level of scrutiny or discussion that took place at them.

Board oversight 2018 – 2020.

187. There are some papers sent to the Board between 2018 – 2020 which suggest that maternal safety was discussed. For example, in January 2019 there was a maternity dashboard provided to the Board which was the subject of discussion. I set out below the NHSI's concerns about the relative paucity of oversight from the Board overall, which I share.

[57] Maternity Oversight Committee Meeting, 11 March 2019
[58] Maternity Oversight Committee Meeting, 10 June 2019.
[59] See summary 9 September 2019.

188. The NHSI report identifies the following concerns about the planning and action taken after April 2018:

(a) The MOC only received a brief summary update in June 2019 – but this was at the request of Mr. Reid, the Chair.

(b) Ten actions were described as "not on track" – again Mr. Reid in this meeting asked for details of any obstacles to completion to be brought to the following meeting – this does not seem to have happened and there was no update at future meetings.

May 2020 internal review

189. In May 2020, the Women and Children's Care Group undertook an internal review of the action plan following the RCOG report. The findings (which were authored by the Director of Midwifery and Care Group Director) were:

(a) Some of the actions would not have properly addressed the associated RCOG recommendation even if fully implemented.

(b) The evidence files kept by the Trust relating to the recommendations did not always contain relevant evidence showing either (a) the actions or (b) the recommendation.

(c) Out of 37 actions set out following the report, 22 had been addressed, 11 were only partly achieved and 4 were not achieved.

(d) The governance processes for the action plan were not "robust", and there was not proper sign off processes for actions being recorded as "delivered".

(e) 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.

Recommendations and action

190. The NHSI report made 3 recommendations. The Trust responded to these with actions in every case.

Recommendation One

191. The Board should satisfy itself that the governance issues have been addressed, including the flow of information from local to corporate governance forums and the ongoing oversight of action plans.

192. Trust response:

(a) A revised governance process throughout the organisation, including review and revision of the Assurance Committees.

(b) Introduction of a Leadership Committee to strengthen decision making

(c) Introduction of a Transformation Committee

(d) Introduction of an executive-led Maternity Quality Committee, to review and challenge delivery of quality actions prior to consideration at the assurance committee.

(e) Clearer lines of accountability in any oversight and assurance.

(f) Introduction of a new Performance Management Framework.

(g) Introduction of processes for the management and dissemination of evidence for assurance.

(h) Reviewing the governance processes in Care Groups by the Chief Executive (who came into post in 2020).

(i) New leadership team in the Care Group put in place from November 2019, including a New Director of Midwifery and alterations at Clinical Director level.

(j) Development of a Maternity Improvement Plan to incorporate all action plans from local and national reports and reviews with oversight from the new committees set out above.

Recommendation Two

193. The Board should satisfy itself that the actions arising from the RCOG report are complete or are no longer required and have made a difference.

194. Trust Response

(a) It shall review the RCOG actions as part of its Maternity Improvement Plan.

(b) Actions which are not on track are being reviewed, amended or updated and subject to ongoing monthly monitoring.

(c) Improvement to the service have been evidenced through the improved ratings in the most recent CQC inspection

Recommendation Three

195. All actions from a variety of reports are included within one Maternity Improvement Plan to ensure oversight in one place (and avoid overlaps or duplication).

196. Trust response:

(a) Development of more formal transformation programmes with six work streams. All maternity related plans shall be assigned to a stream, enabling a thematic review to be taken.

Deloitte review – 2020: Maternity Incentive Scheme review

197. Deloitte, who are, inter alia, a firm of national management consultants were asked, as part of a larger piece of work on risk-based performance reviews undertaken for the Trust, to examine how the Trust had submitted self-certifications about maternity safety for 2018/19 and then 2019/20. In effect, if the Trust could certify that it had met a number of maternity safety actions, it would receive a diminution in the premiums it pays to insure itself against claims concerning obstetric and maternity related negligence, as part of NHS Resolution's Clinical Negligence Scheme for Trusts (CNST). The 2019/20

declaration was made following Board approval in August 2019. This certification turned out to be incorrect and, following a query from NHS Resolution (the body which oversees the insurance and claims arrangements for NHS Trusts) and a review of evidence, the declaration for 2019/2020 was withdrawn.

