Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of ICB Board Committee

Date: Thursday 2nd November 2023
Time: 12:00 – 15:10
Location: Somerset Hall, The Precinct, Portishead, BS20 6AH

Agenda Number :	6.1
Title:	Local Maternity and Neonatal System Update
Confidential Papers	

Commercially Sensitive	No
Legally Sensitive	No
Contains Patient Identifiable data	No
Financially Sensitive	No
Time Sensitive – not for public release at this time	No
Other (Please state)	No

Purpose: For Information

Key Points for Discussion:

- Maternity and Neonatal update
- The Three Year Delivery Plan
- Saving Babies Lives Version 3
- Maternity Incentive scheme Year 5

Recommendations:	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
Previously Considered By and feedback :	Paper has been taken through the Outcomes, Quality & Performance Committee
Management of Declared Interest:	None declared
Risk and Assurance:	The report and appendices provide an update to the ICB Board Committee in relation to key risks to performance and quality within the system and highlight supporting mitigations which are in place.
Financial / Resource Implications:	None

Legal, Policy and Regulatory Requirements:	None
How does this reduce Health Inequalities:	Not referenced
How does this impact on Equality & diversity	Not referenced
Patient and Public Involvement:	None
Communications and Engagement:	The reports are provided to the ICB Board Committee for information and discussion.
Author(s):	Layla Toomer- Patient Safety Lead Maternity & Neonatology BNSSG ICB
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd- Chief Nursing Officer BNSSG ICB

Agenda item: 6.1

Report title: Maternity and Neonatal System Update

This report is designed to give oversight and assurance of the current maternity and neonatal position within BNSSG.

LMNS Functions- (Appendix 1 Governance Structure)

- To be the Maternity arm of the ICB allowing a direct line of sight from maternity providers to ICB board (as per Ockenden Report)
- To plan, design and deliver maternity & neonatal services to local BNSSG population.
- To accelerate action to transform services and to achieve 50% reductions in stillbirth, neonatal deaths, maternal deaths and brain injuries
- To lead and ensure quality and safety in Maternity & Neonatology across BNSSG
- To bring together all the people who are involved in providing and organising maternity & neonatal care
- To provide support to maternity units to achieve more personalised and safer care and to provide unbiased evidence-based information to help pregnant people make choices about their care
- To continuously drive quality improvement across all areas of maternity and neonatology
- Support the tackling of health inequalities in maternity provision and lead on the LMNS Equity and Equality action plan
- To lead on the Perinatal Quality Surveillance Model (PQSM) ensuring both acute providers share and learn from safety incidents
- To share local safety data and recommendations with NHSE through the Regional Perinatal Quality and Safety Group (PQSSG)
- To deliver the key objectives for maternity services within the Three Year Delivery Plan as set by NHSE
- To ensure our maternity services are fully implementing Saving Babies Lives Version 3 with quarterly reporting through the LMNS board
- To sign off and have oversight of the Trusts Maternity Incentive Scheme (MIS) declaration of the ten safety actions (currently year 5)

Ockenden Compliance (Appendix 2 Ockenden report 2022)

- Out of the 92 Immediate and Essential Actions (IEA) documented within the Ockenden Report; Both NBT and UHBW have 24 outstanding actions, work is ongoing with all of them, and none are Red Rag Rated. Actions yet to be completed are themed under training, workforce and specialist service / clinic capacity.

Kirkup Progress (Appendix 3 Reading the Signals Report)

- The Perinatal Transformation Board (PTB) continues to review and monitor progress being made with regards to the recommendations from Kirkup and Ockenden, this feeds into the Divisional and Trust governance structures.
- The Women's experience group works in collaboration with the Maternity & Neonatal Voice Partnership to gather feedback from women using maternity services, to ensure concerns are acted upon and service improvements are co-produced.
- First complaints panel with MNVP representation on the 27th of September.
- Plans to commence the perinatal culture programme in quadrumvirate perinatal teams in November.

Maternity Incentive Scheme (MIS) Year 5 (Appendix 4)

- MIS Year 5 standards launched end of May 2023
- Agreed system meetings to take place to ensure consistency of evidence and share learning and best practice for achieving all 10 safety actions
- Gap analysis of new standards in progress. Initial areas of concern identified:
- Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
- Element 2: Fetal Growth – risk assessment, surveillance and management
- LMNS leading discussions between UHBW and NBT with regards to implementation of completing uterine artery Dopplers for women identified at high risk of FGR before 23+6 weeks gestation. Also reviewing scan capacity & Pathways
- Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
- Increased training requirement, moving from current provision of 2.5 days per annum to 5 days per annum, implication for staffing, training team uplift to facilitate additional training and accommodation requirements to facilitate additional study days

Three Year Delivery Plan (Appendix 5)

- Launched March 2023
- Acknowledgement of the amazing work delivered through the transformation programme, we are now moving forward into a new programme, maternity, neonatal and the single delivery plan (three year). Emphasis on LMNS, being a part and central to continue to move this work forward.
- Strong emphasis of the joining maternity and neonatal and the quadrumvirate working.
- Service user voice needs to be amplified and used from the initial setting for improvement and quality with the correct financing, so they have an equal place at the table.
- Aims to prioritise the delivery of safer, more personalised and more equitable care
- Brings together actions from Ockenden, East Kent, Long Term Plan and Maternity Programme

- The plan has 4 themes/chapters to provide focus and rationalise the asks from different reports and plans- 1) Listening to and working with women and families with compassion 2) Growing, retaining and supporting our workforce 3) Developing a culture of safety, learning and support 4) Standards and structures that underpin safer, more personalised and more equitable care
- Each objective sets out an ambition of 'what good looks like'
- Clearly determines what Trusts, ICB's/LMNS' and NHS E must do to achieve the targets
- A 'Determining Success' section sets out all the outcome and progress measures at each level which will demonstrate the interventions are making a positive difference. This includes both quantitative and qualitative measures as well as regulatory backstops. Assurance processes will be streamlined and simplified to reduce administrative burden on trusts and systems.
- LMNS collaborating with the Acute Provider Collaborative (APC) to support the Trusts to agree system and individual action plans in response to the plan with a joint system workshop planned.
- Mapping and gap analysis completed from both Trusts and LMNS and developing 'what good looks like' as an aspirational plan for the next 3 years. (**Appendix 6**)

Saving Babies Lives Version 3 (Appendix 7)

- Saving Babies Lives Version 1 released in 2016
- Designed to tackle stillbirth and neonatal death
- Developed by groups brought together by NHS England, including midwives, obstetricians and representatives from stillbirth charities
- Version 3 was due to launch in March 23 but delayed to June 23
- Building on the achievements of the previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance and frontline learning to reduce unwarranted variation.
- Implementation Tool released by NHSE in July 23
- NHSE target of compliance by March 24
- Linked to MIS Safety Action 6
- Additional element from Version 2 (Management of Diabetes in Pregnancy)
- Extensive increased requirement for evidence and audit from previous versions
- Requires a total of 73 interventions- NBT have escalated to their Trust Board (recorded as Trust Level Risk) concern that the volume of work to evidence the elements will be challenging

CQC

- CQC are visiting all Maternity Units that have not had an inspection in the last 3 years prior to the end of this calendar year
- Both of the Trusts within BNSSG fall into this category so an inspection is imminent

Appendices

1) Governance structure of LMNS
2) Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust- Donna Ockenden 2022
3) Reading the signals- Maternity and neonatal services in East Kent- the Report of the Independent Investigation- Bill Kirkup 2022
4) Maternity Incentive Scheme Year 5- NHS Resolutions
5) Three Year Delivery Plan- NHS England
6) Mapping of current BNSSG position against The Three Year Delivery Plan
7) Saving Babies Lives Version 3- NHS England

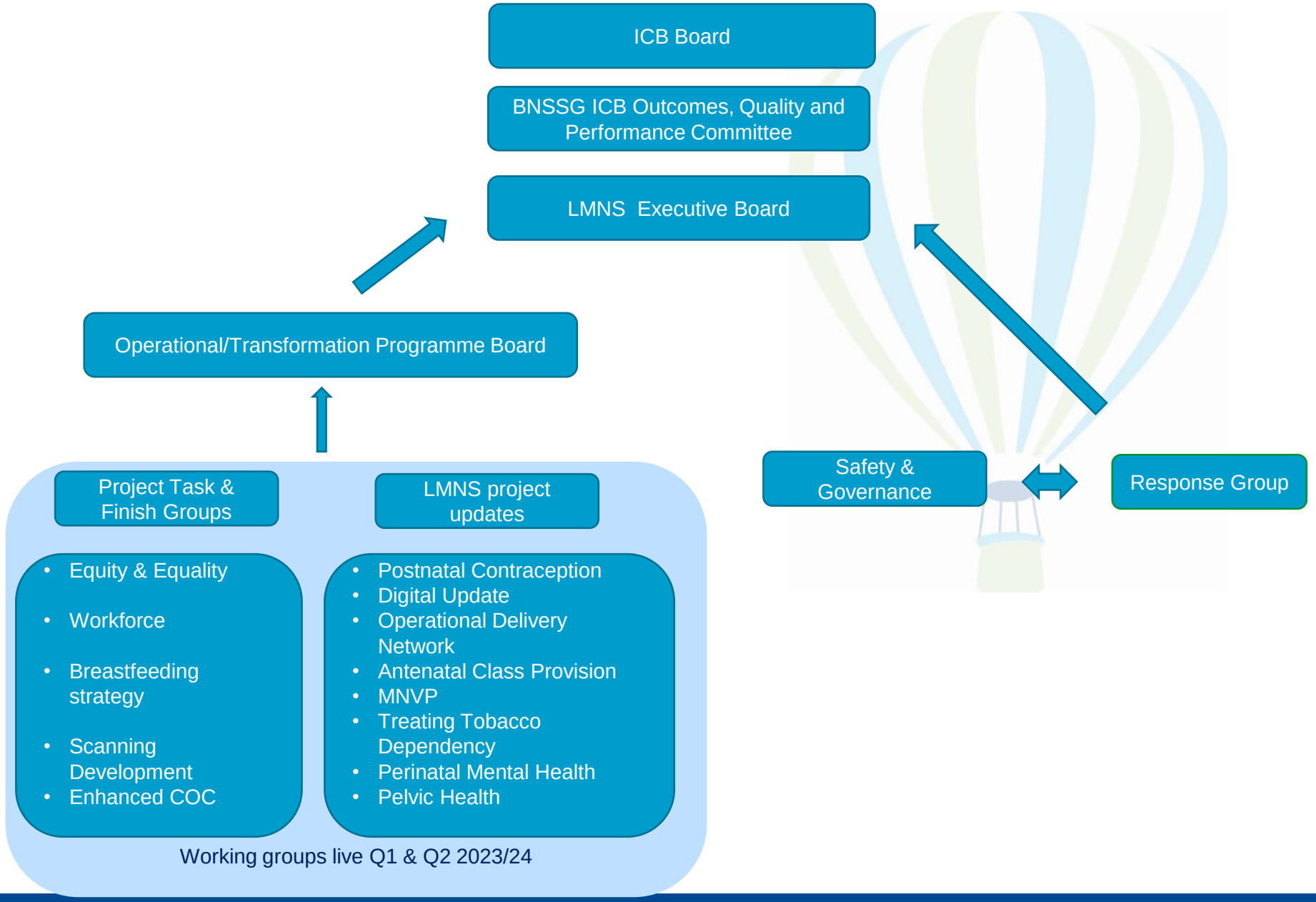
Glossary of terms and abbreviations

LMNS	Local Maternity and Neonatal System
MIS	Maternity Incentive Scheme- also sometimes referred to as CNST
MNVP	Maternity and Neonatal Voice Partnership- maternity services work in collaboration with our MNVP to ensure the voices of our population are heard
NBT	North Bristol Trust
UHBW	University Hospitals Bristol & Weston
FGR	Fetal Growth Restriction- babies born below the 3rd centile
CQC	Care Quality Committee

