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Independent report

Ockenden review: summary of findings, conclusions and essential actions

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

30 March 2022

Dear Secretary of State

I publish the final report of the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, at a time when the NHS continues to face significant challenges arising from the coronavirus (COVID-19) pandemic. In the 2 years of this pandemic since early 2020, the NHS and its staff have had to be ever more innovative in the ways services are delivered to ensure the provision of high-quality care to patients.

NHS staff – including maternity teams who have worked throughout this pandemic – are exhausted. We have seen so many frontline NHS staff go above and beyond the call of duty to support and care for their patients in these truly extraordinary times. Our NHS is rightly held in high regard by so many for the lives it saves and the care it provides.

However, this final report of the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.

This review owes its origins to GRO-A, and her parents GRO-A GRO-A and GRO-A; and to GRO-A, and her parents GRO-A and GRO-A GRO-A's and GRO-A's parents have shown an unrelenting commitment to ensuring their daughters' short lives make a difference to the safety of maternity care.

It was through their efforts that your predecessor, the former Secretary of State for Health Jeremy Hunt, requested this independent review. When it commenced, this review was of 23 families' cases, but it grew to include reviews of nearly 1,500 families, whose experiences occurred predominantly between 2000 and 2019.

This final report follows on from our first report (https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust), which was published in December 2020. In the first report, we outlined the local actions for learning (LAfL) and immediate and essential actions (IEAs) to be implemented at the trust and across the wider maternity system in England.

This second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed. For this second report, my independent maternity review team have identified a number of new themes that we believe must now be shared across all maternity services in England as a matter of urgency to bring about positive and essential change.

Our LAfL for the trust and IEAs must be implemented by the Shrewsbury and Telford Hospital NHS Trust with the IEAs considered by all trusts across England in a timely manner.

Since the publication of our first report, the government has introduced a range of measures and invested very significantly in supporting maternity services across the country (https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-%20committee-report-safety-of-maternity-services-in-england). This focus and funding is a significant stride in the right direction. Much of this funding is for workforce expansion. NHS Providers (https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf), as cited in the recent Select Committee report (https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm) has estimated the cost of full expansion of the maternity services workforce to be £200 to £250 million. We endorse and support this view.

In the last year since our first report was published, we have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing attrition of maternity staff, and providing the required funding for a sustainable and safe maternity workforce is essential. Continuing progress on funding the maternity multi-professional workforce requirements now and into the future will mean that we can continue to ensure the safety of mothers and their babies, and meet the government's key commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths, and brain injuries in babies occurring soon or after birth by 2025 (https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps).

In our first report, we wanted to ensure that families' voices were central as, for far too long, women and families who accessed maternity care at the trust were denied the opportunity to voice their concerns about the quality of care they had received. Many hundreds of families who received maternity care at the trust have told us of experiencing life-changing tragedies that have caused untold pain and distress. In order to ensure families' voices are heard, listened to and acted upon within maternity services, the NHS will need to continue progress on the role of the independent senior advocate role within maternity services that was an IEA in our first report.

Secretary of State, through our work to date we have recognised a critical need for timely and independent reviews of serious maternity incidents to ensure lessons are learned and changes implemented effectively. We note and endorse the creation of a Special Health Authority to oversee maternity investigations (https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560), taking over the work of the Healthcare Safety Investigation Branch. We fully support your view that the provision of "independent, standardised and family focussed investigations of maternity cases that provide families with answers" is essential.

We further urge that there must be a timeliness to this work since delay in introducing change and learning leads to the risk of repeated incidents, as we saw at the Shrewsbury and Telford Hospital NHS Trust. We would expect that learning

and service change from maternity incidents be introduced into clinical practice within 6 months of the incident occurring, and that all investigations are independently chaired.

Finally, and importantly, Secretary of State, we state that the Department of Health and Social Care (DHSC) and NHS England and Improvement (NHSEI) must now commission a working group – independent of the Maternity Transformation Programme – that has joint Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

Thank you, Secretary of State, for your ongoing support.

Yours sincerely,

Donna Ockenden

Chair of the Independent Maternity Review

Why this report is important

The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent.

The families who have bravely contributed to this review know all too well the devastation which follows such events, and have explained to my review team and me that they want this review to answer their questions. Families have also clearly explained that they want what happened to them to matter, and to ensure that, in future, voices such as their own are listened to and heard, and that meaningful and sustained changes will be made to try to ensure that what happened to them will not happen to others in future.

The accounts of families involved in events at maternity services at the Shrewsbury and Telford Hospital NHS Trust has not only put a spotlight on this service, but also on other maternity services across England, as can be seen by recent reports of concerns in a number of other trusts. That is why this report aims to not only address specific concerns about the Shrewsbury and Telford Hospital NHS Trust, but to provide IEAs for all maternity services across England. Sometimes that spotlight can feel harsh to staff on the front line doing their very best in what are often extremely challenging circumstances. As a multi-professional clinical review team, largely made up of midwives and doctors currently working on a daily basis in NHS maternity services across England, we understand that.

Even now, early in 2022, there remain concerns that NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight.

However, it is our belief that if the 'whole system' underpinning maternity services commits to implementation of all the IEAs within this report, with the necessary funding provided, then this review could be said to have led to far-reaching improvements for all families and NHS staff working within maternity services.

The size and scale of this review is unprecedented in NHS history. After reviewing the experiences of so many families, and listening carefully to both those families and to the past and present staff who came forward, we have been given a once-in-a-generation opportunity to improve the safety and quality of maternity service provision for families across England – now and in the future.

Donna Ockenden

Chair

Executive summary

This independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust ('the trust') commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt MP when he was Secretary of State for Health and Social Care, and commissioned by NHS Improvement, to examine 23 cases of concern collated by the tireless efforts of the parents of GRO-A GRO-A and GRO-A, who both died after birth at the trust in 2009 and 2016 respectively.

Since the review was commissioned, it has grown considerably. Our independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the trust between the years 2000 and 2019.

It has previously been reported that this review was considering 1,862 family cases. However, after removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents – therefore, a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

In line with the terms of reference, the review examined the trust's internal investigations where they occurred. In addition, the review team has considered:

- external reports into the trust's maternity services over these years (national regulatory reports and locally commissioned reports)
- local clinical governance processes, policies and procedures
- ombudsman and coroner's reports

Throughout this process, our priority has been to ensure that the families impacted by the maternity services at the trust are heard. They wanted to understand what had happened to them, as well as ensure that, finally, lessons are learned so that no further families experience the same harm and distress that they did.

Families were offered a variety of methods to engage with the review team, and share accounts of their care and treatment. Throughout this report, we have included vignettes of the care received by families, either through our review of their maternity care considering the documentation that was received from the trust, or by quoting family members directly from their communication with the chair of the review or team members.

As well as listening to families, the review team wanted to ensure that staff had an opportunity to be heard also. In 2021, the review team interviewed 60 present and former members of staff about their opinions on the maternity services they worked within. We also offered staff the opportunity to complete a questionnaire for the review, which 84 staff did. We have included vignettes of these interviews and questionnaires throughout this report in order to ensure that staff voices are clearly heard.

In the final weeks leading up to publication of the report, a number of staff withdrew their co-operation from the report and therefore their content (or 'voice') was lost from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified. This was despite our reassurance that staff would only ever be identified as 'a staff member told the review team…"

Within this report, we have included a timeline of events that led up to the commissioning of this independent review (see 'Concerns that led to this review' below or Chapter 1 of the full report). This highlights a number of cases that became known of, many in the public domain between 2001 and 2016, as well as a number of external reviews from the various commissioning and regulatory bodies that took place during the period under review.

It would be expected that the number of incidents featured in this timeline would have warranted closer scrutiny of maternity services at an earlier point than we are at now. However, in our opinion, due to concerns around other clinical areas within the trust and also due to the significant turnover at executive and board level, issues within maternity services remained largely unseen. This was to the detriment of the families receiving care.

Patterns of repeated poor care

Through the review of 1,486 family cases, the review team has been able to identify:

- thematic patterns in the quality of care and investigation procedures carried out by the trust
- where opportunities for learning and improving quality of care have been missed

For example, in the 9 months preceding the avoidable death of GRO-A GRO-A in March 2009, the review team has identified 2 further incidents of baby deaths that occurred under similar circumstances.

In GRO-A 2008, baby GRO-A was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal

Unit. GRO-A 's mother was considered to have a low-risk pregnancy and, even after she reported episodes of severe uterine tenderness and tightening at 31 weeks, this risk profile was not changed. She reported reduced baby movements the day before her labour at 37+5 weeks gestation, but, on her admission, the baby's heart rate was not monitored appropriately. GRO-A was delivered with no signs of life and died at 6 days old when care was withdrawn.

