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Rt Hon Sajid Javid MP
Secretary of State
Department of Health and Social Care
39 Victoria Street
London, SW1H 0EU

4 May 2022

Dear Secretary of State,

Thank you for your letter of 14 April in relation to Donna Ockenden's report on maternity services at Shrewsbury and Telford NHS Trust (SaTH) which makes a number of important local and national recommendations.

We have been highlighting safety concerns about the maternity services of SaTH for a number of years. We have been concerned about the trust's ability to sustain improvement since first recommending special measures in November 2018. We therefore welcome the additional spotlight which the Ockenden report has brought on the quality and safety of its maternity provision.

I do, however, remain worried that despite the concerns of both my team and local families, and the enhanced support from NHSE, the rate of improvement at the Trust remains too slow.

Our response to the findings of the Ockendon report

The Ockenden report makes clear that regulators, including CQC, the Royal Colleges, including those of Midwives, Obstetricians and Gynaecologists, Anaesthetists, and Paediatrics and Child health must continue to strengthen their collective efforts of collaborative working.

Our relationships with these key partners have been developed and strengthened in recent years, including CQC becoming an active participatory member of the **Maternity Transformation Programme** and working with the GMC and NMC to develop our shared understanding of risk.

We are also now using reports from the Royal College of Obstetricians and Gynaecologists (RCOG) invited reviews of Trusts to inform our regulation. The RCOG was heavily criticised for not alerting us to its findings, instead only releasing the report to the Trust. RCOG policy is now to send a copy of the final report to the organisation's healthcare regulatory bodies.

Of the 15 'Immediate' and 'Essential' actions in the Ockenden Report, two reference us directly. The first action relates to **workforce planning and sustainability** and the report endorses recommendations from the Health and Social Care Committee

Report: *The safety of maternity services in England*[1], around minimum staffing levels and training. We support the government's acceptance of this action. We have continued engagement with local maternity and neonatal system partners, NHS Resolution and NHSE/I to solidify this action.

The second action relates to **listening to women and families**. As part of our focused maternity inspection programme (see below) we now have direct engagement with organisations representing women using maternity services and their families. This includes Maternity Voices Partnerships, and other organisations such as Five X More, to ensure we have a range of sources that allow us to hear women's voices. Their views form a key part of our intelligence.

We also launched our latest strategy[2] in May 2021 within which we have identified four key themes: People and communities; Smarter regulation; Safety through learning and; Accelerating improvement. Running through each theme are two core ambitions: Assessing local systems and; Tackling inequalities in health and care.

Through this strategy we have set out a further series of improvements that will continue to ensure our regulation of maternity services is robust and allows us to shine a light on poor care so relevant stakeholders can take the appropriate action and improve the care for women using services.

For example, under our strategic theme, **'safety through learning'**, we will continue to promote and check on open and honest cultures within maternity services and we will continue to review key themes, including: developing maternity leadership, addressing workforce challenges, ensuring multi-disciplinary training, supporting freedom to speak up, and transparent learning and reporting cultures**.**

As part of our core ambition **'tackling health inequalities'**, we will continue to ask maternity services about work on maternity equity and engagement during inspection and monitoring activity and continue to learn from women who use services and who face inequality.

We will apply our learning from maternity services in hospitals to community services, as well as antenatal and postnatal services and expect services to use people's experiences and equality data to review and act on outcomes and respond to the needs of their local population. We will also continue to improve how we work with equality data to assess safety and quality of people's care and work with others to do this.

We are also planning to carry out formal research with an academic partner to more systematically understand why poor cultures arise, with a view to finding ways to include this in our methodology. We would be happy to work collaboratively with you team in this area.

Recent findings and ongoing concerns with maternity services nationally

[1] https://committees.parliament.uk/publications/6578/documents/73151/default
[2] https://www.cqc.org.uk/about-us/our-strategy-plans/new-strategy-changing-world-health-social-care-cqcs-strategy-2021

The ability of a service to improve is to a large extent a factor of the ability of the wider Trust to listen, learn and improve. In the case of SaTH, it has been rated Inadequate and been in Special Measures/part of NHSE's Recovery Support Programme since 2018. There are other trusts, for example in Nottingham and East Kent, that are similarly struggling to improve. There is an important question about the effectiveness of improvement support within the NHS Acute sector and how this can be strengthened further.

Our ratings data indicates that there has been an improvement in the safety of maternity services over time, but that this has been too slow. In our report 'The state of care in NHS acute hospitals 2014 to 2016', published in April 2018, we raised concerns that our initial round of comprehensive NHS acute hospital inspections had resulted in half of all maternity services being rated as requires improvement or inadequate for 'Safety'.

Our Getting Safer Faster briefing in March 2020 showed that this had improved to 39%. But figures from July 2021 show a slight decline since then, with 41% of services rated as inadequate or requires improvement for 'Safety'. This must be considered in the context of the more risk-based approach to inspection we have taken since the onset of the pandemic.

Nevertheless, while the picture has improved from our very first assessment, **we still have a number of ongoing concerns about maternity safety at some individual hospital trusts.** We are closely monitoring those services, and we will update Parliament on the latest position in this year's State of Care report.

Our current programme of risk-based, focused maternity safety inspections involves a more focused assessment of relational elements such as teamworking, culture, staff and patient experience which in turn is helping to pinpoint where action can be taken in individual services. We reported on the key findings emerging from the first nine of these inspections in our thematic report 'Safety, equity and engagement in maternity services' which published in September 2021.

In addition, we are also working with patient safety consultant, James Titcombe and a small group of stakeholders to design and facilitate a provider roundtable listening event that will be held later in the Spring. The event will offer an opportunity for frontline maternity staff to share best practice and learning that can be used by other trusts to drive improvement. It will also generate insight that can be used by us, system leaders and the wider NHS to support that improvement work in action. We will ensure your team are briefed on the outputs and insight from the session.

The need for further work

Whilst the Ockenden Report looked at one trust over a specific period of time I am concerned about a number of maternity services across the country.

It is vital to understand what lies behind the slow pace of change and gain a greater understanding of the particular challenges faced by teams working in maternity services and how these can be most effectively managed.

As a regulator there are limitations in terms of what we can do on our own, with our powers restricted to closing, or limiting services. Therefore, a system wide response is needed, with practical support to improve. We will continue to call out poor care, as we have done already, but without a coordinated response from system partners, both nationally and locally, we will continue to see these issues remain within maternity services.

I would be happy to meet with you to discuss our findings in more detail.

Yours sincerely,

Ian Trenholm
Chief Executive