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

BNSSG Local Maternity and Neonatal System Governance


ICB Board
BNSSG ICB Outcomes, Quality and Performance Committee
LMNS Executive Board
Operational/Transformation Programme Board
Project Task & Finish Groups
LMNS project updates
Equity & Equality
Workforce
Breastfeeding strategy
Scanning Development
Enhanced COC
Postnatal Contraception
Digital Update
Operational Delivery Network
Antenatal Class Provision
MNVP
Treating Tobacco Dependency
Perinatal Mental Health
Pelvic Health
Working groups live Q1 & Q2 2023/24
Safety & Governance
Response Group

BNSSG Local Maternity & Neonatal System Meeting Overview

Operational /Transformation Board

- **Frequency:** Every other month
- **Duration:** 2 hours
- **Chair:** Layla Toomer
- **Audience:** Transformation midwives, local authorities,HoM's, DoM's, neonatal leads, MNVP's, digital midwives, project leads,AHSN, Perinatal Mental health,ODN
- **Purpose:**
  - **Operational Programme oversight-** risks & issues at workstream & project level, **progress at project level (process)**, decisions required.
  - **Support-** support, advice & unblocking project level issues
  - **User voice**

LMNS Executive Board

- **Frequency:** Every other month
- **Duration:** 1.5 hours
- **Chair:** Rosi Shepherd
- **Audience:** CNO's ,HoMs, DoMs, Safety Leads for LMNS, finance,MNVP Lead
- **Purpose:**
  - **Strategic programme oversight**- risks & issues at programme level, **progress at programme ambition level (outcomes),** decisions required, finance, Safety & Quality progress & issues
  - **CNST** oversight and update
  - **Support-** Advice & guidance at senior leadership level. Communication & Engagement into Trusts

Safety & Quality

- **Frequency:** Every other month
- **Duration:** 2 hours
- **Chair: Sneha Basude**
- **Audience:** Governance midwives, obstetricians, safeguarding,
- **Purpose:**
  - **Monitoring minimum data set** (Perinatal Quality Surveillance Model)
  - **Review safety ambition progress (Ockenden, East Kent, CNST, CQC)**
  - **Review staff feedback**
  - **Review service user feedback**
  - **Share learning from incidents**
  - **Develop shared clinical governance**
  - **Oversight of safety transformation (SBLCB, MNSIP, Maternal Medicine Networks)**

Response Group

- **Frequency:** Every other month
- **Duration:** 2 hours
- **Chair-** Sneha Basude
- **Audience:** Obstetricians, neonatologists, Governance and safety midwives
- **Purpose:** A system wide forum to discuss clinical governance changes, challenges or issues.
- Outward safety meeting taking into account National recommendations and changes
- Reporting on regional and national meetings and updates

OCKENDEN REPORT - FINAL

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

30 March 2022

Return to an Address of the
Honourable the House of Commons
dated 30 March 2022 for

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

HC 1219

Ordered by the House of Commons to be printed on 30 March 2022

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at https://contactus.dhsc.gov.uk

ISBN 978-1-5286-3229-4

E02725921 03/22

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of Her Majesty's Stationery Office

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 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 Kate Stanton Davies, and her parents Rhiannon Davies and Richard Stanton; and to Pippa Griffiths, and her parents Kayleigh and Colin Griffiths. Kate's and Pippa'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 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 which 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 Local Actions for Learning for the Trust and Immediate and Essential Actions, 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[1] and invested very significantly in supporting maternity services across the country. This focus and funding is a significant stride in the right direction. Much of this funding is for workforce expansion. NHS Providers[2], as cited in the recent Select Committee report[3] has estimated the cost of full expansion of the maternity services workforce to be £200m - £350m. 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

1 https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-committee-report-safety-of-maternity-services-in-england

2 https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf

3 https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

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[4].

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 which 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 Immediate and Essential Action 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[5] to oversee maternity investigations, taking over the work of HSIB. 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 six months of the incident occurring and that all investigations are independently chaired.

Finally and importantly Secretary of State we state that DHSC and NHSE&I 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.

Thank you Secretary of State for your ongoing support,

Yours sincerely,

Donna Ockenden

Chair of the Independent Maternity Review

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

5 https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560

Acknowledgements

The work contained in this final report and the first report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, came about from the exceptional efforts of parents Rhiannon Davies, Richard Stanton, and Kayleigh and Colin Griffiths, who daughters died as a result of the care they received at the Trust.

The deaths of Rhiannon and Richard's daughter Kate in 2009, and Kayleigh and Colin's daughter Pippa in 2016 were both avoidable. Owing to their unshakeable commitment to ensure the precious lives of their babies were not lost in vain, this review has implementation of meaningful change, not only in maternity services at The Shrewsbury and Telford Hospital NHS Trust – but also across England. As we publish this final report, we want to acknowledge and pay tribute to Rhiannon, Richard, Kayleigh and Colin.

Very importantly, and as Chair of this review, I want to extend my heartfelt thanks to all of the families who have come forward to share their experiences. So many families have explained to me that for more than two decades they have tried to raise concerns but were brushed aside, ignored and not listened to. My review team and I have listened to families and heard their concerns and distress. This final report has come about following the careful consideration by my review team of 1,592 clinical incidents involving mothers and babies resulting from the maternity care of 1,486 families. Their contribution to this review and report has, in my view, been central to a review of maternity services which I hope and believe will now save lives and reduce harm in maternity services across England.

Thanks to the bravery and determination of all the families in sharing their experiences we have produced this report, which my review team colleagues and I believe will continue to shape the learning which will profoundly change maternity care now and in the years to come. Never again should families be left to grieve or suffer in isolation, with the additional pain of feeling their legitimate concerns are being ignored. Our intention is that this report will underpin the future journey of maternity services in England, so that maternity services will be safer, will hear families better and will be more accountable.

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 Immediate and Essential Actions 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 remains concern 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 Immediate and Essential Actions 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 all 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

CONTENTS

Section 4: Our call for essential action following completion of this review

Appendices:

Explanation of Terminology

In this report the review team has used words or medical terms which some readers may not be familiar with. While we have tried to keep the use of such words and terminology to a minimum, at times it is unavoidable. This is so we can accurately address specific clinical issues we found within our review as well as make recommendations to improve maternity care now and in the future at the Trust and across the NHS in England.

To try to aid readers' understanding where we think language has become technical, where the terms are used for the first time, we direct readers to a glossary (found at the end of the report) which will give further explanation of their meaning.

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 (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, 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) and examined local clinical governance processes, policies and procedures, as well as 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 as well. 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 cooperation 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 which led up to the commissioning of this independent review (see chapter 1). 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 which 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, and identify where opportunities for learning and improving quality of care have been missed.

For example, in the nine months preceding the avoidable death of Kate Stanton-Davies in March 2009, the review team has identified two further incidents of baby deaths which occurred under similar circumstances.

In May 2008 Baby Joshua was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit. Joshua'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. Joshua was delivered with no signs of life and died at six days old, when care was withdrawn.

In January 2009 Baby Thomas was born following his mother's long, slow labour stretching 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. Thomas briefly had a heartbeat but at 34 minutes of age resuscitation was stopped.

Then on 1 March 2009 Rhiannon Davies gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the two weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage Kate's health as she was born severely anaemic. Kate 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 six hours of age.

The review team found evidence of poor investigation into all three 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 three cases were not isolated incidents and throughout this review we have found repeated errors in care, which 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 and 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 four cases were found to have significant or major concerns in maternity care which 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 per cent) 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 per cent) were identified to have significant or major concerns in the maternity care provided which 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, being assessed for emergency intervention during labour or 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, hypoxic ischaemic encephalopathy and unfortunately death.

Some of the causes of these delays were due to the culture amongst 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 amongst 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 which 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, which negatively affected the operational running of the service. The review team identified how it was widely accepted that the labour ward coordinator 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 a lack of 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 2018/2019 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 Local Actions for Learning 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 Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

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

OCKENDEN REPORT - FINAL

Section 1

History, methodology and families

Introduction

Our first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*, was published in December 2020[1]. The report, which was outside the terms of reference for this review, was prepared at the request of the then Minister of State for Patient Safety, Suicide Prevention and Mental Health Nadine Dorries MP. It observed important emerging themes which required urgent action following review of the maternity care experienced by 250 families. The aim was to focus on immediate improvements for the Trust through **Local Actions for Learning** (LAfL) and the wider maternity system across England with **Immediate and Essential Actions** (IEAs).

This second publication reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care we have found. Of importance, and in accordance with the Terms of Reference, this report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

From its start, in the summer of 2017, we have seen the number of families included in this Secretary of State Independent Maternity Review increase substantially from the original 23 families. It is now recognised that this review is likely to include the largest ever number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

We reported in July 2020 that 1,862 individual families were included in this review. After further analysis and validation of data with the Trust, the total number of families included in this review is now established to be 1,486 resulting in 1,592 clinical reviews of care. The majority of cases are from the years 2000 to 2019. However, a number of families came forward in the early period of the review whose care preceded these years and it was agreed by NHS England that, where possible, their care would also be reviewed.

All care and treatment provided to families, the quality of any Trust-led incident investigations, Trust-led reviews, external reviews and the resultant recommendations, actions and learning have been considered with reference to the relevant guidance and standards of the day, by clinicians who were in clinical practice at the time.

Every clinical review undertaken has been led by expert clinicians and each case has been carefully considered using a consistent standardised methodology. The multidisciplinary review team has been expanded during the process to reflect the growing number of families. The majority of reviewers currently work in clinical posts at trusts across England, with the number of team members who have been a part of the review since its start exceeding 90.

Over the course of the review, the team has faced many challenges and these are explained in more detail within the report. These have been mainly related to systems and processes required in order to undertake a review of this size, as it became evident that the required protocols, procedures and structures were not immediately available to support it. The COVID-19 pandemic at times impeded progress as our clinicians quite rightly prioritised their NHS commitments.

We have always emphasised that the voices of the families are central to this review. Throughout, we have ensured that families have been updated on the review's progress and we have worked closely with support agencies to ensure that listening, counselling and psychological help is and has been available for those in need.

The voices of staff at the Trust have also been important to assist with our understanding of events. We launched our Staff Voices engagement strategy to reach out to both former and current staff at the Trust. They were offered the opportunity to engage with us through an initial questionnaire survey and further conversations to share their experiences of working at the Trust. Despite reaching out through social media and the local press including radio, TV and a local newspaper and joint messaging with the Trust, fewer staff and ex-staff contacted us than we had anticipated or hoped for.

1 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

At the time of publication only just over 100 current and former staff had contributed to the review with a further number of staff withdrawing from the review in the weeks before publication. This led to a number of last minute changes to the report as we were unable to use staff contributions without their consent. Those staff withdrawing were apologetic but most were concerned about being identified in the report. Despite our assurances, they maintained that they did not want to be quoted in the final report and we respected their decision.