In GRO-A 2009, baby GRO-A was born following his mother's long, slow labour, which stretched over more than a day. His mother, who had given birth to a large baby during a previous pregnancy, had been treated as a low-risk case throughout this pregnancy, and no check for gestational diabetes was conducted. She had been due to give birth in a midwifery-led unit, but was admitted to the antenatal ward in the consultant-led unit. The review team found that, despite abnormal heart rate readings, a high dose of oxytocin infusion was used, and his mother was infrequently monitored. In the hour before birth, examinations showed signs of obstructed labour and uterine rupture, as well as difficulties establishing the baby's heart rate, but despite this, a ventouse delivery was attempted before an emergency caesarean was conducted. GRO-A briefly had a heartbeat but, at 34 minutes of age, resuscitation was stopped.

Then, on GRO-A 2009, GRO-A gave birth to GRO-A at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the 2 weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage GRO-As health as she was born severely anaemic. GRO-A suffered a cardiopulmonary collapse at 90 minutes of life and was transferred by air ambulance to a tertiary neonatal unit, where she died shortly after arrival at 6 hours of age.

The review team found evidence of poor investigation into all 3 of these cases, which took place within less than a year of each other, as well as a lack of transparency and dialogue with families. This resulted in missed opportunities for learning, and a lost opportunity to prevent further baby deaths from occurring at the trust.

Unfortunately, these 3 cases were not isolated incidents and, throughout this review, we have found repeated errors in care that led to injury to either mothers or their babies. During our work, we have considered all aspects of clinical care in maternity services including:

- antenatal
- intrapartum
- postnatal
- obstetric anaesthesia
- neonatal care

In total, 12 cases of maternal death were considered by the review team. They concluded that none of the mothers had received care in line with best practice at the time and, in three-quarters of cases, the care could have been significantly improved. Only one maternal death investigation was conducted by external

clinicians, and the internal reviews were rated as poor by our review team. These internal investigations frequently did not recognise system and service-wide failings to follow appropriate procedures and guidance. As a result, significant omissions in care were not identified and, in some incidents, women themselves were also held responsible for the outcomes.

As part of the review, 498 cases of stillbirth were reviewed and graded. One in 4 cases were found to have significant or major concerns in maternity care that, if managed appropriately, might or would have resulted in a different outcome.

Hypoxic ischaemic encephalopathy (HIE) is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two-thirds (65.9%) of all HIE cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns. However, these were unlikely to influence the outcome observed.

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9%) were identified to have significant or major concerns in the maternity care provided that might or would have resulted in a different outcome.

The review team found that, throughout the review period, staff were overly confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care. For example, the neonatal unit at Royal Shrewsbury Hospital continued to work as a neonatal intensive care unit for many years after it had been re-designated as a local neonatal unit. Although the review team noted that care provided by staff in the unit was generally good, it was operating beyond its designated scope. Staff suggested this was due to a lack of capacity within the surrounding services, but this view has been rejected by the neonatal network.

Internally, within maternity services at the trust, women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments. There are also multiple examples within this report where there were delays in women being:

- admitted to the labour ward during induction of labour
- assessed for emergency intervention during labour
- reviewed by consultants in the postnatal environment

On occasion, this resulted in families being discharged from hospital, but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care. Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions.

Failure in governance and leadership

Throughout the various stages of care, the review team has identified a failing to follow national clinical guidelines, whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation. This, combined with delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, HIE and, unfortunately, death.

Some of the causes of these delays were due to the culture among the trust's workforce. The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear among midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace and limited the ability of the service to make positive changes.

Unfortunately, these poor working relationships were also witnessed by families and, in some cases, mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives.

In addition, repeatedly throughout this review, we have heard from parents about a lack of compassion expressed by staff – either while they were still receiving care or in follow-up appointments and during complaints processes. Examples include clinicians being unprepared for follow-up briefings with families, and response letters to complaints including inaccurate information, justifying actions or omissions in care, and in some cases even including explanations that laid blame on the family themselves for the particular outcome.

As summarised earlier, there were often delays in escalation of care to appropriate clinicians. In part, these delays in care could be attributed to staffing and training gaps at the trust. The review team found there were significant staffing and training gaps within both the midwifery and medical workforce that negatively affected the operational running of the service. The review team identified how it was widely accepted that the labour ward co-ordinator did not have supernumerary status, often having their own clinical caseload, preventing them from being readily accessible to junior staff and the wider midwifery team for clinical advice, care planning and support.

Similarly, the medical staff rotas have been overstretched throughout the time period covered by the review. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available. Where locum doctors filled in rota gaps, there is evidence of them being unsupported and, on occasions, unsafe clinical practice was not addressed or challenged. Staff also cited suboptimal staffing levels and unsafe inpatient-to-staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.

The review has found the trust leadership team up to board level to be in a constant state of churn and change. Therefore, it failed to foster a positive environment to support and encourage service improvement at all levels. In addition, the trust board did not have oversight or a full understanding of issues and concerns within the maternity service, resulting in neither strategic direction and effective change, nor the development of accountable implementation plans.

Our consideration of clinical governance processes and documents at the trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings, and some significant cases of concern were not investigated at all. In fact, the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology in order to avoid external scrutiny, so that the true scale of serious incidents at the trust went unknown until this review was undertaken.

Where investigations took place, there was a lack of oversight by the trust board. Unfortunately, the review believes this has persisted in some incident investigations as late as 2018 to 2019 considered as part of this review.

This meant that consistently, throughout the review period, lessons were not learned, mistakes in care were repeated, and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of external reviews carried out by external bodies, including local clinical commissioning groups and the Care Quality Commission, during the last decade. The review team is concerned that some of the findings from these reviews gave false reassurance about maternity services at the trust, despite repeated concerns being raised by families. It is the review team's view that opportunities were lost to have improved maternity services at the trust sooner.

Local actions for learning, and immediate and essential actions

This review has considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and, as a result, has made a significant number of recommendations for improvement of care across each of the maternity disciplines.

In total, more than 60 LAfL have been identified specifically for the trust in light of the care received by the 1,486 families featured in the review. The review team are encouraged by staff reports that, following our first report in December 2020, there does seem to have been a recent improvement in maternity services at the trust with increased numbers of senior clinicians employed.

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 IEAs that 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 (https://www.england.nhs.uk/mat-transformation/implementing-better-births/continuity-of-carer/) until – and unless – safe staffing is shown to be present
- strengthened accountability for improvements in care among 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.

Concerns that led to this review

The Ockenden review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017. The following is a chronology of reports and reviews into the trust's maternity services over this time.

This timeline shows the failure of the trust's maternity services to listen to families and learn from critical incidents spanning the entire period of the review.

In 2001, a woman gave birth to a baby in very poor condition who subsequently died at 21 minutes of age. The cause was due to failure to recognise abnormalities in the fetal heart monitoring. The family felt that there was no attempt to be honest with them in subsequent correspondence from the trust and they claimed that, as well as clinical mistakes, there was obfuscation and a cover-up. The family subsequently took legal action against the trust in order to get answers that they had been unable to get from the trust before litigation commenced.

In 2002, a baby girl named GRO-A died following a traumatic ventouse and forceps delivery. The subsequent independent medical report prepared for this family found severe failings in obstetric care. The mother described how at that time she felt like a 'lone voice in the wind' trying to raise concerns about the trust's maternity unit. GRO-A's mother made multiple attempts to publicise what had happened to her daughter including appearing on national television on the 'This Morning' programme in 2006.

GRO-A's mother told the review chair in late 2018:

> " I hope that, by speaking out, other women who've suffered in childbirth will come forward … to expose the cover-ups that clearly happen… at the time, because I ended up on This Morning as well, talking about this, and the amount of women that day that phoned in, who'd gone through similar things, and it gave me a kind of peace because I knew that they were getting help in the right direction."

2007: Healthcare Commission

In 2004, 2 babies were born in poor condition that resulted in cerebral palsy. These cases were reported in the local press at the time and the solicitor who represented both families wrote to the then regulator of NHS trusts, the Healthcare Commission (HCC) and the Shropshire and Staffordshire Strategic Health Authority calling for an inquiry. The review team has not seen any evidence that an inquiry took place.

Three years after the experience of these families in April 2007, the HCC wrote to the then CEO of the Royal Shrewsbury Hospital regarding its concerns about the maternity service (https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf). The HCC said they had received concerns in March 2006 with regards to poor care resulting in birth injuries. The allegations raised with the HCC were that:

- staff failed to recognise and act upon abnormal cardiotocograph (CTG) tracings
- there was non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines
- there was a lack of, and inappropriate, staff training

The HCC:

- visited the maternity service and said it was satisfied that CTG training for staff and a CTG audit had been introduced, and that the trust was following NICE guidance
- considered that the concerns raised did not meet its criteria for an investigation and therefore did not undertake one, but suggested areas for improvement with a plan to monitor the implementation of the recommendations until it was satisfied that sufficient progress had been made
- noted the trust's low caesarean section rate of 14% in 2005 compared with the UK national average of 23.2%

- did not examine unplanned admissions to the neonatal intensive care unit (NICU), rates of HIE or relevant other near misses

This was a significant lost opportunity for learning at an already troubled trust.