198. NHSI and the CQC know of this concern. This review includes examination of governance processes from the Care Group to the Board and the level of scrutiny by the Executive team, and how far the Trust Board knew of those declarations – including the depth of information provided: quality of assurance: and rigour of debate and the role of the MOC.

CQC report – 2020

199. The most recent CQC report was published in April 2020, following visits in November 2019.[60] This included maternity care at the PRH – but not the RSH. The CQC also carried out what it called a "*well led*" review in 10 January 2020, interviewing Board members, and the Executive team. They also asked staff about leadership and governance, looked at reports, audits, minutes, feedback.[61]

200. This latest report found that maternity care at the PRH required improvement, and the hospital overall required improvement. The RSH was rated as requires improvement for leadership and PRH as inadequate. There were 75 things that the Trust had to comply with following this report but which were not serious enough to justify regulatory action.

201. The CQC issued nine requirement notices to the Trust, and issued eight new conditions of registration, and varied two existing conditions. They also issued a warning notice[62] – a precursor to regulatory action, so that if steps are not taken, then enforcement action would follow. General improvement in governance

[60] CQC report, April 2020.
[61] CQC summary of findings, April 2020.
[62] S29A of the [Care Standards Act]

and risk assessments were identified.[63] The RSH maternity service was not examined, but for those at PRH, there was still identification of:

(a) Ensuring that high risk women are reviewed by the correct member of staff.

(b) That grading of incidents reflects the level of harm.

(c) That the senior leadership team has processes for governance and oversight of risk and quality improvement.

202. All of these were raised at the previous CQC report. The 2020 CQC report also identified that there was a lack of stability in the Executive team.

The Ockenden Review

203. The "Emerging Findings" from the Ockenden Review were published on 10 December 2020. They involved examination of 250 cases relating to maternity care at the Trust over a number of years. 1,862 cases are being examined in total from 2000 – 2019 alongside some cases which pre-date the millennium. One of the cases examined by Donna Ockenden was that of Mr. Stanton and Ms. Davies.

204. Ms. Ockenden makes several points of relevance to this complaint. First, she identifies that local investigations and previous national maternity reviews were either not implemented, or did not create change within the Trust.[64] Second, that there is no point in having reviews and reports that do not lead to meaningful change, and that maternity services must change and get safer.[65] The review identifies a number of Local Actions for Learning and Immediate and Essential actions, which it asks to be implemented expeditiously.[66] This is alongside implementation of the Immediate and Essential actions across all relevant professional bodies and all Trusts.

[63] 2020 CQC report, Summary of findings.
[64] First Ockenden Report, Dec 2020, paragraph 1.13.
[65] First Ockenden Report, paragraph 1.14.
[66] First Ockenden Report, Dec 2020, paragraph 1.16

205. The review was concerned with looking into each individual case and examining the standard of care and identified concerns or failings and how they could be avoided in the future. However, the review also looked at the governance processes of maternity services within the Trust[67]. It says that it will make findings based upon the governance documentation only in the final report.[68] The preliminary conclusions set out in the 2020 review identifies the following:

    (a) Inconsistent governance processes for reporting, investigation, learning and implementation of maternity wide changes.

    (b) Inconsistent multi professional engagement with investigations into serious incidents in maternity services, with sometimes cursory processes or not getting to why the problem occurred – sometimes blaming mothers.

    (c) Clear examples of not learning lessons for serious incident reports and make changes in practice, in particular around place of birth, management of labour, and not escalating concerns to senior level when problems became apparent and continuing errors in the assessment of foetal wellbeing.