Since our first report, we are encouraged to hear of progress at the Trust through its improvement programme in response to both our **Local Actions for Learning and Immediate and Essential Actions**. Indeed, we heard through staff of the willingness of their colleagues and themselves to learn from the review, in order to continue to improve and work towards building and maintaining a safer local maternity service.

The review team was particularly encouraged by the overwhelming positive response to our first report from maternity colleagues across England and the wider NHS. We were equally encouraged to see that our call for action to ensure investigations, reviews and reports that lead to meaningful change was heard.

We acknowledge that the proposed funding of £95million towards workforce and training provided by NHS England and Improvement is a major stride in the right direction. However, we are equally conscious that this is only the start of the journey and state that what is required in order to continually improve safety in maternity services is a multi-year funding increase for workforce expansion and training, in forthcoming years.

Our **Immediate and Essential Actions** from this report, based on our findings from the clinical reviews and listening to the voices of both families and staff, identify that the wider system must invest further in staffing across the whole maternity team to ensure that there are sufficient numbers, and that the workforce is equipped with the right skills and is able to deliver care in the right place at the right time.

Until proposed staffing levels are improved to recognise the increasing complexities of maternity care in the 21st century, NHS maternity services must not, and cannot, focus on the implementation of midwifery continuity of carer. Before continuity of carer is recommenced in any form there must be a thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future. Further investment in enhancing staff numbers across the multidisciplinary team will go a long way to improve overall safety in maternity services.

Whilst the review has been heartened by the Trust's progress over the last year, NHS England and Improvement must continue to provide appropriate support and ongoing oversight of its continued progress. Regulators such as the Care Quality Commission together with the Royal Colleges, including those of Midwives, Obstetricians and Gynaecologists, Anaesthetists, and Paediatrics and Child Health must continue to strengthen their collective efforts of collaborative working to hasten the implementation of these further **Local Actions for Learning** and **Immediate and Essential Actions** outlined in this final report.

We are aware that since the inception of this review, there are now at least two other independent maternity service reviews in progress. This may be indicative of some wider systemic issues. At this very moment there may be other maternity services across England which are facing challenges that impact on their ability to provide a safe service as a result of insufficient staffing levels, substandard governance processes, and structures which impede learning.

Over and over, families have expressed their two key wishes for this review. They want answers so that they can understand what happened during the care they received and why. We hope that this report will go some way in identifying and explaining the factors that contributed to the systemic failures which led to the harm they experienced. Secondly, they want the system to learn. We note that as a result of our findings in our first report, through our **Local Actions for Learning** and **Immediate and Essential Actions** the Trust and the wider NHS are beginning to learn and improve. We anticipate that through this report the learning will be sustained. No more families should have to live with the consequences of poor governance systems and structures within the NHS.

We must ensure that for all the families who contributed to this review there continues to be visible, measurable and sustainable change at the Trust and across the wider maternity system in England. That change through the implementation of our **Local Actions for Learning** and **Immediate and Essential Actions** will be the legacy of these families and the terrible loss and harm they have experienced.

Chapter 1

Concerns that led to this review

1.1 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.

1.2 This timeline shows the failure of the Trust's maternity services to listen to families and to 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.

1.3 In 2002 a baby girl named Olivia 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. Olivia'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.

1.4 Olivia'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

1.5 In 2004, two babies were born in poor condition which 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.

1.6 Three years after the experience of these families in April 2007 the Healthcare Commission wrote to the then CEO of the Royal Shrewsbury Hospital[2] regarding its concerns about the maternity service. 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[3] (CTG) tracings, that there was non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines and there was a lack of, and inappropriate, staff training.

1.7 The HCC visited the maternity service and said it was satisfied that CTG training for staff and audit had been introduced and that the Trust then used NICE guidance. The HCC considered that the concerns raised with it 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. The HCC noted the Trust's low caesarean section rate of 14 per cent in 2005 compared to the UK national average of 23.2 per cent. The HCC did not examine unplanned

2 Healthcare Commission Letter to the Trust's Chief Executive Officer 18 April 2007 https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf

3 See glossary

admissions to the Neonatal Intensive Care Unit (NICU), rates of hypoxic ischaemic encephalopathy (HIE) or relevant other near misses. This was a significant lost opportunity for learning at an already troubled Trust.

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

RECOMMENDATIONS	
CTG	The Trust should send a copy of the latest CTG audit to the Commission and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of/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, i.e. 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 Commission.
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 Joshua, and baby Kate Stanton-Davies in 2009

1.9 In March 2009 baby Kate Stanton-Davies died following her birth at Ludlow birth centre. Richard Stanton and Rhiannon Davies, Kate's parents have up to the present day voiced their concerns about the circumstances surrounding Kate'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 May 2008, also at Ludlow Birth Centre. Baby Joshua 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 Joshua'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.

1.10 In summary, the births of baby Joshua and Kate Stanton-Davies 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.

1.11 A paediatric death review (an internal investigation by the Trust) occurred in September 2008 following the death of baby Joshua in May 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 Kate Stanton-Davies was born 10 months after baby Joshua in the same birth centre an ambulance was not called for 90 minutes, despite signs that Kate was seriously unwell from birth.

1.12 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 Joshua's death in 2008 did not result in any actions or learning. It is also noted that when the subsequent death of Kate Stanton-Davies was investigated[4] by Debbie Graham Ms Graham could not locate any definitive guidance for the operating of Ludlow MLU for 2009[5]. This was despite the fact that after the earlier death of baby Joshua these issues were raised as being of importance to ensure the safety of mothers and babies, yet no action appears to have been taken.

1.13 Joshua'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 Joshua'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..'* Joshua's father described the Trust as *'ducking and diving, avoiding telling the truth, they've been dodging and weaving all these years..*' Joshua's parents eventually commenced litigation in order to get the answers they wanted from the Trust.

1.14 The Ockenden review team has also searched within the vast amount of information provided by the Trust for relevant guidelines. The SaTH 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 Joshua and 15 months after the death of Kate Stanton-Davies to ensure this critically important clinical guideline was introduced.

1.15 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' (CCGs) review

1.16 In 2013, there was a review into the maternity services at the Trust by the two Clinical Commissioning Groups[6]. 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.

1.17 The CCGs' review of risk management focussed on reported serious incidents and near misses in the period April 1, 2012 to March 31, 2013[7]. 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*

4 Graham, D. Independent Review of the case of Kate Seren Stanton-Davies at the Shrewsbury and Telford Hospital NHS Trust (2015) https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf

5 Ibid n3 p25

6 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group. Maternity Services Review The Shrewsbury and Telford Hospital NHS Trust (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

7 Ibid n5 p5

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 to other local units was attributed in part to *'diligent reporting*[8]" and a thematic analysis was recommended to understand the reasons for this higher NICU admission rate.

1.18 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 more in neonatal chapter 12). 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'.* There is no evidence in the documentation provided to the review team by the Trust that this recommendation was actioned, (see more in clinical governance chapter 4). There is also no evidence that the CCG held the Trust to account for meeting these very important recommendations.

1.19 The 2013 CCG review also included comments from 47 women across 13 maternity service user focus groups[9]. 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.

1.20 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.

1.21 Although, as commented by the authors of the CCG report, 90 per cent of the patient feedback was favourable the 10 per cent 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*

8 Ibid n5 p7

9 Ibid n5 p19

who provided valuable feedback[10]' 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.

1.22 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[11] and in the minutes it noted '[*some] concern about some families' experiences but this was in the context of generally good services.'*

NHS Litigation Authority

1.23 In March 2014 the Trust was assessed by the NHS Litigation Authority[12]. This assessed the maternity service for organisation, clinical care, high risk conditions, communication, and 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 (CNST) standards at the time were assessed almost entirely from self-reporting of guidelines and procedures.

1.24 In 2014 there was a Deanery (medical training) review[13] into the training received by obstetrics and gynaecology staff. Under areas for improvement and with reference to clinical governance it said:

1.25 *'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

1.26 In 2015 there was a Care Quality Commission Quality Report on SaTH[14] which 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 independent review

1.27 In 2015 there was an independent review by Debbie Graham[15] which reviewed the high profile case of Kate Stanton-Davies and made some criticisms of the Trust's response to the family.

1.28 The independent review by Graham found that although clinical governance processes were in place in 2009, at the time of Kate's 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 Kate's death being raised as a Serious Incident (SI). Instead of an SI investigation the death was investigated as a High Risk Case Review (HRCR), and secondly as an unconnected midwifery supervisory investigation, therefore no learning started to occur from Kate's death until the findings of the coroner's inquest in 2015, 6 years after Kate died.

10 Ibid n5 p3

11 2014 Trust Board papers supplied to the review team

12 NHS Litigation Authority Clinical Negligence Scheme for Trusts. Maternity Clinical Risk Management Standards 2013-14. The Shrewsbury and Telford Hospital NHS Trust. Level 3. (2014)

13 NHS Health Education West Midlands. PMET Review Findings Report Summary (2014)

14 Care Quality Commission. Shrewsbury and Telford Hospital NHS Trust Quality Report (2015) https://api.cqc.org.uk/public/v1/reports/0826982d-e4d9-48da-bc92-a78c8fc9b933?20210518113404

15 Ibid n3

1.29 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 Pippa Griffiths

1.30 Kayleigh Griffiths gave birth to her daughter Pippa Griffiths at home in April 2016. Pippa died the day after her birth due to neonatal meningitis from Group B streptococcus infection. Kayleigh Griffiths had phoned midwifery staff about Pippa'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 Pippa would have survived had post-delivery literature been given to Pippa's parents, and had a complete systematic enquiry into her neonatal health taken place.

1.31 Kate's and Pippa's parents (Rhiannon Davies, Richard Stanton, Kayleigh and Colin Griffiths) 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 Kate's death in 2009. At interview with the chair of this review in December 2017 Colin Griffiths, Pippa'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'.*

1.32 Kayleigh, Pippa'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 April 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[16]] 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…" '*Kayleigh continued: *'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 Richard and Rhiannon Davies and I made contact with them…I contacted the Chief Exec at SaTH and said, you know, this has got to be investigated…'*

2017 Ovington Review (internal)

1.33 In 2017 the Quality and Safety Committee of SaTH 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 2007-2017[17] was authored by Colin Ovington, then working within the Trust, and published in 2017.

1.34 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.

16 X – identifier removed by review team

17 Ovington, C. Report Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017) https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

2017 Royal College of Obstetricians and Gynaecologists Invited Review

1.35 In 2017 there was a Royal College of Obstetricians and Gynaecologists Invited Review and subsequent report into the maternity services based on a visit to maternity services at the Trust carried out from 12-14 July 2017[18]. This report noted the following:

- 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 which reported on interim progress on the recommendations from the original report.

2020 NHS Improvement response

1.36 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 two 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) to 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.

1.37 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* in July 2020[19].

1.38 This NHSI review noted that twelve 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 three 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.

1.39 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,

18 Royal College of Obstetricians and Gynaecologists. Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust (2017)

19 NHS Improvement. 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 (2020) https://www.england.nhs.uk/midlands/publications/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/

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.

1.40 When the report was finally presented to the Trust Board the covering paper was overwhelmingly positive in tone, with its twelve-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.

1.41 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.

1.42 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.

1.43 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 CQC) with regard to its findings. Instead the RCOG had only released the report to the Trust. At the time[20] the RCOG sent reports arising from Invited Reviews to the service/Trust that had been reviewed, without always notifying regulators[21]. The 2015 policy was clear that the RCOG would *'encourage dialogue…with regulatory agencies and authorities'* and *'encourages the sharing of the report with the CQC...'* (RCOG 2015, p3).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'.*[22]

2018 Care Quality Commission

1.44 In 2018 there was a CQC report[23] which rated the maternity service inadequate 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 December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning'*.