In the letter from the HCC to the trust dated April 2007, the following recommendations were made:

Concern	Recommendation
CTG	The trust should send a copy of the latest CTG audit to the HCC and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of or inappropriate staff training	Skills drills training programmes should be evaluated and revised where necessary.
Risk management systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)	The trust needs to improve the quality of the action plans resulting from clinical incident cases and high-risk case reviews – that is, the actions need to be clearly measurable, the accountable person named and they should have timescales.
How policies and procedures are rolled out to staff and embedded in practice	Policies and procedures should be reviewed in a timely manner, in line with national guidance, and staff should be clear of any revisions.
Clinical governance	The trust should share its revised clinical governance structure with the HCC.
Clinical risk adviser	The trust should consider the need for permanent additional resource for the clinical risk adviser for the children and maternity service.

2008: baby GRO-A in 2008 and 2009: baby GRO-A GRO-A

In GRO-A 2009, baby GRO-A died following her birth at Ludlow Birth Centre. GRO-A and GRO-A, GRO-A's parents, have up to the present day voiced their concerns about the circumstances surrounding GRO-A's death and about the safety of maternity services at the trust.

The Ockenden review team notes that another baby was born the year before, in GRO-A 2008, also at Ludlow Birth Centre. Baby GRO-A died a few days after birth

after also being born in a very poor condition. A review of this case by the review team has noted that there were significant concerns in the care provided to GRO-A 's mother and that there was not an appropriate investigation. The coroner did not hold an inquest, following receiving information provided by the trust, but the family explained to the review chair that they were not involved in these discussions between the trust and the coroner.

In summary, the births of baby GRO-A and GRO-A have similar features. Both mothers presented with antenatal clinical concerns and reduced fetal movements, there were concerns during the labours, there were resuscitation concerns for both babies and both babies required air ambulance transfer. Both families were dissatisfied with the internal investigations and failure to obtain answers to their questions.

A paediatric death review (an internal investigation by the trust) occurred in September 2008 following the death of baby GRO-A in GRO-A 2008. The minutes of the meeting state that all midwives were up to date with neonatal resuscitation and:

> " advised all midwives to call 999 at the first sign of mother or baby being compromised."

This was also stated in the action plan which said:

> " an ambulance should be called as soon as there are indications that transfer of mother or baby may be required due to the time lag in the ambulance arriving."

When GRO-A was born 10 months after baby GRO-A in the same birth centre, an ambulance was not called for 90 minutes despite signs that GRO-A was seriously unwell from birth.

One overarching theme from this review is that, over the years, there has been a failure within maternity services at the trust to investigate and learn from serious clinical incidents. It is apparent that baby GRO-A 's death in 2008 did not result in any actions or learning. It is also noted that when the subsequent death of GRO-A GRO-A was investigated by Debbie Graham (https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf), Ms Graham could not locate any definitive guidance for the operating of Ludlow midwife-led unit for 2009. This was despite the fact that, after the earlier death of baby GRO-A , these issues were raised as being of importance to ensure the safety of mothers and babies, yet no action appears to have been taken.

GRO-A 's parents were scathing of the trust, and their lack of transparency and openness and their failure to learn. In a meeting with the review chair in early 2022, GRO-A 's mother told of:

> " phoning and phoning the [Royal] Shrewsbury Hospital for over a year, waiting and waiting for answers… They were always on leave, always in surgery, always not available. No one spoke to me."

GRO-A 's father described the trust as:

> “ ducking and diving, avoiding telling the truth. They’ve been dodging and weaving all these years.”

GRO-A ’s parents eventually commenced litigation in order to get the answers they wanted from the trust.

The Ockenden review team has also searched within the vast amount of information provided by the trust for relevant guidelines. The Shrewsbury and Telford Hospital NHS Trust guideline ‘Resuscitation of the Neonate at a Midwife-Led Unit or a Home Birth by a Midwife and When to Summon Assistance’ was first implemented in June 2010. It took just over 2 years after the death of baby GRO-A and 15 months after the death of GRO-A to ensure this critically important clinical guideline was introduced.

In 2015, a woman had a delayed transfer from the midwifery-led unit and fetal monitoring was not undertaken during the transfer period. The baby was delivered in very poor condition and subsequently died. The family were critical of the ensuing investigation and of correspondence with the Trust, and said during a meeting with the Ockenden review team that they had been:

> “ put off, fobbed off and had obstacles put in our way.”

2013: clinical commissioning groups’ review

In 2013, there was a review into the maternity services at the trust by the 2 clinical commissioning groups (CCGs) (https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D). This review was commissioned following concerns over an increased incidence of serious clinical adverse events and the safety of the clinical model of maternity care in Shropshire.

The CCGs’ review of risk management focussed on reported serious incidents and near misses in the period from 1 April 2012 to 31 March 2013.

The review team has found evidence of significant underreporting and cases that should have been investigated not being investigated, so it is our view that the CCGs’ review would have underestimated the scale and volume of the incidents at the time. The CCG review also looked at policies, clinical governance systems, care pathways and training, and concluded that:

> “ there was an openness and transparency in reporting and investigation culture, which has led to a higher reporting of serious incidents than would have been reported elsewhere.”

The review stated further:

> “ there is a robust approach to risk management, clinical governance and learning from incidents.”

The higher reported rate of unexpected admissions to the NICU compared with other local units was attributed in part to “diligent reporting” and a thematic analysis

was recommended to understand the reasons for this higher NICU admission rate.

Of note in this CCGs' report is a recommendation for neonatal services that:

> " measures to implement standards for 'Local Neonatal Units' are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care."

There is evidence within this second Ockenden report that this recommendation was not implemented (see Chapter 12 of the full report). Furthermore, a recommendation concerning serious incidents said that the trust must:

> " ensure serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework (https://www.england.nhs.uk/patient-safety/serious-incident-framework/)."

There is no evidence in the documentation provided to the review team by the trust that this recommendation was actioned (see Chapter 4 of the full report). There is also no evidence that the CCG held the trust to account for meeting these very important recommendations.

The 2013 CCG review also included comments from 47 women across 13 maternity service user focus groups. It should be noted that this survey took place when the labour ward was at the much older Royal Shrewsbury Hospital prior to a move in 2014 to a new purpose-built maternity unit at the Princess Royal Hospital, Telford, so any negative comments on the condition of the estate could be reasonably disregarded.

Within the 2013 report, there were some very positive comments from women:

> " All of the staff involved in my care – both during my pregnancy and in labour – were excellent. The midwife who dealt with my labour was first rate."

> " The care we had was excellent – the midwives acted swiftly to save my daughter's life, as did the neonatal ward in Shrewsbury."

However, there were also some very concerning negative comments:

> " I had a terrible experience and ended up being treated for post-traumatic stress following this birth, ahead of my second child. I felt frightened and not listened to during the birth and was 'cared' for by a rude uncaring doctor."

> " The whole experience of labour and the birth was horrific. The midwife was horrible, the on-call consultant was bad tempered."

> " I felt the midwives were unprofessional and rude. I had no help with feeding and consequently felt really alone. I thought midwives would be kind and they weren't a bit. They just kept telling me how busy they were. I don't want to have another baby at Shrewsbury."

> " I had an awful experience giving birth, the midwife was horrible to me, I felt I got no support. Afterwards in the ward I got no help with breastfeeding."

> “ I felt that my concerns during labour were not addressed, that I was made to have a natural birth when an emergency c-section was more appropriate just so they didn’t dent their precious natural birth rate target. I felt like I was on a butcher’s slab.”

Although, as commented by the authors of the CCG report, 90% of the patient feedback was favourable, the 10% negative feedback contains some very concerning family stories indicating poor maternity care. The sample size of 47 women was also very small. The report thanks “the young mums who provided valuable feedback”. It is of note that the families’ concerns, which do not appear to have been followed up by the CCG, are very similar to many of those heard by the Ockenden review team.

The overall assessment from this CCG review was that this was a safe and good-quality service. The report states:

> “ It is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust…”

The trust board reviewed this report in papers supplied to the review team and, in the minutes, it noted:

> “ [some] concern about some families’ experiences but this was in the context of generally good services.”

2014: NHS Litigation Authority assessment

In March 2014, the trust was assessed by the NHS Litigation Authority[footnote 1]. This assessed the maternity service for:

- organisation
- clinical care
- high-risk conditions
- communication
- postnatal and newborn care

The trust was awarded the Level 3 standard – this was the highest standard available to be awarded. It should be noted that the Clinical Negligence Scheme for Trusts (https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/) standards at the time were assessed almost entirely from self-reporting of guidelines and procedures.

In 2014, there was a Deanery (medical training) review[footnote 2] into the training received by obstetrics and gynaecology staff. Under areas for improvement and with reference to clinical governance it said:

> “ The trust must integrate clinical governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from clinical incidents, and that any learning points are clearly disseminated to trainees appropriately.”

There is no evidence that has been seen by the review team that this was actioned by the trust.

