NHS Improvement Board Item

Paper Title:	Update on the independent review of maternity services at Shrewsbury & Telford Hospital NHS Trust and NHS Improvement regulatory action
Agenda item:	7 (Public session)
Report by:	Amanda Pritchard CEO NHS Improvement Stephen Powis, National Medical Director
Paper type:	For noting

Organisation Objective:

NHS Mandate from Government	☐	Statutory item	☐
NHS Long Term Plan	☐	Governance	☒
NHS People Plan	☐		

Action required:

The Board is asked to note the update on the Shrewsbury & Telford Hospital NHS Trust independent maternity review, and the wider action being undertaken by CQC and NHS Improvement in response to quality concerns.

Executive summary:

The SATH independent maternity review, chaired by Donna Ockenden was established in 2017, at the request of the Secretary of State for Health, to investigate the handling of 23 cases relating to perinatal and maternal deaths at the Shrewsbury and Telford Hospital NHS Trust (SaTH). Since then more families have come forward and the Trust has identified other cases of potential concern. The maternity review has therefore widened its scope and is now considering 1862 cases. A police investigation was launched following concerns raised by affected families. The CQC has also recently raised concerns about medical and emergency department services at the Trust.

NHS Improvement's central team is, with the assistance of the DHSC, supporting the maternity review to ensure it has the resources and information it needs to deliver a timely and effective report and the NHS can learn from the findings. The improvement support and regional teams are providing targeted support to the Trust to address concerns over care delivery. The NHS Improvement Chair and Chief Executive have also convened a formal 'Board to System' review meeting.

Background

1. In April 2017, the Secretary of State for Health (Jeremy Hunt) asked NHS Improvement to commission an independent review into the investigation of cases relating to perinatal and maternal deaths at the Shrewsbury and Telford Hospital NHS Trust (SaTH).

2. The purpose of the Review is to consider the quality of investigations and implementation of their recommendations relating to a number of alleged avoidable perinatal and maternal deaths, and cases of avoidable maternity and newborn harm at Shrewsbury and Telford Hospitals. The Review was originally established to investigate 23 cases identified by two families who wrote to the Secretary of State. Donna Ockenden, a midwife with experience of quality reviews, was appointed as Chair.

3. Following the launch of the Review a significant number of additional families have come forward. In 2018, to provide context for the original cases, NHS Improvement requested an 'Open Book' review of Trust records involving maternal and newborn incidents. When Prof Stephen Powis took on sponsorship of the Review in May 2019 from NHS Improvement Medical Director, Kathy McLean, he agreed with Donna Ockenden that the open book cases and any other cases of concern should be included for consideration, to ensure the independent Review was comprehensive.

4. Following further media attention in November 2019 and appeals by Donna Ockenden for any other affected families to come forward in November 2019 and April 2020, the number of cases rose to over 1300. The revised Terms of Reference, which reflects the expanded scope of the Review, was published in November 2019.

Latest status

5. At the request of Donna Ockenden and with encouragement from NHS Improvement, the Trust recently searched its paper records for any other maternity incidents between 2000-2018. Around 500 additional records involving maternal death, neonatal death and infant brain damage have now been found bringing the total under review to 1862. Donna Ockenden confirmed in a press release on 21 July 2020 that any further cases should be sent directly to the Trust so that she can focus efforts on completing the review from this point. As part of her review she will consider these cases to see if they were as a result of poor care.

6. The minister responsible has asked that Donna Ockenden produces a report by the end of the year in order to share the learning with front line maternity services as soon as possible.

7. Responsibility for NHS Improvement sponsorship of the Review has transferred to the National Director for Patient Safety, to allow the National Medical Director to focus on the COVID-19 response and NHS recovery.

Handling of a Report by the Royal College of Obstetricians and Gynaecologists

8. NHS Improvement launched an investigation, following a complaint, into the trust's handling of a report by the Royal College of Obstetricians and Gynaecologists following an invited review in 2017. NHS Improvement's head of investigations has worked with an independent assessor to review this and the report published on 21 July 2020.

9. The investigation found that whilst the Trust acted reasonably with regards to their challenge of the RCOG's report and their concerns about the impact of adverse media on staff were understandable, governance arrangements were not operating effectively and there were unnecessary delays to internal board scrutiny.

Police investigation

10. On 30th June 2020 West Mercia police announced the launch of an investigation into maternity service and provision at SaTH. This is because affected families have raised concerns about the Trust with them in the past.

11. The purpose of the investigation is to ascertain if there is evidence of offences which reach the criminal threshold for prosecution. The investigation will seek to identify if there is evidence to support a criminal case. The police have advised that this should not affect the progress of Donna Ockenden's Review.

Regulation of care quality

12. The Trust entered special measures (quality) in 2018 following advice from the CQC and in advance of the CQC's assessment of 'inadequate'. Warning notices were issued for the emergency department (ED) and maternity. More recently a comprehensive CQC inspection report was published 8th April 2020 and rated the Trust overall 'Inadequate'. New concerns related to urgent and emergency pathways and issues with staff attitudes were identified. The requirements must be met by the end of August 2020.

13. The Trust has responded to the CQC's letter with an action plan. It is worth noting that the executive team have all been newly appointed including the chief executive, medical director, director of nursing, HR director and director for finance.

14. Our regional team has been providing SATH with additional support. Since the latest CQC letter of intent, a different approach has been agreed between the Trust, regional team and the national intensive support team which has resulted in an 'improvement team' being deployed into the Trust under the leadership of an experienced Improvement Director. The quantum of support involves additional capacity against areas identified by CQC, Trust and the region (the letter from CQC to NHS Improvement and NHS Improvement's response to this letter are enclosed for information).

15. Areas of support relate to:

- Named Co-ordinator to support Ockenden requests and increase turnaround.
- Continued support from the Maternity Support Programme with a named improvement lead.
- Executive Improvement Director, with governance and quality background.
- Project management support.
- Quality governance expertise to work with divisions to align processes and risk management issues.
- Data and analytical support to improve information and accuracy of reporting.
- Operational flow support to address embedding new practices in ED in collaboration with ECIST colleagues.
- Leadership development and Improvement Lead to support the Trust consistently address issues of culture and accountability.
- Developing relations with local population to ensure the public and patients have confidence to use services
- Financial expertise to support delivery of transformational improvements.
- Experienced ex Director of Nursing to focus on professionalism and ward accreditation roll out.
- Transformational expertise to work alongside the medical director and support clinical engagement and pathway redesign.
- Yet to be confirmed but operational HR to address backlog HR issues and Senior comms expertise to assist in improving media management and interest.

This team have been rapidly brought together and some are already working in the Trust, but a formal commencement event is planned for 31 of July with a 30/60/90 plan to identify key performance indicators and deliverables. There is ongoing support in the form of coaching and mentorship for the full executive team.

16. A Board to system meeting took place in July 2020 led by Baroness Dido Harding as NHS Improvement Chair and Amanda Pritchard This reviewed what Shropshire, Telford and Wrekin system need to address at a strategic level to ensure the organisation can demonstrate the pace of improvement CQC have requested.

17. Additionally, the regional team is exploring other direct support offers from neighbouring organisations to provide resilience in advance of winter.

Support for those affected

18. Donna Ockenden's team is trained in handling cases of bereavement and is also signposting affected families to local support services. Midlands Partnership NHS Trust are working with SaTH and the maternity review team to provide enhanced support to staff and affected families.