1.45 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.

1.46 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.

---

20 Royal College of Obstetricians and Gynaecologists Invited Reviews a guide (2015) https://www.rcog.org.uk/globalassets/documents/about-us/invited-reviews/rcog-invited-reviews---a-guide-oct-2015.pdf

21 Royal College of Obstetricians and Gynaecologists. Statement regarding an Invited Review by Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust (2020) https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/

22 Royal College of Obstetricians and Gynaecologists. Invited Review Service: https://www.rcog.org.uk/en/about-us/invited-review-policy/

23 Care Quality Commission 2018 report Shrewsbury and Telford NHS Trusts https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

1.47 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'* and there were 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'.*

1.48 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..'* and 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.

1.49 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'."*The same interviewee commented that *'there was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team'.*

1.50 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.

1.51 The Trust had an executive team and Board that had continual change and churn over the period of this review, with documentation provided to the review team by the Trust[24] showing 10 Board Chairs from 2000, with 10 Chief Executive Officers (CEO) 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.

1.52 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

1.53 In late 2021 the review team also spoke to some senior staff of the Clinical Commissioning Groups (CCG) 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 SIs 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 SI investigations and learning from other services across the whole Trust and not just maternity.

24 Who's Who at the Trust – internal document received by the review team on 9 September 2020

Missed opportunities

1.54 In summary this was a Trust which 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.

1.55 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 which was struggling with other significant concerns.

Case Study

Thematic review of three cases at the Trust sharing similar themes within a nine month period (2008-2009)

1a.1 Here we examine the case of Kate Stanton Davies and deaths of two other babies which occurred within a short time period at the 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.

1a.2 Within nine months, between May 2008 and March 2009, there were three 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 three cases there are significant failings in the care and treatment provided, omissions in the subsequent investigation into care, and failure to learn and establish processes for safe delivery in the midwifery-led unit (MLU) and consultant unit.

1a.3 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.

Baby Joshua 2008:

1a.4 The maternity review team has found evidence of a case that occurred nine months earlier than that of Kate Stanton Davies. In May 2008 a baby boy called Joshua was born at Ludlow midwifery led unit (MLU) in poor condition. Joshua was transferred by air ambulance to the Royal Shrewsbury Hospital (RSH) Neonatal Unit and died there on day 6 after his care was withdrawn.

1a.5 Joshua'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. Joshua's mother reported three episodes of severe uterine tenderness and tightening. One occasion led to an ambulance admission to RSH and this review team believes that concealed abruption should have been considered by clinicians at the time.

1a.6 Joshua'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[25] 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.

1a.7 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. Joshua was transferred unsecured on a stretcher and ventilated by valve and mask in the air ambulance to RSH where he was ventilated, and remained comatose until treatment was withdrawn on day 6, after a head scan revealed severe widespread damage to Joshua's brain.

1a.8 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.

1a.9 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

25 See glossary

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.

1a.10 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.

1a.11 There are a number of documents provided to the review team by the Trust which 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.

1a.12 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.

1a.13 The review team has been aware of internal reports of concern around the lack of vital resuscitation equipment being available at Ludlow. As well as a lack of familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation. In addition the lack of ability to monitor oxygen saturation and to monitor the baby during resuscitation, and the lack of facility to thermoregulate and monitor the baby in the air ambulance.

1a.14 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.

1a.15 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.

1a.16 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'*, and *'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'.*

Baby Thomas 2009

1a.17 In January 2009, after the birth and death of Joshua but before Kate Stanton-Davies 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 Thomas 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.

1a.18 The mother was booked for an MLU delivery despite having had a very long previous labour with a macrosomic[26] 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.

1a.19 The mother was admitted to the consultant-led antenatal ward, contracting at 4cm dilatation. 19 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[27]. An hour prior to eventual birth by caesarean section there were classic signs of uterine rupture including haematuria[28], 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[29]. 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[30] was found. The baby briefly had a heartbeat, but at 34 minutes of age resuscitation was discontinued.

1a.20 A DATIX[31] 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.

1a.21 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.

1a.22 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.

The Stanton Davies family and baby Kate 2009:

1a.23 Two months after the birth and death of baby Thomas and 9 months after the birth and death of baby Joshua, baby Kate died avoidably on 1 March 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.

1a.24 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 Kate's grieving parents. The inquest concluded that Kate should not have been born at Ludlow. The 2 weeks of reduced fetal movements prior to labour was a factor in Kate being born anaemic, as she had likely suffered repeated episodes of feto-maternal haemorrhage[32]. The MLU staff failed to provide Kate and

26 See glossary
27 See glossary
28 See glossary
29 See glossary
30 See glossary
31 See glossary
32 See glossary

her mother Rhiannon 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. Kate died shortly after arrival by air ambulance at a tertiary neonatal unit.

1a.25 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 Kate's death appropriately, failed to hold staff to account and failed to address her parent's concerns, and particularly those pertaining to the inadequacy of the supervisory investigation. Further external opinions revealed that midwives did not consider her mother Rhiannon's antenatal care as a whole and did not consider the bigger picture, which would have indicated that Kate 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.

1a.26 Consideration of these three cases of term babies, Joshua, Thomas and Kate 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 Joshua, Thomas and Kate the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.

1a.27 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 Kate Stanton-Davies, and before her the birth and death of baby Joshua and then baby Thomas.

Chapter 2

How we approached this review

2.1 This Independent Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (SaTH or similar abbreviation) was commissioned in May 2017 by NHS Improvement (NHSI) at the request of the Right Honourable Jeremy Hunt MP, then Secretary of State for Health and Social Care. This was in response to concerns raised with Mr Hunt by Rhiannon and Richard Stanton Davies and Kayleigh and Colin Griffiths about the deaths of their daughters in 2009 and 2016 respectively and about 21 further families which experienced adverse outcomes at SaTH. These concerns were with regards to the maternity care received at the Trust and with the failure of the Trust to provide satisfactory answers to questions asked about the care it provided.

2.2 The first terms of reference in 2018 were written for the planned review of 23 families, but were amended in November 2019 to encompass a much larger number of families. Both the first and the current terms of reference are found in appendices 5 and 6.

2.3 This is the second report published by the Ockenden review team. The original plan was to publish one complete report when the reviews of all the cases had been completed. However in July 2020, following an increase in the number of families included in the review, the then Minister of State for Mental Health, Suicide Prevention and Patient Safety, Nadine Dorries MP, requested a first report focussing on important early actions and learning to improve local and national maternity services. That first report, based on the first 250 clinical reviews, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Hospital Trust*[33] was published on 10 December 2020.

2.4 For this second report we have reviewed all reported cases of maternal and neonatal harm in the period 2000-2019. As stated in the terms of reference, these comprise cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other complications in mothers and newborn babies. A number of cases were reviewed outside of these years and the earliest case reviewed was in 1973 and the latest in 2020. In total this review has examined the maternity care of 1,486 families resulting in 1,592 clinical incidents involving mothers and babies.

The start of the review in 2017

2.5 When this review began in late 2017 a small team of six obstetricians, midwives, neonatologists and administrative staff were recruited by Donna Ockenden (chair of the review) to begin work as agreed with NHSI. During summer 2017 and early 2018 some original hospital records were transported securely from the Trust to the review's office in Chichester, West Sussex and reviews were undertaken by the clinical team using these records.

2.6 Although this review commenced with 23 families many more came into the review through a number of different channels up until July 2020. This was in response to Trust-led action, word of mouth, social media and press reports. As a consequence the review continued to change and grow throughout the period, as we describe below.

2.7 The period under review has been largely determined by the data the Trust provided to the review team and the terms of reference (TOR) formulated by the review team and NHSI. The year 2000 was identified as a starting point because the first case within the original 23 Secretary of State cohort occurred in 2000.

33 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

2.8 The terms of reference for the review were revised in November 2019 to take account of many further families' cases coming to the review's attention. Many of these additional clinical cases came from the Trust directly reporting families to the review. For instance, a large number of additional cases were reported to the review team by the Trust following a data collection exercise referred to as the 'Open Book', in which the Trust (supported by NHSI) undertook an internal investigation to identify cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. This started as an electronic review in autumn 2018 but further cases were added later in July 2020 (Extended Open Book) after analysis of paper records held by the Trust. The Open Book and Extended Open Book exercises resulted in more than 700 cases of poor outcomes across the four categories within the period 2000-2018 being referred to the review.

2.9 As requested by NHS Improvement, (NHSI) the Ockenden review team drafted an interim report based on early findings and progress which was sent to NHSI in January 2019. Prior to this in autumn 2018 NHSI had formed an oversight committee to scrutinise the work of the Ockenden review team, comprising NHSI, RCOG, RCM and CQC, to which it circulated the interim report. This committee was subsequently withdrawn after concerns were raised by families and in the media.

2.10 The interim report was leaked to the media by an unknown source in November 2019. In response, the number of families contacting the review rose rapidly. Over the course of the review further media coverage resulting from debates in Parliament and from police enquiries resulted in large numbers of families contacting the review.

2.11 In addition, further families were referred to the review by local solicitors representing families and there were additions to the review following contact with the local coroner.

The families within the review have been assigned to a number of different cohorts as shown in Table 1.

Table 1: Family cohorts and timing on entering the review

COHORT	DESCRIPTION	YEAR
Secretary of State (SOS)	The original 23 families at the foundation of the review	2017
Original Direct Contact	Families contacted the Chair having learnt of the review through contact with other families or via social media	2018-2019
Legacy (the Trust named this the 'Legacy' cohort)	Trust-led investigation of further cases identified by the review team following scrutiny of documents pertaining to the Secretary of State cohort of 23	2018
Original post-media coverage	In response to growing media interest	2018-2019
Open Book (Trust-named)	NHSI-led data gathering at the Trust (electronic records only)	May 2019
Post-November 2019 media coverage	In response to the interim status update to NHSI which was leaked to the media	November 2019
Post-parliamentary adjournment	In response to a parliamentary adjournment debate on the review	January 2020
Solicitor	Families approached a law firm in response to media coverage which then referred them to the review team	April 2020
Extended Open Book	Trust-led data gathering (to include all paper copies of medical records)	July 2020
Post-West Mercia Police announcement	In response to West Mercia Police statement regarding the launch of an investigation	July 2020
Coroner	Coronial referrals to the review	July 2020
Saves and Learning (Trust-named)	The Trust identified a number of cases to demonstrate learning within maternity services – a selection of these cases were then passed to the review team	October 2020

Changes to the organisation of the review

2.12 By the time of the first COVID-related national lockdown in March 2020 the review had received only a small number of medical records and associated governance documents from the Trust. There were significant delays in receiving medical records from the Trust throughout 2018 and 2019 with NHS Improvement needing to intervene to try to secure the release of records on an ongoing basis.

2.13 In consequence of the growth in the size of the review's investigation NHSE&I commissioned a company to provide the review with an Electronic Document Records Management System (EDRMS) so that the team could access securely Trust medical records which were scanned and uploaded remotely. This was expedited because owing to lockdown the review team's progress was temporarily halted as the team were unable to travel to the review office. The team commenced accessing the medical records via this secure platform from July 2020. All medical records that had been received from the Trust were securely returned to the Trust once the EDRMS system was up and running.