2015: Care Quality Commission report

In 2015, there was a Care Quality Commission Quality Report (https://www.cqc.org.uk/provider/RXW/reports) on Shrewsbury and Telford Hospital NHS Trust that followed on from a visit to the trust in 2014.

The overall rating for maternity services was 'good'. It is noticeable that in this CQC report other trust services such as medical care, surgery and urgent and emergency services were rated as 'requires improvement'.

The CQC did comment that staffing levels should be improved on the labour ward and also commented that:

> " the trust must ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised, so that service development and learning can take place."

However, this comment was a trust-wide action and not specific to the maternity service.

2015: Debbie Graham's independent review

In 2015, there was an independent review by Debbie Graham (https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf), which reviewed the high-profile case of GRO-A and made some criticisms of the trust's response to the family.

The independent review by Graham found that, although clinical governance processes were in place in 2009, at the time of GRO-As birth there was a disconnect between policy and the systemic mechanisms in place, which prevented effective clinical governance activity from being embedded into the culture of the organisation.

This lack of a safety culture within maternity services at the trust prevented GRO-As death being raised as a 'serious incident'. Instead of a serious incident investigation, the death was investigated as a 'high-risk case review' and, secondly, as an unconnected midwifery supervisory investigation. Therefore, no learning started to occur from GRO-As death until the findings of the coroner's inquest in 2015, 6 years after GRO-A died.

In its conclusions, the Graham report stated that:

> " the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services… In particular the development of advocate roles within the trust that will work to strengthen the voices of patients and their families so they may be heard in the future."

2016: baby GRO-A

GRO-A gave birth to her daughter GRO-A at home in GRO-A 2016. GRO-A died the day after her birth due to neonatal meningitis from Group B streptococcus infection. GRO-A had phoned midwifery staff about GRO-A's feeding, breathing and other symptoms a number of times overnight after her birth and before she died, but had been reassured. It was established at the coroner's inquest that GRO-A would have survived had post-delivery literature been given to GRO-A's parents and a complete systematic enquiry into her neonatal health taken place.

GRO-A's and GRO-A's parents (GRO-A and GRO-A GRO-A) wrote a joint letter to the trust board in April 2017 expressing concern about maternity services at the trust, discussing their own losses and other cases, and saying that nothing had been learned and nothing had changed with regards to maternity services since GRO-A's death in 2009. At interview with the chair of this review in December 2017, GRO-A, GRO-A's father, described the behaviour of the trust at the time of her death and afterwards as feeling:

> " like it was a sweep under the carpet, that's what it felt like."

GRO-A, GRO-A's mother, described to the chair of the review in November 2017 the significant effort the family made to try to get the trust to investigate her death in GRO-A 2016. She said:

> " So…I left it until late May, and then it went into June and we'd heard nothing at all from them so I phoned… and said: 'What's happening? Surely there's an investigation taking place?' And [X] said to me: 'Oh, it's just an internal thing, we're looking into it, but if you've got any questions just send them to me and I'll ask them to look at them'…

> " I…said : 'It's not right, you don't just have a sudden, unexplained death and then say there's no investigation and the family's not going to be involved.' So I went online straight away and got some NHS England guidance up about involving families and sent it… emailed it… And said there's got to be more to it, and I sent… some questions… And, from there, I contacted… I was just thinking something's not right and I'd seen a lot about GRO-A and GRO-A GRO-A, and I made contact with them… I contacted the chief exec at SaTH [Shrewsbury and Telford Hospital NHS Trust] and said, you know, this has got to be investigated…"

2017: Ovington review (internal)

In 2017, the Quality and Safety Committee of Shrewsbury and Telford Hospital NHS Trust] commissioned an internal review into the maternity services following on from concerns raised by bereaved parents and the increased perinatal mortality rate, which had resulted in public attention. This report, Review of Maternity Services 2007 to 2017 (https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-

Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf), was authored by Colin Ovington, then working within the trust, and published in 2017.

The Ovington report made recommendations that the maternity service should ensure that governance arrangements are more transparent and open, and should improve the learning from incidents and investigations. It recommended engaging peers from other trusts to assist in the investigation and learning from incidents, and that the trust should use a standardised process for investigating stillbirths and neonatal deaths.

It is unclear whether these recommendations were ever acted upon since the review team has not been provided with or seen any connected action plan or any evidence of completion of the actions following that report.

2017: RCOG invited review

In 2017, there was a RCOG invited review and subsequent report into the maternity services based on a visit to maternity services at the trust carried out from 12 to 14 July 2017[footnote 3]. This report noted that:

- there were workforce issues, with insufficient numbers of consultants providing obstetric cover. It also noted that middle-grade rotas were not always filled by the deanery meaning that the maternity service relied on overseas trainees and locums
- risk management and governance systems were inadequate with a lack of resources
- incident reporting was inadequate with little evidence of widespread learning from incidents
- the assessors viewed the allocation of the workforce across the sites as a patient safety issue
- current morale among the midwifery workforce was very low
- the midwifery manager on-call rota required managers to deal with clinical areas they had no experience with
- the perinatal mortality rates had remained above average compared with rates in similar trusts. The assessors did not see evidence of action plans and resulting changes in practice to act on this concern

The RCOG report was not presented to the trust board until July 2018 and, when presented, it was prefaced by a report addendum dated 27 April 2018 that reported on interim progress on the recommendations from the original report.

2020: NHS Improvement response

Concerns were raised by families as to the time taken for this report to be presented to the trust board. On 29 November 2019, a letter of complaint was sent to the National Medical Director by 2 families.

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

In response to this letter, NHS Improvement’s investigation team conducted a review into these allegations and published the document ‘Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust’ (https://www.england.nhs.uk/midlands/publications/review-of-the-handling-of-a-report-produced-by-the-royal-college-of-obstetricians-and-%20gynaecologists-on-maternity-services-at-shrewsbury-and-telford-nhs-trust/) in July 2020.

This NHS Improvement review noted that 12 months elapsed between the RCOG’s site visit and the report being presented to the trust’s board. It noted that, when the draft report was received 3 months after RCOG’s site visit, a number of trust staff were unhappy with the findings, feeling it was not an accurate representation of the service. The CEO, in part guided by maternity staff feedback, initially did not accept the RCOG draft report.

Following further discussions with RCOG, the trust did then accept the report in early January 2018, but remained concerned about its tone and content, particularly in relation to the executive summary. The trust made representations to RCOG to address this and also proposed a follow-up exercise to evidence improvements the trust felt it had made. The RCOG declined to make any further changes to the report, but did agree to this follow-up exercise to be conducted as a ‘progress review meeting’ at the RCOG’s premises in London. The RCOG did not visit the trust to assess the ‘improvements’ for themselves.

When the report was finally presented to the trust board, the covering paper was overwhelmingly positive in tone, with its 12-point summary reflecting only the most complimentary aspects of the addendum itself. The overall result was a document that gave the impression that issues in the maternity service had been largely resolved, when in fact there was still significant further work to do.

The NHS Improvement report further found that governance arrangements at the maternity service and care group level were not operating effectively in relation to the report and associated action plan. Although a lot of work was initially done to implement actions and keep the action plan updated, there had been very limited ongoing scrutiny of the plan by local or corporate governance forums. This was concerning given the severity of some of the issues identified in the 2017 RCOG report.

The NHS Improvement report noted that the trust was not obligated to commission the RCOG invited review but chose to do so and committed from the start to publish the results, knowing that this would open it up to further scrutiny. However, when the outcome was less favourable than hoped for, the primary focus of maternity services and the trust seemed to shift towards the perceived public

reaction to the report, rather than getting the right internal assurance and scrutiny to ensure the necessary improvement of patient services.

Following the publication of the RCOG report, there was significant criticism in the media and from families that the body had not alerted the regulator (the Care Quality Commission) with regard to its findings. Instead, the RCOG had only released the report to the trust.

At the time, the RCOG sent reports[footnote 4] arising from invited reviews to the service or trust that had been reviewed without always notifying regulators. Page 3 of the 2015 policy[footnote 5] was clear that the RCOG would "encourage dialogue… with regulatory agencies and authorities" and "encourage the sharing of the report with the CQC…".

The RCOG policy was subsequently strengthened in 2020 with the policy stating that:

> " the RCOG will send a copy of the final report to the organisation's healthcare regulatory bodies."

2018: Care Quality Commission

In 2018, there was a CQC report that rated the maternity service inadequate (https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust) under the safety domain. Of note, there were concerns about cardiotocograph training and mandatory training. The report also commented:

> " We found areas of concern that were raised in our last inspection [of] December 2016 – for example, service-wide sharing of learning from serious incidents was not evident [and] not all staff could give an example of learning."

The review team has been contacted by and interviewed a number of staff who have worked at the trust over the period of this review. A number of trust staff at board level have also been contacted by the review team and interviewed – these have included some current and former chief executive officers, chairs of the trust, chief nurses and medical directors.