206. Relevant themes related to the complaint are also explored by Ms. Ockenden. In particular, she identifies that the turnover of ten Chief Executives in 20 years, with eight in post between 2010 to date, and four of those as interim CEOs, would have led to a lack of continuity. Furthermore, there have been ten chairs of the Board since 2000, and considerable turnover amongst Executive and Non-Executive directors which meant a loss of "*organisational memory*". Furthermore, until 2019, Ms. Ockenden states that there was a tendency to view maternity problems as "*historical*" or "*legacy*".

207. The review report identifies that even from 2015, there was evidence that some serious incidents were not investigated using a systematic and multi professional approach.[69]

[67] First Ockenden Report, Dec 2020, paragraph 1.13
[68] First Ockenden Report, paragraph 2.9
[69] First Ockenden Report, Dec 2020, Paragraph 2.14.

208. The review further identified a number of serious deficits in all aspects of past maternity processes including

(a) injudicious use of oxytocin,

(b) incorrect use of forceps,

(c) refusal to undertake caesarean section even where required,

(d) lack of anaesthetic oversight.[70]

209. There was also poor bereavement care, and a lack of kindness and compassion to families during births and afterwards. By contrast, the quality of neonatal care was overall seen as of high quality, although some recommendations were made.[71] Several local actions for learning are identified which seem to replicate those identified in previous reports and review, including appropriate training and a better assessment of risk.

210. As far as governance structures are concerned, Ms. Ockenden recommended the need for:

(a) Clinical governance of the maternity department to be appropriately resourced to investigate adverse outcomes.[72]

(b) Maternity department clinical governance must include a multidisciplinary team structure, Trust risk representation, clear and auditable systems of identification and review of cases of potential adverse outcomes and serious incidents in line with NHS England Serious Incident Framework 2015.

(c) There should a dedicated Lead Midwife and Lead Obstetrician who have demonstrated expertise to focus upon and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.

[70] First Ockenden Report, Chapter 4
[71] First Ockenden Report, paragraphs 4.96 – 4.100, p24.
[72] First Ockenden Report, Chapter 4.

211. Ms. Ockenden and her team identify a number of "Immediate" and "Essential" Actions which are applicable across all NHS Trusts, not just Shrewsbury and Telford Hospital NHS Trust. As is also acknowledged, many of these are not new recommendations and are largely formed from recommendations made in previous reports, and from recurrent themes from the 250 cases in Shrewsbury and Telford and Wrekin.[73] Including in these recommendations are:

    (a) A requirement that all maternity Serious incident reports should be sent to the Trust Board (every 3 months) for scrutiny:

    (b) The provision of an independent senior advocate role which reports to the Trust: each Trust Board should have a Non-Executive Director with oversight of maternity services, with specific responsibility for hearing the voices of women and family.

212. Following on from the Ockenden review, Board members involved in the response to this identified that the Trust implemented a strengthened review of incidents and risks which were reported on a weekly basis to the CQC. This was to ensure that appropriate investigation of incidents and risks occurred in a timely manner.

213. I cannot hope to do justice to the recommendations and learning set out in the Final Ockenden review of March 2022, but would certainly advise that anyone with an interest in , or oversight of maternity care should read every page of it. I have not therefore attempted to summarise its very many findings and actions at this stage, but have sought to insert those most relevant to the issues with which I was tasked to assess throughout the body of the report. The final report reaches broadly the same conclusions in respect of governance and oversight as did the interim report which I have summarised.

Transformation Programme 2020

[73] First Ockenden Report, Dec 2020, Chapter 5

214. In August 2020, the Trust launched a "Transformation Programme" to build on all the issues identified by reviews of the Trust, but also national reviews. As part of this there was a workstream based upon working with patients, with an External Expert Advisory Panel to be chaired by Dr. Kirkup (a national expert on maternity care and author of the Morecambe Bay Review) as well as others.