2.14 The review's internal governance structures were adjusted in response to the high volume of enquiries from families who contacted through emails, social media and telephone calls. All of the initial family contacts were recorded, with follow-up arranged, then an assessment and full clinical reviews were conducted where required. In April 2020 a press statement was released advising the public that the review would close to new families in July 2020.

2.15 The first Ockenden report published on 10 December 2020 was outside the original terms of reference but was requested by the Minister to ensure early learning was disseminated to the Trust and the wider NHS. That first report has occasioned some delay to the publication of the final report.

Closure to new families and progression to final report

2.16 When the review closed to new families in July 2020 it confirmed that 1,862 families came within the review. This was widely reported in the media.

2.17 It should be noted that well over this number of families contacted the review; however the events experienced by some of those families fell outside the review's terms of reference and the review team advised them of the alternative routes they could explore, including approaching the Trust through the email address it had set up for families if they had any concerns.

2.18 Once the screening process had been completed there were 1,815 families for whom the review requested medical records in order to conduct full medical reviews. The reduction of 47 cases arose from a number of duplicate cases, (where for example the Trust and the review team had two different names for a woman following marriage).

2.19 After excluding cases where there were missing hospital records or where consent for participation in the review was not given or could not be obtained the final number of families included was 1,486. Some mothers had more than one incident reviewed over the period of this review and in total 1,592 clinical incidents have been reviewed.

Clinical incident categories and data validation

2.20 Families have been assigned to clinical incident categories. The four clinical incident categories described above (maternal deaths, stillbirths, neonatal deaths, and HIE) were defined by NHSI and the Trust when undertaking the Open Book data collection exercise. The remaining categories (maternal morbidity, cerebral palsy, and the combined category) were defined by the review team to encompass other clinical incidents and issues the families experienced.

Table 2: Clinical incident categories

CLINICAL INCIDENT CATEGORIES
Maternal deaths
Stillbirths
Neonatal deaths
Hypoxic ischaemic encephalopathy
Maternal morbidity
Cerebral palsy
Combined category*

**Combined category: comprises medical termination of pregnancy, missed fetal abnormality, intraventricular haemorrhage, infant death, child death*

2.21 All of the families assigned to the maternal morbidity category self-referred to the review and were largely motivated to do this following reports about the review in the media, or through speaking to other families already within the review. The Trust was aware of a few of these cases, where the family had initially raised concerns through the Trust's complaints process. However, the majority did not have any form of governance investigation, whether initiated through the Trust's clinical incident investigation process at the time of the incident or through the complaints process. The overall conclusion by the review team is that the Trust appeared not to be aware of these families' concerns.

2.22 The majority of the families in the cerebral palsy category also self-referred. Similarly, the majority of these families did not have a Trust investigation at the time of their maternity episode. Many of the families reported being concerned about their baby from the time immediately following their birth and spent a number of years trying to find out from health professionals, or through commencing litigation, why their child had been damaged.Whilst the review spans the years 2000 to 2019 it should be recognised that the review team were contacted by many families whose maternity episode at the Trust occurred before 2000 and the earliest case reviewed was in 1973.

2.23 A total of 170 families from before 2000 and 15 families from after 2019 are included in this review by agreement with NHSE&I as a variation to the original terms of reference. Reviews of these cases have been largely determined by the availability of medical records, with the team being unable to review family cases where there were no medical records. For all the cases under review the standards of care that would have been considered acceptable at the time the incident or concern occurred, and the policies and normal practice at that time, have been used as the benchmark.

2.24 Families included within the review after December 2018 are those who self-referred and a small cohort named by the Trust as 'Saves and Learning'. The families within the Saves and Learning cohort were offered to the review team by the Trust as it wished to demonstrate learning and positive service change in its approach to categorising and investigating serious incidents. Some of these cases had been investigated by the Healthcare Safety Investigation Branch (HSIB). The review team felt that as these cases were offered as examples of change and progression, the governance processes for them should also be reviewed. More detailed commentary on this cohort is included within the clinical governance chapter.

2.25 Families who contacted the review with more recent concerns about their maternity experience were referred back to the Trust to be addressed through the Trust's formal complaints process and timeline. The small number of families from 2019 who self-referred and who remained with the review were those who continued to be dissatisfied with the Trust's response to their concerns. The review includes 15 families

from 2019-2020. Some families from 2021 and 2022 also came forward wishing to share HSIB reports and their experience. The review team advised these families to contact the Trust as we were unable to consider their case due to the review being closed.

2.26 The review received some enquiries and heard accounts from a small number of families with poor maternity experiences at other NHS Trusts across England. Following discussion with NHSE&I the review team advised those families to contact the trusts concerned.

Clinical review methodology

2.27 The core review team comprised obstetricians, midwives, obstetric anaesthetists and neonatologists, with professionals from other disciplines joining the team as and when their specialist expertise was required. Over the course of the review the number of clinical reviewers recruited increased to reflect the growing number of families to be considered. The majority of reviewers retained clinical posts at NHS trusts across England, from Leeds to Plymouth, and all review team members remain on their relevant professional registers.

2.28 As the family numbers grew, the methodology for the clinical reviews underwent several iterations, with the process more efficiently managed once the bespoke electronic platform had been built. Each of the family cases has been reviewed, discussed and graded in accordance with the methodology agreed. The clinical care has been graded using a long-established grading of care[34] scoring system developed by the University of Leicester which was also used in the *Report of the Morecambe Bay Investigation*[35] (2015) by Dr Bill Kirkup.

Governance documentation

2.29 Much of this review centres on the quality of the governance processes in place within the Trust, the quality of clinical incident investigations and any subsequent learning following clinical incident investigations. In our first report, we mentioned that we had received a large volume of governance documentation from the Trust which we had yet to consider. We also reported that in the 250 cases considered to date there was evidence that some serious incidents were not investigated. Subsequently we have found that a number of these cases were investigated, but the governance documentation had not been sent to the review team.

2.30 In the summer of 2021 we were advised by the Trust that it had located many boxes of documents potentially relating to former patients and staff, which had been stored in an unused accommodation block. Subsequently it was confirmed that 171 of those boxes contained information relating to maternity cases. Initially the Trust advised the review team that the maternity governance records found were copies of information already sent to us. This was not correct.

2.31 The review had forecast completion of most of the clinical reviews by mid-August 2021 in order to commence writing the report, which was then planned for publication in December 2021. The Trust provided the review team with information relevant to the families we were aware of, undertaking the screening and sorting of this information themselves, the review team were not involved. Having received this new governance documentation concerning so many families in July 2021, concerns were escalated to NHSE&I as this meant that the reviews already undertaken would need to be reconsidered in light of the new information. Our ability to deliver a second report in December was now severely compromised. The Trust continued to send governance documentation until the end of September 2021, which we agreed as a cut-off date. At this late stage, we had received documentation concerning more than 500 families within the review meaning that each case needed to be reopened and the new documents needed to be reviewed in order to determine whether they changed the reviewer's findings and conclusions following the clinical review which had already been completed.

34 https://pubmed.ncbi.nlm.nih.gov/12390986/

35 Kirkup, B. The Report of the Morecambe Bay Investigation. (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Family voices

2.32 Many families have been offered the opportunity to meet with the chair of the review. From December 2017 until the beginning of 2020 these meetings were through one-to-one meetings in Shrewsbury. These were supported by telephone and email conversations with senior midwives working as part of the review team. Following severe flooding in the Shrewsbury area, and as the COVID pandemic ensued, video-conferencing platforms were used. Conversations were recorded and transcribed, the families were offered copies of the transcript so that they could review and add to their conversation, and the recordings were deleted.

2.33 The review has contacted the families regularly with an all families update on the review's progress. As the review grew in size and the pandemic lengthened, making travel very difficult, it was clear that the review chair would not be able to offer all families a face-to-face meeting. Instead families were invited to submit their accounts and questions via email, phone call or in writing to the review team.

2.34 Families have been offered support through a collaboration with SANDS, Bereavement Training International, and Child Bereavement UK. There is also a psychological support service provided by Midlands Partnership NHS Foundation Trust which will be discussed in detail later on in this report.

Staff Voices

2.35 The Staff Voices engagement strategy, which will be discussed in detail later in the report, was also significantly delayed. This was firstly and understandably at the request of the Trust due to the enormous pressures that it was facing due to the impact of the COVID pandemic. The Trust then delayed the launch of the Staff Voices process which was scheduled for February 2021, until April and then 11th May 2021. There were several hurdles which the review team had to overcome owing to the way that the Trust launched the process within its organisation. This, alongside the late delivery of significant amounts of governance documentation contributed to further concerns about the ability to publish this report by December 2021.

Data platform

2.36 The review team spent many hours screening telephone conversations and emails in order to ensure that the families included within the review met the terms of reference. From November 2019 it became increasingly evident that maintaining records on a system originally intended for 23 families was no longer viable.

2.37 NHSE&I were unable to either provide us access to a fit for purpose secure electronic platform or suggest any other review or public enquiry which could help with recommending a platform for holding the review data, as a review of this volume appeared to be unprecedented. In August 2020 the review commenced conversations with an external provider and were able to secure a contract for development of a bespoke data platform which could be accessed remotely. This data platform was able to securely hold family details and it enabled the review team to write up their clinical findings directly onto the platform.

2.38 The review team started using the platform in April 2021 and transferred over all data from previously completed reports, including the 250 cases reported on in the first report. This enabled the review team to work more responsively and flexibly as the majority of clinical reviewers were now working remotely.

Limitations with regard to data comparisons

2.39 There are limitations that should be acknowledged when interpreting the data presented in this review. For instance, we are unable to be certain whether all cases which meet the terms of reference between 2000 and 2019 have been identified and shared with the review. We anticipate that, using the approaches described above, most of the cases have been identified. However it remains the case, (especially with so much governance material found stored at the Trust in an inappropriate setting and provided to the review team so late in the review process) that there may have been cases that have not been provided to us.

2.40 Finally, we are also cognisant that the Trust has not provided us with information regarding families who experienced adverse outcomes more recently than December 2018, which is the cut-off date it applied in the Open Book and Extended Open Book exercises.

Working with the Shrewsbury and Telford NHS Hospital Trust

2.41 Throughout, the review has been keen to maintain good working relationships with the Trust. There have been several attempts to establish consistency and good communication by ensuring that the review team have a key point of contact at the Trust to assist with swift responses to requests. These contacts changed over time as staff joined and left the Trust.

2.42 The review team also received a very small number of emails from families who have received good care at the Trust. These were acknowledged and shared with the Trust.

Reporting progress to NHSE&I

2.43 The review team has been conscious of the time this review has taken. Following on from the publication of the first report in December 2020 the review team and NHSE&I both wished to follow this up with the final report in December 2021. As outlined earlier the delay in publication to March 2022 has been due to several factors: introducing new electronic data systems, delays in receiving information from the Trust and delays in engaging Trust staff for their views, the complexities of managing a review of this size, and the fact that most of the reviewers in the team held full-time NHS positions.

2.44 During the national COVID restrictions in January 2021, we became increasingly worried regarding the reduced availability of our clinical team owing to the pandemic pressures and the need for them to quite rightly prioritise their NHS commitments. We raised this concern with NHSE&I and with their assistance, and that of the Royal Colleges, we were able to welcome additional colleagues to the team between March and May 2021. This was essential as our projected plan between January and July 2021 was to complete in excess of 1,200 clinical reviews.