A number of themes have come from these interviews and, broadly, this feedback forms a consistent picture of the culture in the trust during the period of this review with the documentary evidence also considered by the review team.

It was clear from a number of staff interviews that this was a trust which had a number of problems. A board member told the review team that:

> " there seemed to be a number of political issues making reform of services difficult."

There were also comments that the populations of Shrewsbury and Telford differed, and that:

> “ everybody in Telford wanted all the services in Telford and everybody in Shrewsbury wanted all the services in Shrewsbury.”

One staff member said to the review team:

> “ People just didn’t do anything… and there just wasn’t a culture of accountability for completion.”

Another commented that:

> “ this wasn’t just a maternity unit in chaos and under pressure, this was a whole organisation where it was difficult to find an area which was not under pressure.”

The review team has noted that, for many years, there have been concerns with regard to safety and performance across the whole of the trust, including the emergency department.

One interviewee described the maternity service as:

> “ the Republic of Maternity, where, often, the maternity service seemed to consume its own smoke, and didn’t like having oversight by the corporate team.

> “ There was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team.”

Over a prolonged period, the trust board and executive team were dealing with a situation where the general standard of the whole organisation was poor and according to a staff member:

> “ women’s and children’s was largely trusted to take responsibility for their own affairs and, to some extent, there was less scrutiny of them by virtue of the fact that they were perceived as being satisfactory to good.”

The impression given from multiple staff interviews with the review team was that the maternity department preferred to manage its service without trust oversight.

The trust had an executive team and board that had continual change and churn over the period of this review, with documentation[footnote 6] provided to the review team by the trust showing 10 board chairs from 2000, with 10 CEOs from 2000 to early 2020, of which 8 were in post between 2010 and the current day.

This lack of continuity at board and CEO level resulted in a loss of organisational memory and contributed to this ‘self-management’ and lack of oversight of a maternity service that had clearly been in trouble for many years. The overwhelming impression of the staff interviews is that, despite significant evidence to the contrary, the maternity unit, up until about 2017, was actually not considered to be a trust risk.

One staff member interviewed stated that, following serious incident reports, there would have been recommendations made, and that often these reports and

recommendations were good, but what was missing was the follow-up of the actions from the recommendations. It was said that:

> “ there just wasn’t a culture of accountability for completion.”

Concerns from local external bodies

In late 2021, the review team also spoke to some senior staff of the CCGs in post between the years 2013 to 2020.

We were told that the CCGs did have concerns about maternity services at the time, and were aware of the local press reports and family concerns. The CCGs had concerns about the length of time that serious incidents took to be reported and we were told by a contributor that:

> “ reviews of serious incidents seemed to take a long, long time to happen and there was an impression of evasiveness around how the learning from those reviews was shared.”

The same contributor told the review team that the CCG did have meetings with the maternity service representatives from the trust, but were assured that “things were improving” and were told that the CCGs were in any event “limited in their power to change things for the better”.

It should be recognised that the CCGs were also concerned about serious incident investigations and learning from other services across the whole trust, and not just maternity.

Missed opportunities

In summary, this was a trust that had a number of problems, but the perception was that, until 2017, the maternity service was not a major risk.

The consistent message coming from both senior maternity staff and from trust board members was that external reports into the maternity service were generally favourable, and that there were more pressing problems in other services at the trust. The management of the maternity service was perceived to be competent and able, and governance concerns seem to have been managed within the service and not escalated.

The review team believes that the trust board and the CCGs were ‘reassured’ rather than ‘assured’ with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures, this message was lost in a wider healthcare system that was struggling with other significant concerns.

Case studies

Thematic review of 3 cases at the trust sharing similar themes within a 9-month period (2008 to 2009)

Here we examine the case of GRO-A and the deaths of 2 other babies that occurred within a short time period at the Shrewsbury and Telford Hospital NHS Trust. Throughout this report we highlight repeated incidents where maternity services at the trust failed to investigate, learn and make impactful changes to improve patient safety.

Within 9 months, between May 2008 and March 2009, there were 3 neonatal deaths of babies that should have led to a systematic review of governance processes, strong actions and learning as well as a coronial inquiry into safety at the trust. In all 3 cases, there are:

- significant failings in the care and treatment provided
- omissions in the subsequent investigation into care
- failures to learn and establish processes for safe delivery in the midwifery-led unit (MLU) and consultant unit

Most concerning is a lack of transparency and honesty in communication with the families concerned, despite internal recognition at the trust that the investigations were not robust.

These case studies contain a number of technical medical terms – please see the Glossary in the full report for definitions.

2008: baby GRO-A

The maternity review team has found evidence of a case that occurred 9 months earlier than that of GRO-A. In GRO-A 2008, a baby boy called GRO-A was born at Ludlow MLU in poor condition. GRO-A was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit and died there on day 6 after his care was withdrawn.

GRO-A 's mother was considered low risk with a previous pregnancy and birth, and it seems an assumption was made that she would deliver in the freestanding MLU at Ludlow. There was no analysis of risk to ensure normality and whether or not it was appropriate or not to deliver in Ludlow.

However, from 31 weeks of pregnancy the maternal risk changed. GRO-A 's mother reported 3 episodes of severe uterine tenderness and tightening. One occasion led to an ambulance admission to Royal Shrewsbury Hospital and this review team believes that concealed abruption should have been considered by clinicians at the time.

GRO-A 's mother reported decreased fetal movements the day prior to labour at 37+5 weeks gestation. No admission CTG was performed; she progressed quickly in labour, and an amniotomy performed at 9cm revealed significant meconium. Seventeen minutes later, her baby was delivered with no sign of life. No ambulance

had been called in preparation for delivery and no attempt was made to perform a CTG once the meconium was identified.

Two midwives at the unit attempted to resuscitate the baby, but did not follow UK resuscitation guidance. A paediatrician doing a peripheral clinic took over the resuscitation. An ambulance road crew arrived to help. GRO-A was transferred unsecured on a stretcher, and ventilated by valve and mask in the air ambulance to Royal Shrewsbury Hospital where he was ventilated, and remained comatose until treatment was withdrawn on day 6, after a head scan revealed severe widespread damage to GRO-A 's brain.

The review team observes that timely intermittent auscultation was not performed in labour and what monitoring did occur was not described in an accepted manner. The review team is concerned by alterations added to the notes in a different pen that appear to change the fetal heart rate recordings documented during labour.

Placental histology confirmed a significant abruption with an attached and organised blood clot. The pathologist concluded that the abruption was silent and established. Despite this, the explanation given to the parents at the bereavement consultation was that the abruption must have been acute in the final 15 minutes of labour, perhaps secondary to a tight umbilical cord causing an unpredicted, acute placental detachment. This is despite no evidence of fresh blood loss at birth or post-partum haemorrhage. The bereavement letter stated “nothing could have been done or predicted” and lacked any apology or reassurance that lessons would be learned.

The review team do not accept this opinion of the likely pathology. In addition, we observe from the maternity records supplied by the trust that the meconium revealed prior to birth was thick and established, indicating that the release was likely to have been some time before, perhaps in the days leading to labour when decreased fetal movements were reported. The review team consider that concealed abruption most likely occurred in the third trimester, contrary to the opinion offered to the parents at the bereavement appointment.

There are a number of documents provided to the review team by the trust that show discrepancies between the factual events and what was actually discussed with the parents. There are also extracts that contain additional information, which was not disclosed to the family. This information is found in incident reports filed by members of staff and communications between professionals provided to the review team by the trust.

The review team conclude that the risk management review of this incident by the trust failed to follow appropriate local investigation processes to identify the root cause. The trust also failed to decide on appropriate actions in order to prevent similar harm in the future. It is of concern that a decision to refer to the coroner was reversed by a small number of individuals within the trust who decided to manage this incident internally.

The review team has been aware of internal reports of concern around the lack of:

- vital resuscitation equipment being available at Ludlow

- familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation
- ability to monitor oxygen saturation
- ability to monitor the baby during resuscitation
- facility to thermoregulate and monitor the baby in the air ambulance

Documents shared with the review team by the trust show that the lack of a portable resuscitaire in Ludlow MLU had been on the maternity risk register since 2005. The trust did not support this concern and excused the lack of equipment on the basis that it would only be used by a neonatologist. There was an assessment of the resuscitation equipment at the unit, but no details were given of the outcome. The review team is concerned by the response to this risk as it demonstrates poor evidence of learning. The additional information around the maternity risk register and the fact that this was a known risk regarding Ludlow MLU was never detailed to the parents during their meeting with the obstetrician or to any other professionals outside the organisation.

A few weak action points from this case were circulated via a memorandum suggesting that change in practice was not mandatory and it was optional whether to use CTG monitoring if a woman presented with reduced fetal movements at the MLU. It also suggested it was optional to summon an ambulance when amniotomy was performed with evidence of meconium.

