Final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust published

Review into almost 1,600 clinical incidents identified failures to listen to families, failure to learn from clinical incidents and failure of multiple external bodies to act in improving maternity services at the Trust over two decades.

The final report of The Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, has been published today (30 March 2022).

The review has examined cases involving 1,486 families between 2000 and 2019, and reviewed 1,592 clinical incidents where medical records and family consent was gained. The Ockenden review team spoke to the families involved about their care and examined medical records. In addition, current and former members of staff completed surveys, were interviewed and contacted the review team to talk confidentially. The review team also scrutinised vast volumes of documentation provided by the Trust.

The review found repeated failures in the quality of care and governance at the Trust throughout the last two decades, as well as failures from external bodies to effectively monitor the care provided. This final report identifies hundreds of cases where the Trust failed to undertake serious incident investigations, with even cases of death not being examined appropriately. The review found that where investigations did take place they did not meet the expected standards at that time and failed to identify areas for improvement in care.

These combined failings led to missed opportunities to learn, with families experiencing repeated serious incidents and harm throughout the period of the review.

Chair of the review Donna Ockenden, said: “Throughout our final report we have highlighted how failures in care were repeated from one incident to the next. For example, ineffective monitoring of fetal growth and a culture of reluctance to perform caesarean sections resulted in many babies dying during birth or shortly after their birth. In many cases, mother and babies were left with life-long conditions as a result of their care and treatment.

“The reasons for these failures are clear. There were not enough staff, there was a lack of ongoing training, there was a lack of effective investigation and governance at the Trust and a culture of not listening to the families involved. There was a tendency

of the Trust to blame mothers for their poor outcomes, in some cases even for their own deaths.

“What is astounding is that for more than two decades these issues have not been challenged internally and the Trust was not held to account by external bodies. This highlights that systemic change is needed locally, and nationally, to ensure that care provided to families is always professional and compassionate, and that teams from ward to board are aware of and accountable for the values and standards that they should be upholding.

“Going forward, there can be no excuses, Trust boards must be held accountable for the maternity care they provide. To do this, they must understand the complexities of maternity care and they must receive the funding they require.”

In December 2020, the Independent Review published a first report following the examination of 250 family cases which identified a number of Local Actions for Learning for the Trust and local commissioners, as well as Immediate and Essential Actions for all maternity services in England. This final report issues more than ***60 specific Local Actions for Learning for Shrewsbury and Telford Hospital NHS Trust*** covering nine areas including:

1. Improving management of patient safety
2. Patient and family involvement in care and investigations
3. Improving complaints management
4. Care of vulnerable and high risk women
5. Diabetes care
6. Multidisciplinary working
7. Midwifery-led units and out-of-hospital births
8. Staffing, including anaesthetic staffing
9. Communication with GPs.

In addition ***15 Immediate and Essential Actions*** for all maternity services in England were identified covering ten key areas including:

1. **Financing a safe maternity workforce:** NHS England must commit to a multi-year investment plan to ensure the provision of a well-staffed workforce. Appropriate, minimum staffing levels must be agreed nationally, and locally, with these staffing levels adhered to.

2. **Essential action on training:** sufficient protected time must be allocated for training across all maternity specialisms including routine refresher courses as well as multidisciplinary team training, particularly in emergency drills.

3. **Maintaining a clear escalation and mitigation policy when agreed staffing levels are not met:** escalation should go to the senior management team, the Board, the patient safety champion and local maternity system (LMS). The Midwifery Continuity of Carer model must be suspended across all Trusts unless they can demonstrate staffing meets the minimum requirements. It should not be reinstated until robust evidence is available to support its reintroduction.

4. **Essential roles for Trust Boards in oversight of their maternity services:** Boards must work with their maternity departments to develop a process of regular reports and reviews to ensure improvement plans and actions take place. Every trust should have a patient safety specialist dedicated to maternity services.

5. **Meaningful incident investigations with family and staff engagement and practice changes introduced in a timely manner:** All investigation reports must use language that is easy for families to understand and lessons from clinical incidents must form the basis of a multidisciplinary training plan. A change in clinical practice must be evidenced by six months after an incident has occurred.

6. **There must be mandatory joint learning across all care settings when a mother dies:** a joint review panel must include representations from all clinical settings which were involved in the mother's care. Post-mortem examinations must be conducted by expert pathologists in maternity and all learning must be introduced into clinical practice within six months of the investigation concluding. Investigations when a mother dies must be timely and treated as urgent and vital rather than families having to chase up trusts for conclusions as we have seen.

7. **Care of mothers with complex and multiple pregnancies:** Care must be provided by specialists who are familiar with managing complex pregnancies and multiple pregnancies. Where these specialisms are not found within a trust there must be early discussions with a nearby unit that has that expertise.

8. **Ensuring the recommendations from the 2019 Neonatal Critical Care Review are introduced at pace:** Maternity and neonatal services must continue to work towards a position of at least 85 per cent of births at less than 27 weeks gestation take place at a maternity unit with an onsite NICU and that appropriately trained consultants and staff are available 24/7.

9. **Improving postnatal care for the unwell mother:** 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 and staffing levels must be appropriate in order to deliver this.

10. **Care of bereaved families:** Bereavement services must be available every day of the week, not just Monday to Friday and staff must be trained to take post-mortem consent. All trusts need to ensure they have a system for follow-up appointments for families who have been bereaved.

In addition, the review also calls for NHS England to invest in a recruitment and retention drive to alleviate pressures in understaffed maternity services, more investment in training for midwives, support staff and doctors, as well as actions to ensure midwives and their medical colleagues want to remain working in the NHS. We acknowledge last week's funding announcement of £127million by NHS England for maternity services, this is still significantly short of the £200-£350million amount recommended by the Health and Social Care Select Committee in June 2021.

Donna added: "A death of a mother or baby, or a birth incident which results in an injury should never be ignored. Thorough and timely expert investigations have to be undertaken which result in meaningful actions that improve quality of care, diagnosis and processes going forward.

"There should never again be a review of this scale, in both numbers, and the length of years across which these concerns remained hidden. I pay tribute to all the families that have been involved in this review and thank them for working with me and my team. I would also like to extend my heartfelt thanks to my independent review team, the majority of whom have worked with me alongside their own clinical responsibilities. Families and your colleagues across the NHS tell me every day, how grateful they are for your efforts and I would like to recognise your dedication today.

"The legacy of this review should be a maternity service across England that is appropriately funded, well-staffed, trained, motivated and compassionate and willing to learn from failings in care."

ENDS

Notes to editors

About the review:

The Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was commissioned by NHS Improvement on behalf of the then Secretary of State for Health and Social Care Jeremy Hunt in 2017. After the parents of Kate Stanton Davies and Pippa Griffiths who sought further answers for the daughter's deaths in 2009 and 2016, identified theirs and 21 other maternity cases of concern at the Trust.

During the last five years the scope of the review was extended to include 1,862 family cases, the majority of which received treatment at the Trust between 2000 and 2019. 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 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.

The review team used medical records, documentation from the Trust and interviews and surveys with families to conduct each clinical incident review. The team also conducted an engagement exercise with staff past and present to ascertain an understanding of the culture of the organisation. Vignettes from family and staff interviews are used throughout the report to highlight findings made by the review team.