Request to delay publication

2.45 In August 2021, recognising that the December publication date was now compromised owing to the late delivery of the large amount of governance documentation from the Trust and the delay with the staff voices engagement strategy, the review team wrote to the Secretary of State for Health and Social Care raising concerns and suggesting an alternative publication date of March 2022. Following discussions this extension of time was agreed by the Parliamentary Under Secretary of State, Minister for Primary Care and Patient Safety, Maria Caulfield MP.

Family feedback

2.46 It is not possible or appropriate to publish clinical reviews of all individual families' experiences in the report. However it has always been intended that the review team would feedback to families in a way that will help them to understand what happened during their maternity care. In August 2021, the review team wrote to NHSE&I outlining the reasons why giving individualised feedback to families about what had happened in their care was so important and why the feedback should be given by the review team. This process of feedback has been agreed and will take place throughout April, May and June 2022.

Closedown of the review

2.47 The review team has used an independent legal team for advice throughout the review. In particular we have received advice on data protection aspects of the review, and will be closing down the review and archiving its records in accordance with all legislative requirements.

Cost of the review

2.48 From its inception, the review has always been mindful that it has been financed through public funding. The review chair has held senior positions within the NHS and is well aware that large budgets have to be managed accordingly with demonstrable accountability for expenditure. All costs have been clearly accounted for each month and ranged from day to day office costs, to the management of the various secure platforms.

2.49 Since 2017, it is publicly reported that the Trust (via NHS Resolution) has paid out at least £50million to families as compensation for babies who have suffered brain damage or have died. In 2018/19, across England, there were 188 successful maternity claims averaging £9.9million each, amounting to £1.86billion in total (NHS Resolution 2019)[36].

2.50 The additional hidden costs for patients of failures in clinical care include relationship breakdowns, mental health issues and ongoing family suffering, which invariably lead to an increase in demand for resources across health and social care. All of these consequences have been acknowledged, recognised and witnessed through the review team's meetings with families in the course of the review.

2.51 Whilst the review team recognises that the costs for conducting this review are significant, they are a fraction of the cost of one successful cerebral palsy claim. It is intended that our **Local Actions for Learning** and the **Immediate and Essential Actions** are deemed strong enough to continue their positive influence of enhancing the safety culture within maternity services across England, in addition to clearly stating the essential sustainable improvements required within the maternity service at the Trust. They are intended to help with the ongoing repair and restoration of public confidence and trust in maternity services both locally in Shropshire and more widely across England.

36 https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/

Chapter 3

Supporting the families during our review

Three tiers of dedicated family support

The Listening Ear service (Tiers 1 and 2)

3.1 The Listening Ear service, comprising three partner organisations: Bereavement Training International, Child Bereavement UK, and SANDS, was commissioned directly by the review team to be available for all families involved in this review. We recognised that the experience of families coming forward and their case being discussed and revisited with them would reignite difficult and painful feelings.

3.2 Key objectives of the Listening Ear service were as follows:

- To offer a support service, not a counselling service, providing in most cases a one-off listening ear session to families.
- To act as a second tier sign-posting service, providing details of national and regional support services for ongoing or specialist support.
- To provide onward referral to a dedicated team of psychologists offering specialist psychological support (Tier 3) where appropriate, or if requested by the family.

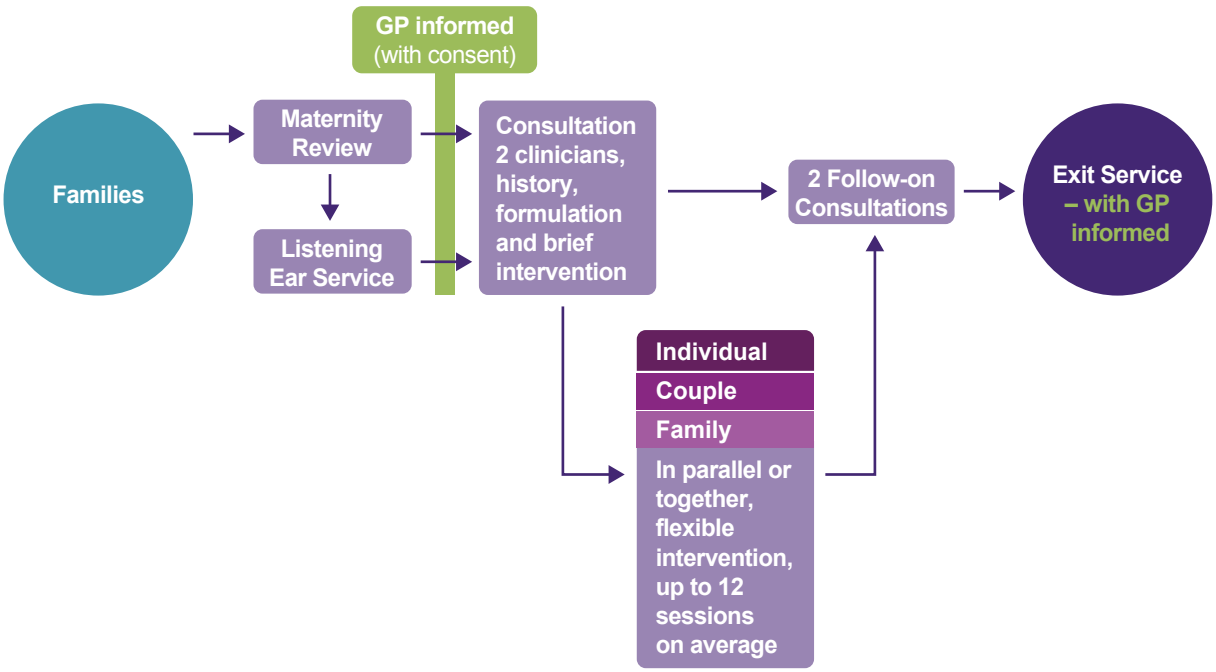
Specialist psychology service (Tier 3)

3.3 As the review team began meeting with families to review their adverse maternity experiences the Chair of the review identified that further support was needed for some families. There was recognition of a gap in service provision for those with complex grief, trauma and emotional distress. This service was beyond the scope of primary care services, but in most cases would not reach the criteria for secondary mental health services. Working in collaboration with the local clinical network and other system-wide stakeholders a specialist psychology service, hosted by Midlands Partnership NHS Foundation Trust (MPFT) and commissioned by NHS England and Improvement (NHSE&I) was established. This dedicated service was designed for families to benefit from an experienced clinician "front-loaded" model, differing from existing services which deliver a stepped model of care.

3.4 A consultant psychologist-led team was recruited to work on a flexible, and at points due to the COVID-19 pandemic remote, basis which also enabled access for those families now living out of the area. Face-to-face provision was also available to any families requesting this, where possible. The duration of support was planned for an 18 month to two year period, with key stakeholders and related care pathways across the local system involved in active, regular review of the emerging clinical data, in order to develop clear plans for transition into relevant care-pathways at the conclusion of this time-limited provision. Extension of the service beyond this timeframe for a period of 3-6 months, to the end of 2022 has recently been requested, in anticipation of the increase in demand following publication of the final report and as families begin to process its findings.

3.5 Access to the specialist psychology service has been via the maternity review team and the Listening Ear service. All families referred were offered a minimum of two consultations (an initial appointment, with the offer of 1-2 subsequent sessions as required) with two psychologists, providing them with an opportunity to feel that their experiences had been listened to and heard. Through embedding this model it was

anticipated that many families would be able to receive support and sufficient intervention at the point of consultation: promoting a positive, strengths-based model, acknowledging the resources families had drawn upon, often over many years, in their own lives to cope with what they had been through. The option of further intervention sessions with two clinicians provided the versatility of either two clinicians working with the whole family, or different parts of a family working in parallel with a different clinician. This model was designed specifically with the importance of continuity of care in mind, in order that families would not have to repeat their story. The diagram below provides an overview of the offer:



3.6 Where initial consultations indicated the need for further psychological interventions, families have been offered a range of NICE recommended treatments based on the individual formulation of their experiences. Treatments have included trauma-focussed Cognitive Behavioural Therapy[37] or CBT, Eye Movement Desensitization and Reprocessing or EMDR[38], couples therapy, and family or systemic interventions. The quality and effectiveness of these interventions has been routinely measured with the use of validated outcome measures, and bespoke client experience measures.

3.7 From the outset the specialist psychology service was developed with a clear exit strategy, remaining responsive to the needs of families, but with the flexibility to adapt the delivery and type of interventions as appropriate, given the time available. Communication with the families has been transparent to explain the scope, access and duration of the service, and with stakeholders preparing for the transition to relevant care pathways both within the NHS and wider local system at the close of this specialist provision.

3.8 Family feedback to the service has highlighted the importance to them of having a dedicated team of specialists with specific knowledge and expertise in the psychological impact of adverse maternity experiences. In particular families have valued the ease of access to the service, with an absence of waiting lists or restrictive referral criteria. Families have also reported how important to them it has been to have the experience of being listened to, understood, and believed, offering the opportunity for a restorative experience of compassionate care.

37 See glossary

38 See glossary

In conclusion

3.9 The provision of a comprehensive package of emotional and specialist psychological support available to all families involved in the review process has been central to helping them navigate the profoundly significant and potentially very painful process of their adverse maternity experiences being reviewed. Many families will have found their maternity experiences to have been life-changing, involving many layers of distress and trauma, with the ripple effects felt by whole families, the wider community, and across generations. The availability of dedicated expert support has meant that families have not had to manage this latest process alone, and have been empowered to have the opportunity to reflect on and understand what they have been through, with professionals committed to facilitating this with care and compassion.

3.10 It is strongly recommended that should any review or investigation be required in the future, this model of family support should be used to inform good practice, drawing on what has been learnt with regards to procedures, protocols and pathways. Above all, there must be recognition that any review of this nature will inevitably impact on those involved, and that the provision of emotional and psychological support should be integral to how the system responds to this need.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER OUR REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

3.11 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

3.12 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Section 2

Internal oversight and external scrutiny

- Background information about the Trust
- Chapter 4. Clinical governance
- Chapter 5. Clinical leadership
- Chapter 6. Our findings following review of family cases

Background information about the Trust

Service overview

3a.1 The maternity service at the Trust is provided as a 'hub and spoke' model with a consultant-led maternity unit surrounded by various midwifery-led units within the Shropshire region.

3a.2 The consultant maternity unit was originally based at the Royal Shrewsbury Hospital site (RSH) until 2014 when consultant-led services were transferred to the Princess Royal Hospital (PRH) site at Telford. Throughout the years there have been a number of midwifery-led units, however some of these are temporarily or permanently closed for intrapartum care due to operational reasons. The current five midwifery-led units are based at Royal Shrewsbury Hospital, the Princess Royal Hospital Telford (the Wrekin unit), Bridgnorth, Oswestry and Ludlow. At the time of publication of this report, the only midwifery-led unit providing intrapartum care is the Wrekin unit co-located (or alongside unit) at the PRH in Telford. There are additional community bases at Whitchurch and Market Drayton.

Geographical area

3a.3 The geographical area covered by the service is approximately 2,500 square miles (including the local authority areas of Shropshire, Telford and Wrekin and parts of mid-Wales). A significant amount of the catchment area is rural; this is likely to be a contributing factor to the number of midwifery-led units within the region and the Trust's ongoing community midwifery service provision.

Birth rate

3a.4 The birth rate figures below have been extracted from the Trust's maternity dashboard and are based on financial years (April - March). The birth rate is gradually decreasing; whilst a proportion of this change is recognised as being in line with the national birth rate, some staff also shared concerns with the review team that women are choosing to give birth elsewhere within the region, rather than at the Trust. One staff member told the review:

'We have a lot of women who come under the Trust's locality but they are choosing to birth elsewhere because they do not want to go there.'