A clinician who cared for the baby initially stated in a letter to the clinical director in July 2008 that they had serious concerns regarding the quality of the case review. They pointed out a number of inaccuracies in the findings of the review and wrote:

> “ I really do wonder whether they have actually read these notes and wonder [about] the quality of the case review.
>
> “ I am concerned that there is evidence the parents have not received an accurate explanation of the events leading up to the birth, during the birth and the resuscitation.”

2009: baby GRO-A

In GRO-A 2009, after the birth and death of GRO-A but before GRO-A GRO-A was born, a multiparous mother delivered in the consultant unit. Uterine rupture was diagnosed at caesarean section after a failed ventouse and prolonged labour with injudicious oxytocin use. The baby, named GRO-A, died at 34 minutes of age and was classified as an early neonatal death. The coroner agreed to the stated cause of death as:

1. Multiple organ failure.
2. Severe HIE.
3. Ruptured uterus and placental abruption.

No post mortem was performed.

The mother was booked for an MLU delivery despite having had a very long previous labour with a macrosomic baby. No gestational diabetes testing was performed in this second pregnancy. Numerous attendances in a long latent phase of labour were apparent and all clinical midwifery reviews highlighted a large for dates baby with poor engagement of the fetal head.

The mother was admitted to the consultant-led antenatal ward, contracting at 4cm dilatation. Nineteen hours later, she was taken to the labour ward for amniotomy at 5cm. During the 11 hours following amniotomy, there were repeated periods of abnormal CTG, and high-dose oxytocin infusion was administered for long periods of time leading to and after full dilatation. The contraction frequency was 5 in 10 minutes for long periods and poor medical input was noted. Vaginal examinations revealed classic signs of obstructed labour of a baby in the deflexed occipito-posterior position.

An hour prior to eventual birth by caesarean section, there were classic signs of uterine rupture including haematuria, breakthrough pain, hypotension, and diminished uterine activity, failure to establish between a clear fetal or maternal heart rate. The midwife sought assistance for possible uterine rupture. A ventouse delivery was initiated 35 minutes later and failed after 3 pulls. A caesarean was conducted 10 minutes later and uterine rupture with placental abruption was found. The baby briefly had a heartbeat, but at 34 minutes of age resuscitation was discontinued.

A DATIX31 submission was generated following this event and the outcome of uterine rupture, early neonatal death and major obstetric haemorrhage (4.8 litres) was classified as low harm. It was stated that the case would be discussed in a case review meeting that same month, but to date the review team has received no documents from the trust pertaining to a risk review or outcomes.

The review team has graded this incident as Grade 3 (the highest grade of harm) and has major concerns with the management of the incident and the apparent lack of scrutiny.

In a bereavement letter, the trust inaccurately informed the parents that the demise was acute and no one could be certain when the rupture occurred. No reference is made in the letter to the reasons why the mother's uterus was ruptured or to the chronic hypoxia revealed by the cord ph. There is no reference in the letter to lessons being learned or actions that could prevent such tragedy in the future.

2009: the GRO-A family and baby GRO-A

Two months after the birth and death of baby GRO-A and 9 months after the birth and death of baby GRO-A, baby GRO-A died avoidably on GRO-A 2009 after her birth at Ludlow MLU. Kate died at 6 hours of age following cardiopulmonary collapse at 90 minutes of life. She was severely anaemic and paediatric help should have been sought earlier.

The case has been reviewed extensively with a highly criticised supervisory investigation, multiple external opinion reports and, finally in 2012, a coroner's

inquest with jury – all of these occurring after constant pressure from GRO-A's grieving parents.

The inquest concluded that GRO-A should not have been born at Ludlow. The 2 weeks of reduced fetal movements prior to labour was a factor in GRO-A being born anaemic, as she had likely suffered repeated episodes of feto-maternal haemorrhage. The MLU staff failed to provide GRO-A and her mother GRO-A with midwifery expertise. Intermittent auscultation in labour was not adequate and opportunities to manage a baby in difficulty during the first hours of life were missed. GRO-A died shortly after arrival by air ambulance at a tertiary neonatal unit.

There have been numerous specialist opinions on this case over a long period of time. It is clear that the trust failed to fulfil its responsibility to establish the facts and establish accountability. In particular, the trust failed to:

- investigate GRO-A's death appropriately
- hold staff to account
- address her parent's concerns, particularly those pertaining to the inadequacy of the supervisory investigation

Further external opinions revealed that midwives did not consider her mother GRO-A 's antenatal care as a whole and did not consider the bigger picture, which would have indicated that GRO-A should not have been delivered in an MLU. The trust's investigation into midwifery practice is described as ineffective and half-hearted, and the consultant feedback is criticised as being badly considered.

Consideration of these 3 cases of term babies, GRO-A , GRO-A and GRO-A who were born and died within 10 months of each other, show that, by early 2009, there was already a systematic failure within the trust to investigate its maternity services.

Following on from their failure to investigate the deaths of GRO-A , GRO-A and GRO-A , the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.

The review team is particularly concerned by the lack of transparency internally within the trust, and the lack of honesty and transparency with families. This is all the more concerning when it is clear that major issues in safety were apparent in both MLU and consultant settings during the period leading up to the birth and death of GRO-A , and before the birth and death of baby GRO-A and then baby GRO-A .

Our findings following the review of family cases

A total of 1,862 cases were either reported by the trust or self-referred to the review. After the closure date for referrals, the database was reviewed and 47 duplications were identified and removed, leaving 1,815 cases.

The review was intended to span the years 2000 to 2019. However, as discussed previously, some earlier and later cases were reviewed in line with the updated terms of reference. The earliest case reviewed occurred in 1973 and the latest in 2020.

Total clinical incidents reviewed

After excluding cases for which hospital records were missing, or where consent for participation in the review was not given or could not be obtained, the final number of families whose cases were reviewed was 1,486.

It is important to note that some families had more than one clinical incident reviewed, as some mothers had more than one pregnancy during the review period.

In total, 1,592 clinical incidents were reviewed. Table 1 outlines the number of families and clinical incidents throughout the review period.

Table 1: time period of family cases included in this review

Years	Number of families	Number of clinical incidents
Pre-2000	170	181
2000 to 2019	1,305	1,393
Post-2019	15	18
Totals	1,486[footnote 7]	1,592

In line with the terms of reference underpinning this review, we reviewed all 1,592 clinical incidents and analysed 2 aspects:

1. We graded the care provided by the trust as set out below in ‘Grading of care’.
2. We reviewed all the maternity governance documentation provided to the review team, and graded the quality and appropriateness of the incident investigation in line with national frameworks at the time.

Grading of care

All the clinical incidents were reviewed by members of the review team, which comprised:

- obstetricians
- midwives
- neonatologists

- other specialists, where appropriate

The clinical care was graded using an established grading of care scoring system (Table 2) developed by the Confidential enquiry into stillbirths and deaths in infancy (CESDI) (https://pubmed.ncbi.nlm.nih.gov/10392116/), which was similarly used in the Morecambe Bay investigation report (https://www.gov.uk/government/publications/morecambe-bay-investigation-report) by Dr Bill Kirkup OBE.

Further details on the findings and the IEAs recommended by this review are described in the accompanying chapters in the full report.

Table 2: grading of maternal and newborn care provided

Grade	Summary description of care	Detailed description of care
0	Appropriate	Appropriate care in line with best practice at the time
1	Minor concerns	Care could have been improved, but different management would have made no difference to the outcome
2	Significant concerns	Suboptimal care in which different management might have made a difference to the outcome
3	Major concerns	Suboptimal care in which different management would reasonably be expected to have made a difference to the outcome

Tables 3a to 3e show the grading of care for the major incident categories. For the incident categories HIE, neonatal death and cerebral palsy or brain damage, the investigation into mother and baby is considered as one family.

It is important to note that a mother or baby can be in more than one category, and this includes the maternal morbidity category and the combined category.

In addition, some mothers had more than one pregnancy where a clinical incident occurred during the period of the review (for example, a stillbirth in one pregnancy followed by another incident in a subsequent category).

Maternal deaths

Table 3a: clinical review findings for maternal deaths

Number of reviews	Grade 0	Grade 1	Grade 2	Grade 3	Percentage of care at grade 2 and 3
12	0	3	6	3	75.0%

There were 12 maternal deaths reviewed and, in 9 of the 12 cases (75%), the review team identified significant or major concerns in the care received. Maternal deaths are further discussed in Chapter 10 of the full report.

Stillbirth

Table 3b: clinical review findings for stillbirth

Number of reviews	Grade 0	Grade 1	Grade 2	Grade 3	Percentage of care at grade 2 and 3
498	193	174	93	38	26.3%

498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in care which, if managed appropriately, might or would have resulted in a different outcome.

HIE

Table 3c: clinical review findings for HIE

Review type	Number of reviews	Grade 0	Grade 1	Grade 2	Grade 3	Percentage of care at grade 2 and 3
Mother[footnote 8]	44	10	5	16	13	65.9%
Baby[footnote 9]	41	26	13	2	0	4.9%

HIE is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two-thirds (65.9%) of all cases.

After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns – however, these were unlikely to influence the outcome observed.