Relationship between Mr. Reid and Ms. Davies and Mr. Stanton

215. Mr. Stanton complains of his treatment at the hands of Mr. Reid. He complains that in public meetings he was silenced and treated inappropriately, and that e-mails were sent by Mr. Reid that were not professional in tone.

216. Mr. Reid responds to those complaints. To summarise, he says:

    (a) He offered to meet Mr. Stanton after his appointment to talk to him on a one-to-one basis to demonstrate that the Trust was listening.

    (b) He says that Mr. Stanton and his supporters came to Board meetings (which were held in public) to "*harass and harangue the Board*". He said that instead of suspending these meetings (which had been subject to previous criticism), he sought to continue the meetings despite what he calls "noisy" interventions. Mr. Stanton, in a meeting in February 2022, categorically refuted to the reviewer that this was the case. He identified that he only came to two board meetings at neither of which he behaved in that way, and was able to identify clearly what he said and why he said it, which was a short intervention to identify that issues concerning maternity care and the RCOG report and their sequelae were not placed on the Board's agenda. I find on the balance of probabilities firstly that Mr. Stanton did not have "supporters" or was not part of that wider group (considering that Mr. Reid has conflated a number of different groups with Mr. Stanton) and that he neither harassed nor harangued.

217. As to the incident in November 2018, he identifies that there was an incident where Mr. Stanton was seeking to intervene in a Board debate and was shouting

at the Board. Mr. Stanton identifies that he did talk to the Board at this meeting, but he was concerned that his voice was not being heard and he was not being able to make his points. He says that he wanted to make his point and then leave the meeting, rather than have to wait several hours before the issue of maternity services arose. Mr. Reid indicates that he had assured Mr. Stanton that he would be able to make his points and at an appropriate time and asked for his co-operation. He then says that Mr. Stanton was disruptive and Mr. Reid spoke over him. He says:

> *"I regret needing to do this but in my opinion it was only necessary because of Mr. Stanton's desire to grandstand [sic] at the meeting with the press in the room"*.

218. Mr. Stanton indicates that there was no "grandstanding". He indicates that he had attended two board meetings of the Trust throughout his time working on issues of patient safety (which has been from 2009 - 2021). He wanted to put one question to the Board about maternity service and staffing which had not been included on the Board agenda. They talked over him. He denies any disruption and says that he did not attend Board meetings to either harangue or harass. He indicates that he attended on his own, and not with others and he was not part of the "campaigning group" identified by Mr. Reid.

219. He subsequently apologised to Mr. Stanton for any upset caused by adopting that approach. He did ask Mr. Stanton to stop talking when he sought to do so.

220. He indicates an occasion where individuals placed soft toys in front of Mr. Reid, saying "*you killed my child*". He mistakenly identified them as part of Mr. Stanton's "group" as he described it. Mr. Stanton is clear that he was not part of that occasion and was not involved in this behaviour or part of any form of "group". I consider on the balance of probabilities that Mr. Reid is confusing Mr. Stanton with others and that given the passage of time, he has in all likelihood, kaleidoscoped events in his mind. This is both understandable and also well recognised as part and parcel of how memory works. For the avoidance of doubt, Mr. Stanton never presented soft toys and were never part of the group which did so.

E-mail correspondence 2020

221. Mr. Reid did not have access to the relevant e-mail he sent to Mr. Stanton but believes that it was to indicate to him that the public Board meeting would need to be held without members of the public due to Covid 19 restrictions. He says that it was the same e-mail that he sent to a number of others. He says that he made it clear that he would be happy to accept any questions he may have and that these would be responded to. He says that he tried to adopt a positive approach. Mr. Reid's perspective is that he wanted to drive improvements in the maternity team and tried to communicate that to Mr. Stanton and Ms. Davies.