Table 1. Annual birth rate at the Trust 2008 – 2020

	YEAR											
WARD	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Shrewsbury MLU	503	478	550	478	421	367	235	207	140	120	69	15
Wrekin MLU	477	488	436	435	401	362	336	359	338	351	285	224
Bridgnorth MLU	86	59	98	69	68	75	68	82	75	26	4	0
Ludlow MLU	100	77	81	86	71	62	49	51	37	12	4	0
Oswestry MLU	90	82	83	87	72	74	69	83	46	15	4	0
MLU Totals	1256	1184	1248	1155	1033	940	757	782	636	524	366	239
Home Births	92	90	96	86	91	86	82	63	63	68	75	56
BBA Other	15	11	19	18	21	8	19	14	25	3	8	41
MLU Totals plus Home Births	1348	1274	1344	1241	1124	1026	839	845	699	592	441	295
All Non CU Births (MLU+Home+BBA)	1363	1285	1363	1259	1145	1034	858	859	724	595	449	336
Shrewsbury/Telford CU	3871	3965	3856	3983	4009	3978	3796	4001	4204	4060	4062	4086
TOTAL BIRTHS	**5234**	**5250**	**5219**	**5240**	**5154**	**5012**	**4654**	**4859**	**4928**	**4655**	**4511**	**4422**

Reference: Shrewsbury and Telford Hospital NHS Trust Maternity Dashboard

Demographic

3a.5 The term demographic refers to the structure of a population including (but not limited to) factors such as age, ethnicity, employment and education status. Data was available from a variety of sources including local data from the Trust, as well as large-scale reports such as the Indices of Deprivation[39]. Now more than ever, it is recognised that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation, are at increased risk of maternal and neonatal morbidity and mortality[40]. Therefore, the continual monitoring of the local demographic is vital in terms of ongoing planning and provision of maternity services[41].

3a.5 The use of electronic maternity information systems (MIS) is now standard in most maternity units in England. However it is important to acknowledge that MIS data is at times incomplete, sometimes because of incomplete data capture as well as individual user input error. Missing data can also be attributed to the constraints and designs of data capture systems, however this is likely to improve with the ongoing development of electronic maternity information systems. It has been recommended that quality improvement indicators should incorporate metrics on data completeness[42].

Ethnicity

3a.6 The majority of women receiving maternity care at the Trust were reported to identify as white British[43]; whilst approximately 10 per cent of the maternity population identified as originating from a Black, Asian or Minority Ethnic background, (BAME) in comparison to a national average of 19-22 per cent[44].

3a.7 Unfortunately, there were 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years (Figure 1). The incomplete datasets are also recognised within the Trust's annual perinatal mortality reports between 2013 and 2018[45].

3a.8 Consequently, there are limitations with regard to the correlation of any trends or themes directly linked to ethnicity. However, due to the evidential links of poor maternal and neonatal outcomes of women from ethnic minority backgrounds, as previously stated, it is suggested that all trusts should aim to improve the accuracy of their datasets as part of quality and safety monitoring. Research suggests this is achievable with the use of self-declaration within maternity booking systems[46].

39 Ministry of Housing, Communities and Local Government (2019) 2019 Indices of Deprivation – Telford and Wrekin. https://www.telford.gov.uk/download/dowidnloads//15603/index_of_multiple_deprivation_2019_-_telford_and_wrekin.pdf

40 Knight, M., Bunch, T., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. Kurinczuk, JJ. (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. (2021) Oxford: National Perinatal Epidemiology Unit, University of Oxford.

41 NHS England and NHS Improvement. *Equity and equality. Guidance for local maternity systems.* (2021) https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

42 *National Maternity and Perinatal Audit Clinical Report 2017* https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf

43 Shrewsbury and Telford Hospitals NHS Trust (2020). Deliveries by Ethnic category and age – 2000-2020.

44 MBRRACE-UK. *Perinatal mortality surveillance report for births* (2013-2018)

45 Ibid n7

46 Jardine, JE., Fremeaux, A., Coe, M., Urganci, IG., Pasupathy, D. and Walker, K. *Validation of ethnicity in administrative hospital data in women giving birth in England: cohort study* (2021) British Medical Journal Open, 11(8). doi: https://doi.org/10.1136/bmjopen-2021-051977

Figure 1. Number of records with incomplete ethnicity data at the Trust 2000 – 2020

Reference: Shrewsbury and Telford Hospital NHS Trust[47]

Age

3a.9 The lower and upper ranges of maternal reproductive age are recognised as a risk factor for adverse outcomes in pregnancy. Although research is limited, evidence suggests younger mothers are at increased risk of various complications including preterm birth and are more likely to have a baby with a low birth weight[48]. Mothers of advanced maternal age are recognised to be at greater risk of complications including pre-eclampsia, preterm birth, stillbirth and neonatal morbidity and mortality[49].

3a.10 Upon analysis of national data for younger mothers, it was observed that the age parameters for 'teenage pregnancy' vary. Whilst the Office for National Statistics (ONS) collates data on conception rates of women aged 15 to 17 years old, national reports into perinatal morbidity and mortality categorise 'teenage' pregnancies as mothers under 20 years old[50]. It is therefore not possible to correlate national teenage pregnancies with perinatal morbidity and mortality.

3a.11 Data from the Trust was compared with data from the ONS to identify whether there was a greater incidence of teenage pregnancies, and pregnancies to women of advanced age, within this review than the national average.

3a.12 The review team noted the Trust predominantly covers two local authority areas, Shropshire as well as Telford and Wrekin. Although the local rates of conceptions to younger mothers have fallen in line with the national average, within Telford and Wrekin teenage conception rates were consistently higher than the national average throughout the timescale of the review (Figures 2 and 3). These findings are also recognised within the Trust's annual perinatal mortality reports[51].

47 Ibid n6

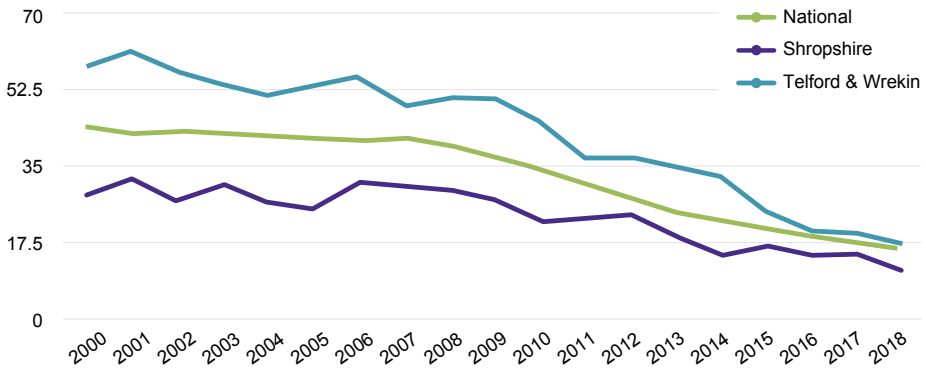
48 World Health Organisation. *Adolescent pregnancy.* (2020) https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

49 Royal College of Obstetricians and Gynaecologists. *Induction of Labour at Term in Older Mothers.* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_34.pdfe

50 Ibid n3

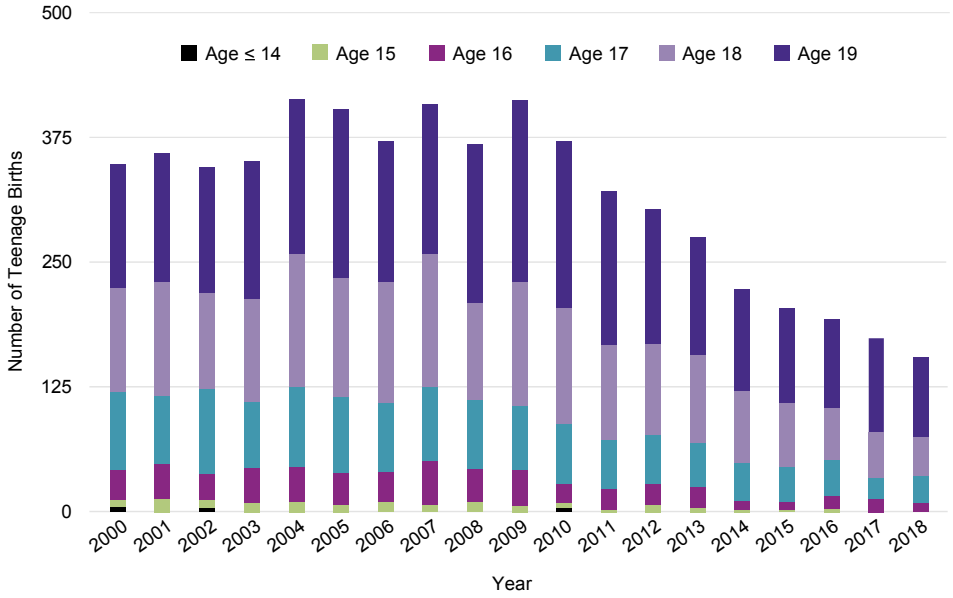
51 Ibid n7

Figure 2: Aged 15 – 17 years of age conception rates per 1000 women



Reference: ONS[52]

Figure 3: Number of teenage births (mothers under 20) at the Trust



**Data from 2019 and 2020 are not reported due to the observed discordance of the annual birth rate reported within the maternity dashboard and birth rate stratified by maternal age provided by the Trust*

Reference: Shrewsbury and Telford Hospital NHS Trust[53]

3a.13 Despite there being a higher proportion of teenage pregnancies at the Trust than the national average, teenage pregnancy cases within the review population (i.e. with adverse outcomes) comprise only 6.4 per cent of cases, which is comparable to the overall proportion of teenage pregnancies at the Trust during the timescale of the review. Consequently, the review team concluded that the increased rate of adverse outcomes observed in the Trust against the national average is unlikely to be due to teenage pregnancies.

3a.14 The incidence of women with advanced maternal age was found to be less than or similar to the national average during the timescale of the review[54]. The lower parameter of advanced maternal age is 35 years old, above which there is a statistically significant increase in the risk of stillbirth and other adverse outcomes

52 Office for National Statistics. *Conceptions in England and Wales:* 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-area-of-usual-residence

53 Ibid n6

54 Ibid n7

listed above. The proportion of women with advanced maternal age at the start of the review was 15 per cent in 2000 and gradually increased to 20 per cent in 2007, after which the proportion did not increase further. This was noted to be in line with national rates of maternities for women aged 35 years and over[55]; therefore, it should not disproportionately affect morbidity and mortality rates at the Trust.

Deprivation

3a.15 Similarly to ethnicity, social deprivation is recognised to be a significant risk factor for morbidity and mortality. MBRRACE-UK reports that women living in the most socially deprived areas[56] are three times more likely to die during or within the year that follows pregnancy than those living in the least deprived areas. Deprivation rates are monitored throughout the country by the assessment of factors such as income, employment, education, living environment, crime, health and barriers to housing.

3a.16 Throughout the time period of the review, a proportion of the geographical area covered by the Trust was regularly ranked within the top 10 per cent of the most deprived areas within the country[57]. Despite this, due to other areas within the region being classified as the 'least deprived', annual perinatal mortality reports consistently highlight the levels of deprivation as similar to the national average[58], therefore morbidity and mortality rates should not be disproportionately affected.