Neonatal death

Table 3d: clinical review findings for neonatal death

Review type	Number of reviews	Grade 0	Grade 1	Grade 2	Grade 3	Percentage of care at grade 2 and 3
Mother[footnote 8]	251	107	74	38	32	27.9%
Baby[footnote 9]	237	182	38	13	4	7.2%

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9%) were identified to have significant or major concerns in the maternity care that might or would have resulted in a different outcome.

Cerebral palsy or brain damage

Table 3e: clinical review findings for cerebral palsy or brain damage

Review type	Number of reviews	Grade 0	Grade 1	Grade 2	Grade 3	Percentage of care at grade 2 and 3
Mother[footnote 8]	147	35	47	45	20	44.2%
Baby[footnote 9]	139	99	30	8	2	7.2%

All of the families in this group self-reported to the review. The diagnosis of cerebral palsy was often made some years following their maternity episode.

On reviewing the medical records, where it was found that the neonatologists at the trust had recorded a diagnosis of HIE in the early neonatal period, a small proportion of families were subsequently transferred to the HIE incident category.

From the remaining cases of cerebral palsy, more than 40% were identified to have significant or major concerns in maternity care which might have resulted in a different outcome. The grading of neonatal care in most of the cases was either appropriate or with only minor concerns.

Maternal morbidity

Within this group were families who did not meet the incident categories identified in the NHSEI and trust-led open book exercise conducted in the autumn of 2018 (maternal death, stillbirth, neonatal death and HIE).

There were 614 women in this group, and they included women who:

- experienced morbidity such as admission to intensive care
- had had a caesarean hysterectomy
- had severe sepsis or major haemorrhage, or reported having experienced rare adverse outcomes such as eclampsia, amniotic fluid embolus or a cardiac arrest

Our reviewers identified significant and major concerns in the care provided to 1 in 4 women in this group. The care provided to the baby was considered appropriate in more than 90% of records reviewed.

Combined category

This group included families who were outside the other categories. Some of these families self-reported. This category included :

- medical termination of pregnancy
- missed fetal abnormality
- neonatal intraventricular haemorrhage
- infant death
- child death

There were 58 cases reviewed in this group. Most of these cases were graded as receiving appropriate care or care with only minor concerns.

Quality of investigation

We graded the quality and appropriateness of clinical incident investigations undertaken at the trust throughout the time period of the review. Nationally, investigative processes have improved over time and this is described further in Chapter 4 of the full report.

Table 4 outlines the grading system used for the clinical incidents from 2011 onwards.

Table 4: grading of investigations from 2011 onwards

Grade	Investigation	Family involvement
Appropriate	Incident investigated by team of clinicians. Appropriate collection of evidence (statements, notes, policies and so on). Appropriate care and service delivery problems identified. Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with family at time of incident. Feedback to family once investigation concluded.
Poor	Any of the above missing (state which).	Very little family involvement or feedback to family lacking after investigation.
None	Incident not investigated.	No family involvement.

The tables below show the results for stillbirths and neonatal deaths for the period 2011 to 2019. The maternal death investigations are discussed more fully in Chapter 10 of the full report.

Where there was no trust investigation, this is shown. In some cases, the review team reported ‘unable to grade’, which was usually due to incomplete documentation. Only where there was sufficient documentation for a review was a grading of ‘appropriate’ or ‘poor’ given.

Table 5: stillbirths (2011 to 2019)

Type of grading	Total number of cases	Total number of cases where an investigation took place (with sufficient data)	Appropriate	Poor	Unable to grade
Investigation	168	100	36%	49%	15%
Family involvement in investigation	168	85	32.9%	40.0%	27.1%

In the period 2011 to 2019, 68 (40%) of the 168 stillbirths reviewed did not have an investigation. Of those where an investigation occurred, 36% were found to be appropriate. Family involvement was graded as appropriate in 33% of cases.

Table 6: neonatal deaths (2011 to 2019)

Type of grading	Total number of cases	Total number of cases where an investigation took place (with sufficient data)	Appropriate	Poor	Unable to grade
Investigation	77	44	54.5%	34.1%	11.4%
Family involvement in investigation	77	41	41.5%	31.7%	26.8%

In the period 2011 to 2019, 33 (43%) of the 77 neonatal deaths reviewed did not have an investigation. Of those where an investigation occurred, 55% were considered to have been appropriately investigated. Family involvement was graded as appropriate in 42% of cases.

In the HIE group, there were 12 cases reviewed for the period 2011 to 2019 and, of these, 8 were investigated by the trust. This group was considered too small to draw conclusions on the quality of the investigation.

Immediate and essential actions to improve care and safety in maternity services across England

We include these immediate and essential actions (IEAs) to improve safety in maternity services across England. These IEAs complement and expand upon the IEAs issued in our first report. We note that NHSEI has supported the implementation of these actions in trusts across England since our first report was published.

These further IEAs arise from findings from this large review into maternity services at Shrewsbury and Telford Hospitals NHS Trust. However, we are aware that similar problems may occur in other trusts across England and, therefore, these actions must be implemented widely in all maternity services.

This review is supporting and endorsing the latest Health and Social Care Committee report The safety of maternity services in England (https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm).

We agree with the select committee that the budget for maternity services be increased by £200 to 350 million a year with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.

We further agree that the DHSC must work with the RCOG and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts to enable trusts to deliver safe obstetric staffing over the years to come.

This work must also consider the anaesthetic and neonatal workforce, and be advised by the:

- Royal College of Anaesthetists (RCOA)
- Obstetric Anaesthetists' Association (OAA)
- Royal College of Paediatrics and Child Health (RCPCH)
- British Association of Perinatal Medicine (BAPM)

In this regard, the review team is also aware of and endorses the initiatives on workforce planning by the RCOA and the current national review of the obstetric anaesthesia workforce by the OAA in response to the first report.

We endorse the Health Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their annual financial and quality accounts.

We endorse the Health Select Committee recommendation that the Maternity Transformation Programme board should establish what proportion of maternity budgets should be ring-fenced for training, but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.

We endorse the recommendation that a single set of maternity training targets agreed in all maternity services in England should be established by the Maternity Transformation Programme board, working in conjunction with and advised by the main Royal Colleges and the Care Quality Commission (CQC).

We endorse the recommendation that training targets should be enforced by NHSEI's Maternity Transformation Programme, the RCM, the RCOG and the CQC through a regular collaborative inspection programme.

Along with staffing and training, the Health Select Committee clearly articulated the need to learn from patient safety incidents. This issue has taken up a large part of both this second report and our first report, and we endorse the committee's

findings that families must be involved in the investigative process, and that lessons must be learned and implemented in a timely way to prevent further tragedies.

We also note the committee recognised that maternity units appear to have been penalised for high caesarean section rates and recommended that there should be an end to the use of total caesarean section percentages as a metric for maternity services. We note the progress on this with the recent advice from NHSEI to trusts[footnote 10] to stop monitoring caesarean section rates.

The recognition that Shrewsbury and Telford Hospital NHS Trust had a lower than average caesarean section rate (and was often praised for this) was identified in our first report. We noted that some mothers and babies had been harmed by this approach, and we welcome the committee's findings and the progress on this.

This review also supports the NHS Maternity Digital Programme (https://digital.nhs.uk/services/digital-maternity-programme). We recognise this as a key enabler to improve quality and safety. The use of maternity digital notes will empower women by providing them with their own digital maternity care plan and record, discussed and agreed with them and their midwife. Enhancing and improving the digital programme will improve communication and ultimately contribute to making maternity care safer.

The Parliamentary Health and Social Care Committee report recommendations on staffing, training and learning from patient safety incidents echo much of the work of our first and now this final report. We believe there is still so much more to do in order to make the maternity service in England the safest it can be. It is our intention that implementation of these further IEAs will make a significant contribution to the delivery of safe maternity care.

Importantly: we state that DHSC and NHSEI must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs, and the recommendations of other reports currently being prepared.

1. Workforce planning and sustainability

Financing a safe maternity workforce

The recommendations from the Health and Social Care Committee report, The safety of maternity services in England (https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm), must be implemented.

The investment announced following our first report was welcomed. However, to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.

Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families and additional mandatory training to ensure trusts are able to safely meet organisational Clinical Negligence Scheme for Trusts (https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/) and CQC requirements.

Minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

The feasibility and accuracy of the BirthRate Plus (https://birthrateplus.co.uk/) tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSEI, RCOG, RCM and RCPCH.

Training

We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.

All trusts must implement a robust preceptorship programme for newly qualified midwives (NQMs), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM position statement (https://www.rcm.org.uk/media/2293/preceptorship-for-newly-qualified-midwives.pdf) for this.

All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience, and provide a structured period of transition from student to accountable midwife.

All trusts must ensure all midwives responsible for co-ordinating a labour ward attend a fully funded and nationally recognised labour ward co-ordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety to tackle behaviours in the workforce.

All trusts to ensure newly appointed labour ward coordinators receive an orientation package that reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.