Thematic Summary of Scolding Report Findings, relating to Board Governance

October 2022

Based on a review of the key findings in the Scolding Report and the more general observations from which the Trust would wish to learn, the following synthesis has been produced. It captures fully the findings and learning for the Trust, which it categorises as follows:

- Theme 1: Board effectiveness – Culture, openness and transparency
- Theme 2: Board effectiveness – Oversight and scrutiny
- Theme 3: Board effectiveness – Leadership, skills and competency
- Theme 4: Board effectiveness – Governance and processes

The learning and actions arising from each of these themes provide the basis of a Board Development Plan.

	Scolding Report Finding	**Learning and actions**
Theme 1: Board effectiveness – Culture, openness and transparency		
1.1	The Trust should not have delayed the publication of the RCOG report.	Ensure Nolan Principles and Code of Accountability are well understood. Incorporate the behaviours required of the Nolan Principles as part of Executive and Non-Executive Directors' annual performance objectives.
1.2	The Trust culture was defensive.	The Trust must ensure that the culture transition strategy and delivery plan address the issues of defensiveness, transparency and candour.
1.3	When under threat, on occasions, the Trust sought to prioritise reputation over transparency and candour	
1.4	The Trust did not have a culture or processes that supported staff effectively.	The Trust must ensure that the culture transition strategy and delivery plan address the issues of staff support, including recruitment and retention.
1.5	The Board culture did not support effective challenge and oversight. See Board effectiveness – oversight and scrutiny.	The Trust must ensure that the culture transition strategy and delivery plan address the requirements for an appropriate culture within the Board where openness and transparency are key and where Board effectiveness includes effective challenge and support. See Board effectiveness – oversight and scrutiny below.
Theme 2: Board effectiveness – Oversight and scrutiny		

2.1	Board too accepting of information and decisions put to them.	As part of this Board Development Plan and in light of these observations and learning, the Board needs to consider and review its current effectiveness and performance in relation to Board preparation and challenge. It needs to explore what constitutes effective challenge and how this can be delivered in a supportive manner. The Board needs to evaluate its performance in this regard following each Board and Board Committee meeting. It also needs to explore "ward to board" oversight. How is the Board and can the Board be sighted on what it needs to know?
2.2	The Board chose to delay publication of a document that should have been put in the public domain, the addendum supplementary report should not have been published 'on top' of the report and the paper presented was "partial and not candid".	
2.3	The Board did not challenge each other effectively.	
2.4	Board members did not prepare sufficiently or challenge effectively	
2.5	Board/NEDs insufficiently skilled in scrutinising detailed/technical information, especially clinical information.	Explore with NEDs any technical knowledge gaps for which training/support may be necessary in order to maximise NEDs' contributions.
Theme 3: Board effectiveness – Leadership, skills and competency		
3.1	Board membership and leadership was unstable.	The Trust must ensure that the leadership development programme delivers leaders at all levels.
3.2	Lack of leadership capability within the Trust	
3.3	The Trust was over-reliant on interim/ temporary staff	
3.4	The Trust did not manage and /or benefit from effective organisational memory.	The Trust should review its current mechanisms for collating and managing the information generated from, and outcomes of, important activities, to secure an effective organisational memory.
3.5	The Board (Chair/NED/Executive) induction and development processes not robust	The Trust must review on-boarding/induction processes to ensure deep understanding of governance, values and processes. The Trust must review Board on-going development, to ensure Board members have an appropriate understanding of risk, opportunities, issues and processes.
3.6	Board/Chair lacked skills in reflective listening and conflict management.	Reflective listening and conflict management training for Board.