All trusts must develop a core team of senior midwives who are trained in the provision of high-dependency maternity care. The core team should be large enough to ensure there is at least one high-dependency unit-trained midwife on each shift 24/7.

All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.

The review team acknowledges the progress around the creation of maternal medicine networks (https://www.england.nhs.uk/publication/maternal-medicine-networks-service-specification/) nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established to ensure the appropriate workforce long term.

2. Safe staffing

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals

When agreed staffing levels across maternity services are not achieved on a day-to-day basis, this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, patient safety champion and local maternity system (LMS).

In trusts with no separate consultant rotas for obstetrics and gynaecology, there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.

All trusts must ensure the labour ward co-ordinator role is recognised as a specialist job role with an accompanying job description and person specification.

All trusts must review and suspend if necessary the existing provision and further roll-out of midwifery continuity of carer model (https://www.england.nhs.uk/mat-transformation/implementing-better-births/continuity-of-carer/)(MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.

The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.

The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.

All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.

Newly appointed Band 7 or 8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.

All trusts must develop strategies to maintain bidirectional robust pathways between midwifery staff in the community setting and those based in the hospital setting to ensure high-quality care and communication.

All trusts should follow the latest RCOG guidance on management of locums (https://www.rcog.org.uk/careers-and-training/starting-your-og-career/workforce/safe-staffing/). The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.

3. Escalation and accountability

Staff must be able to escalate concerns if necessary

There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.

If not resident, there must be clear guidelines for when a consultant obstetrician should attend.

All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.

When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence, trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.

Trusts should aim to increase resident consultant obstetrician presence where this is achievable.

There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.

There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on call should be informed of activity within the unit.

4. Clinical governance – leadership

Trust boards must have oversight of the quality and performance of their maternity services

In all maternity services, the director of midwifery and clinical director for obstetrics must be jointly operationally responsible and accountable for the maternity

governance systems.

Trust boards must work together with maternity departments to develop regular progress and exception reports and assurance reviews, and regularly review the progress of any maternity improvement and transformation plans.

All maternity service senior leadership teams must use appreciative inquiry to complete the national maternity self-assessment tool (https://www.england.nhs.uk/publication/maternity-self-assessment-tool/) if not previously done. A comprehensive report of their self-assessment, including governance structures and any remedial plans, must be shared with their trust board.

Every trust must ensure they have a patient safety specialist who is specifically dedicated to maternity services.

All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.

All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.

All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda, and have links with audit and research.

All maternity services must ensure they have midwifery and obstetric co-leads for audits.

5. Clinical governance – incident investigation and complaints

Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner

All maternity governance teams must ensure the language used in investigation reports is easy to understand for families – for example, ensuring any medical terms are explained in lay terms.

Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

Actions arising from a serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred.

Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred.

All trusts must ensure that complaints that meet the serious incident threshold must be investigated as such.

All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent.

Complaints themes and trends must be monitored by the maternity governance team.

6. Learning from maternal deaths

Nationally, all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy-related pathologies

In the case of a maternal death, a joint review panel or investigation of all services involved in the care must include representation from all applicable hospitals or clinical settings.

NHSEI must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.

This joint review panel or investigation must:

- have an independent chair
- be aligned with local and regional staff
- seek external clinical expert opinion where required

Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.

7. Multidisciplinary training

Staff who work together must train together

Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.

Clinicians must not work on a labour ward without appropriate regular CTG training and emergency skills training.

All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.

Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.

All trusts must mandate annual human factor training for all staff working in a maternity setting. This should include the principles of psychological safety and

upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.

There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies, including haemorrhage, hypertension and cardiac arrest, and the deteriorating patient.

There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well-supported staff teams are better able to consistently deliver kind and compassionate care.

Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.

Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.

8. Complex antenatal care

Local maternity systems, maternal medicine networks and trusts must ensure that women have access to pre-conception care

Trusts must provide services for women with multiple pregnancy in line with national guidance.

Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.

Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.

Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and specialist midwifery staffing.

These recommendations are supported by the NICE guideline (NG137) on twin and triplet pregnancy (https://www.nice.org.uk/guidance/ng137) (2019).

NICE guideline (NG3) on diabetes in pregnancy (https://www.nice.org.uk/guidance/ng3) (2020) should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.

When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.

Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate, and discuss risks and benefits to treatment. Women must be commenced on aspirin 75 to 150mg daily from 12 weeks gestation in accordance with the NICE guideline (NG133) on hypertension in pregnancy (https://www.nice.org.uk/guidance/ng133) (2019).

9. Preterm birth

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth

Trusts must implement NHS Saving Babies Lives Version Two (https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/) (2019).

Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.

Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.

Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival, and are aware of the risks of possible associated disability.

There must be a continuous audit process to review all in-utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and, when delivery subsequently occurs, in the local unit.

10. Labour and birth

Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary

Centralised CTG-monitoring systems should be mandatory in obstetric units.

All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen that might change recommendations about place of birth. These must be shared with women to enable an informed decision regarding place of birth to be made.

Midwifery-led units must:

- complete yearly operational risk assessments

- undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan

It is mandatory that all women who choose birth outside a hospital setting are provided with accurate and up-to-date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information by working together and in agreement with the local ambulance trust.

Maternity units must have pathways for induction of labour (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.

Centralised CTG-monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.

11. Obstetric anaesthesia

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm

Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core data sets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.

Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

Conditions that merit further follow-up include, but are not limited to:

- postdural puncture headache
- accidental awareness during general anaesthesia
- intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions
- neurological injury relating to anaesthetic interventions
- significant failure of labour analgesia

Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience, and reduce the risk of long-term psychological consequences.

All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in the General Medical Council's Good medical practice (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice).

Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core data sets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.

Obstetric anaesthesia staffing guidance to include:

- the role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services while allowing for staff leave
- the full range of obstetric anaesthesia workload including elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training and governance activity
- the competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments
- participation by anaesthetists in the maternity multidisciplinary ward rounds, as recommended in the first report

12. Postnatal care

Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review

Postnatal wards must be adequately staffed at all times.

All trusts must develop a system to ensure consultant review of all postnatal readmissions and unwell postnatal women, including those requiring care on a non-maternity ward.

Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.

Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.

Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward, both day and night, for both mothers and babies.

13. Bereavement care

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services

Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.

All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of

birth. They should have been trained in dealing with bereavement, and in the purpose and procedures of post-mortem examinations.

All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcomes.

Compassionate, individualised and high-quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway (https://nbcpathway.org.uk/).

14. Neonatal care

There must be clear pathways of care for provision of neonatal care

This review endorses the recommendations from the Neonatal Critical Care Transformation Review (https://www.england.nhs.uk/publication/implementing-the-recommendations-of-the-neonatal-critical-care-transformation-review/) (December 2019) to:

- expand neonatal critical care
- increase neonatal cot numbers
- develop the workforce
- enhance the experience of families

This work must now progress at pace.

Neonatal and maternity care providers, commissioners and networks must agree on pathways of care, including the designation of each unit and on the level of neonatal care that is provided.

Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly), and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the LMS or LMNS on a quarterly basis.

Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.

Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, advanced neonatal nurse practitioner and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.

Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.

Neonatal providers must ensure that processes are defined that enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example, out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

Neonatal practitioners must ensure that, once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cm H_2O in term babies, or above 25cm H_2O in preterm babies may be required.

The Resuscitation Council UK's Newborn Life Support (NLS) Course (https://www.resus.org.uk/training-courses/newborn-life-support/nls-newborn-life-support) must consider highlighting this treatment point more clearly in the NLS algorithm.

Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle-grade doctors or advanced neonatal nurse practitioners) and nurses are available in every type of neonatal unit (NICU, local neonatal unit and special care baby unit) to deliver safe care 24/7 in line with national service specifications.

15. Supporting families

Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision

Maternity care providers must actively engage with the local community and those with lived experience to deliver services that are informed by what women and their families say they need from their care.

There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.

Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.

Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.

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1. NHS Litigation Authority, Clinical Negligence Scheme for Trusts: 'Maternity Clinical Risk Management Standards 2013 to 2014.' The Shrewsbury and Telford Hospital NHS Trust, Level 3. 2014.

2. NHS Health Education West Midlands: 'PMET Review Findings Report Summary.' 2014.
3. Royal College of Obstetricians and Gynaecologists: 'Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust.' 2017.
4. Royal College of Obstetricians and Gynaecologists: 'Statement regarding an Invited Review by Rollege College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust.' 31 August 2018.
5. Royal College of Obstetricians and Gynaecologists: 'Invited Reviews: a guide.' 2015.
6. The Shrewsbury and Telford Hospital NHS Trust. 'Who's Who at the Trust.' Internal document received by the review team on 9 September 2020.
7. Four families had clinical incidents that fell both within the 2000 to 2019 years and outside these years. Therefore there are 1,486 unique families in total.
8. Review of the care provided to the mother.
9. Review of the care provided to the baby after birth.
10. Letter dated 15 February 2022 – reference PAR 1393.

↑ Back to top