3.7	Executives insufficiently skilled in sponsoring, preparing and/or writing compliant and effective board papers.	Effective report writing skills training.
3.8	Divisional management insufficiently skilled in sponsoring, preparing and/or writing compliant and effective operational governance papers.	
Theme 4: Board effectiveness – Governance and processes		
4.1	Board and Committee governance framework and processes were inadequate for the requirements of a Trust with issues as complex as those at SaTH – • Board oversight was inadequate • Board Governance Framework was inadequate • Board did not use committee governance structure appropriately and/or to full effect • Embedded: Committee Governance, oversight and escalation processes insufficient	The Trust must review its current governance framework and update it, to ensure effective Board and Committee oversight of Trust performance and activity.
4.2	Organisational (ward to Board) governance structure and processes were inadequate for the requirements of a Trust with issues as complex as those at SaTH. NEDs did not have full picture of what was happening in the Trust.	The Trust must review its current organisational governance framework and update to ensure effective operational oversight of performance and activity.
4.3	The Trust lacked a framework for complex relationship management.	The Trust should develop a framework for complex relationship management, to include the Board.
4.4	The Trust did not have a project management framework and/or programme approach that supported the effective management of multiple complex demands.	The Trust should review its current project management framework and/or programme approach to complex projects.
4.5	Trust did not engage stakeholders in co-production, in a supportive and informed manner.	The Trust should review its current methods for stakeholder engagement to ensure that it supports the co-production of programmes to address issues of patient safety.

The Scolding Report references a number of other reports and reviews:

Report	Recommendation
The RCOG Review	The Trust should review the recommendations within each and ascertain effectiveness of actions identified and delivery of the same
Report of NHS Improvement, October 2018	
CQC report 2018	
The Open Book Review – 2018	
May 2020 internal review	
Deloitte review – 2020: Maternity Incentive Scheme review	
CQC report – 2020	
The First Ockenden Report	

Dr Catriona McMahon
Chair, Shrewsbury and Telford Hospital NHS Trust

APPENDIX 4

The Shrewsbury and Telford Hospital NHS Trust

Board and Committee Governance Review

Review Plan

1. Board Committee Review

A detailed Board Committee Review was undertaken in 2021 and reported to the Audit & Risk Committee in December 2021. The review involved a detailed self-assessment of the effectiveness of each Committee and resulted in a set of very comprehensive recommendations. The recommendations have been summarised and involve a set of "general housekeeping" recommendations common to each of the Committees and a set of bespoke recommendations for each Committee.

Actions –

- Implement the recommendations of the Board Committee Review
- Engage Committee Chairs and Executive Director Leads regarding the recommendations
- Observe each of the Board Committees including review of current agendas
- The recommendations require updated terms of reference for each Committee, annual cycles of business and action trackers

2. Scolding Fit & Proper Person Report

The Scolding Report provides commentary on the Board's governance arrangements including its effectiveness, as does the final Ockenden Report. Based on the key findings and the more general observations contained within the Scolding Report, a set of key learning points and actions can be derived reflecting the following themes-

- Culture, openness and transparency
- Oversight and scrutiny
- Leadership, skills and competency
- Governance and processes

Actions –

- Review Scolding Report and identify key learning and actions for the Board
- Use the review to inform a Board Development Plan, to be shared with the Board

3. Board Effectiveness and Processes

Review current Board effectiveness and processes, through independent observation and Board effectiveness self-assessment. A validated framework should be used as a reference for this review, and as should the Nolan Principles, the UK Corporate Governance Code and Draft Code of Governance

for NHS Provider Trusts, the Healthy Board framework, and the Standards for NHS Board Members. This approach will enable better understanding and corroboration of the findings and key learning for the Board contained in the Scolding Report, and which will better enable a considered and thoughtful Board Development Plan.

Actions –

- Observe Board meetings using recognised tool and provide feedback
- Undertake Board effectiveness self-assessment survey using recognised tool
- Provide feedback on Board meeting observation and self-assessment survey
- Use the output to inform the Board Development Plan

4. Key Outputs

The following are the key outputs from this work –

- A detailed Board Development Plan, informed by the review
- The implementation of the Board Committee review recommendations, including the updating of key governance documentation