3a.17 The overall conclusion of the review team was that the ethnicity data (though incomplete), the deprivation rates, and the maternal age distribution for the Trust should not have caused any disproportionate effect on morbidity and mortality rates at the Trust when compared with the national average.

55 Office for National Statistics. *Birth characteristics in England and Wales:* 2019. (2020) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019#age-of-parents

56 Ibid n3

57 Ibid n2

58 Ibid n7

Chapter 4

Clinical governance

Introduction

4.1 In line with the terms of reference of the review, this chapter aims to explore whether the local governance within maternity services at the Trust met the standards that would be reasonably expected of it between 2000 and 2019. In doing this, the review team examined a broad range of governance documents supplied by the Trust including, but not limited to, risk management documentation, minutes of meetings, job descriptions, incident notifications, investigation reports, policies, guidelines, audits and complaint responses.

4.2 Whilst acknowledging that the review covers a considerable time frame, and taking account of the fact that governance requirements changed over time, the review team found that the working practices and prevailing attitudes within the maternity service and the maternity governance team at the Trust did not pay sufficient attention to the safety of mothers and babies.

4.3 The key themes identified requiring improvement within maternity services at the Trust were:

- The poor quality of incident investigations
- Poor complaints handling
- Local concerns with statutory supervision of midwifery investigations
- Concerns with clinical guidelines and clinical audit

1. Quality of incident investigation

Background and historical context of incident investigation.

4.4 The definitions and processes for reporting and investigating incidents have changed throughout the time period of the review and therefore the review team has been careful to examine how the Trust reported and investigated incidents in relation to the expected standards at the time.

4.5 A patient safety incident is any unintended or unexpected event which can, or does, lead to harm for one or more patients receiving healthcare[59]. In 2003 the National Reporting and Learning System **(NRLS)**, which is a central database where trusts report incidents, was created and thereafter the culture of reporting incidents to improve safety in healthcare improved nationally. Serious Incidents **(SI)** are acts or omissions in care that results in unexpected or avoidable death or serious harm: 'where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified'[60] to prevent it from occurring again. However it was not until 2010 that a nationally consistent definition of what constituted a SI was published and the use of a specific methodology, Root Cause Analysis[61] **(RCA)**, was recommended for conducting these investigations[62].

59 NHS England, *Report a patient safety incident* https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/

60 NHS England, *Serious Incident Framework*, (2015) https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

61 See glossary

62 National Patient Safety Agency *National framework for reporting and learning from serious incidents requiring investigation.* (2010) https://www.afpp.org.uk/filegrab/NPSAconsultationdocument.pdf?ref=1064

4.6 In our first report, we identified some of the key issues from the 250 cases we reviewed, which included inconsistent multidisciplinary input to SI investigations which were often cursory and did not identify underlying systemic failings, and failed to learn lessons. In fact we found that some significant cases of concern were not investigated at all.

4.7 Having now considered the care of all families included in the review, in addition to the aforementioned cases for our first report, the review team has identified the following concerns regarding governance in maternity services at the Trust:

a) Incidents that should have triggered a Serious Incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review **(HRCR)**, apparently to avoid external scrutiny.

b) When serious incident investigations were conducted many were of poor quality.

c) There was a lack of learning and missed opportunities to improve safety.

d) There was a lack of oversight of serious incidents by the Trust's commissioners.

e) There were repeated persistent failings in some incident investigations as late as 2018-2019.

a. Incidents that should have triggered a serious incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review (HRCR), apparently to avoid external scrutiny

4.8 The review team has found a concerning and repeated culture at the Trust of not declaring adverse outcomes as an SI in line with the national framework. Instead, they were inappropriately downgraded and investigated by what the Trust termed a High Risk Case Review (HRCR). This method of investigating incidents, created by the Trust, was less robust, varied considerably in quality and lacked the rigour and transparency of an SI investigation. Notably, HRCRs were not reported to NHS England, the Clinical Commissioning Groups **(CCGs)** or the Trust Board, and therefore avoided external scrutiny.

4.9 In October 2021 during the 'staff voices' 'interviews the review team asked a member of staff for the circumstances in which the HRCR process started appearing within the Trust's local investigation process they responded:

4.10 *One year we were criticised for over-reporting too many Serious Incident investigations. This raised a red flag with the CCG, or the PCT or whatever it was at the time, and they said you've got an awful lot of SIs. We looked back at them and when they were reviewed again, it was decided was that some of them shouldn't have been reported as SIs, we were over-reporting. In our mind these are cases that needed significant review, so we designated them as a High-Risk Case Review, where we will spend quite considerable time looking at them and examining them and trying to learn from them because they are important, but they didn't hit the SI criteria.'*

4.11 The review team saw that frequently an early assessment was made by the maternity service that there was no act or omission in care, which meant that the investigation was downgraded to a HRCR. This meant that the true scale of serious incidents within maternity services at the Trust went unknown over a long period of time.

4.12 The earliest version of the maternity service's Risk Management Strategy available to the review team, version 5, June 2010, correctly defines a Serious Incident (or what was then termed a Serious Untoward Incident) in line with the national guidance[63] and, within section 8.7, includes a clear list of maternity-specific categories that must be investigated as an SI. This list included but was not limited to:

- Maternal death (booked at The Trust and who died up to 1 year following delivery)
- Intrauterine death: over 37 weeks gestation and during an inpatient admission
- Intrapartum death: specifically those that die during labour or during an inpatient admission

63 Ibid n4

- Unexpected neonatal death: from 37 weeks gestation to 28 days post delivery
- Maternal unplanned admission to ITU
- Unexpected admission to NICU: where APGARS[64] are below 4 at 10 minutes and/or the baby has already required intubation.

4.13 Section 8.7.1 said: 'Arrangements for ensuring that all Serious Untoward Incidents undergo a root cause analysis', explains that within the maternity governance meeting 'a decision is made to whether a high risk case review is needed'. Within the document, there is no definition of what an HRCR is. In Version 6.1 from March 2014, section 9.2.9 states that an HRCR will be conducted for those cases 'where there is a poor outcome, patient experience or near miss not fitting the Serious Incident criteria. This additional scrutiny will be an opportunity for transparency, learning and service enhancement'.

4.14 The review team however, found many examples of families who met the criteria to have a full SI investigation, but had an internal HRCR conducted instead. For example, between 2011 and 2019 there were a number of maternal deaths, stillbirths, neonatal deaths and babies born with HIE where an HRCR was conducted. Where these cases correctly underwent a SI investigation, rather than an HRCR, the subsequent investigations were often found by the review team to be of poor quality. Examples of this are found throughout this chapter and other clinical chapters in this report.

4.15 This practice of conducting an internal HRCR when an SI was required is illustrated by a family in **2015**. This involved a baby born by instrumental delivery, which clearly fell outside national guidelines (this delivery occurring with 10 pulls of three sequential instruments). This baby suffered significant skull fractures, brain injury and has ongoing long-term disabilities as a result. Despite this meeting national SI criteria as an act or omission in care which resulted in serious harm[65], the decision was made to conduct an HRCR instead. The HRCR did follow an RCA approach but the quality of the investigation was poor. It did not involve the family, did not identify the root causes but instead concentrated on the incidental findings and the mitigations. Seemingly, the action plan did not offer any learning to the Trust so that similar incidents were prevented from happening again in the future.

4.16 In a typed transcript provided to the review team by the Trust, of a recording of the meeting at which the decision was made to undertake an HRCR instead of an SI for the case of this family, it is stated that an HRCR approach was utilised because *'A high risk case review has a very similar process, but it doesn't get reported to our non-executive, Health England and Tom, Dick and Harry… an SI gets reported all over the patch as far as I can see...'* This approach was taken despite the fact that following its 2014 visit the CQC highlighted its concern to the Trust about an under-reporting of SIs in maternity. There is also evidence from the same meeting that some individual members of staff present were not happy with how the investigation process was being run, with one attendee, (a staff member) insisting that the meeting was recorded. They said: *'My experience of the way that some of the investigations have been run have led me to believe that I should record this'.*

4.17 From the documentation supplied to us by the Trust the review team has been unable to identify when the Trust started using HRCRs or why they were implemented but the 2014 Maternity and Risk Management Strategy, version 6.1 stated that their aim was to *'establish a clear and complete chronology of what happened on the date of the incident and any preceding events that could have impacted on the outcome for the family'.* This is too narrowly focused and so, in many cases, an HRCR failed to identify why the incident occurred, meaning that many learning opportunities were missed. Confusingly, the HRCR investigations often used phrases such as 'Root Cause Outcome', 'RCA meeting' and 'RCA discussion', when in fact a root cause analysis was often not performed. Failing to do this properly meant that families were not given the answers they sought and deserved, the Trust did not identify the underlying issues that led to the incident occurring, and lessons were not learnt, so increasing the risk of further harm to families under the care of the Trust.

64 See glossary

65 Ibid n2

b. When Serious Incident Investigations were conducted many were of poor quality

4.18 When an SI was declared and a full RCA was conducted the quality of the reports was better than for the HRCRs, however many were still not of the standard that would have been expected. The review team has described the specific omissions with regards to serious incident investigation within the chapter on maternal deaths, however the review also found similar themes when assessing other serious adverse outcomes.

4.19 The Royal College of Obstetricians and Gynaecologists **(RCOG)** undertook an Invited Review of maternity services at Shrewsbury and Telford Hospital NHS Trust on 12–14 July 2017. This identified that the Trust's process of investigating SIs was complex and failed to adhere to recommended timescales; in one case reviewed by the RCOG team some 8 months after a stillbirth the report was still incomplete. The RCOG team also identified that the Trust's internal team conducting the investigations was not appropriately resourced or trained in RCA methodology. It also identified that there was no culture of shared learning, that the RCAs often focused on the wrong issues, lacked system wide actions and focused instead on non-specific actions such as 'share report widely' and 'learn from events'. There was no documentation that action plans were completed and recommendations often focused on individuals, rather than recommendations for system changes.

4.20 The Ockenden review team has found similar failings to those identified by the RCOG team in 2017 including long waits for families to be given answers, investigations that focused on describing what happened rather than why, a focus on individual errors rather than systemic issues, and actions that were unlikely to prevent recurrence.

4.21 *A young mother in **2013** had what the RCA described as a 'prolonged pregnancy with intrauterine death' but failed to examine why this occurred and missed causative factors identified by the review team such as lack of fetal monitoring for 15 hours during the induction of labour process. The review team also identified terminology in the Trust report which could be seen as imparting blame on the mother, suggesting that 'patients liked to be left to sleep', putting the emphasis on the mother for not reporting fetal movement concerns, rather than assessing why there was a lack of fetal monitoring. The RCA recommended that fetal viability should be assessed at least once per shift and the Maternity Governance meeting (06.08.13) 'Confirmed with the… manager, [this recommendation was] now embedded in practice and agreed that manager to undertake audit'. The review team however has found no evidence that an audit was undertaken and even within the Trust's 2017 v5.5 Induction of Labour guideline, there is no evidence this practice has been embedded. (2013)*

4.22 *In **2015**, a family did not receive an apology from the Trust, were not involved in the investigation, were not asked to submit questions and waited over 12 months to find out why they suffered an intrapartum stillbirth. The subsequent report focused on individual errors, for example "educational need for midwife – sticker regarding fetal movements absent" and missed the systemic issues contributing to the incident. (2015)*

4.23 *In **2015**, a family waited more than 9 months for an SI to be declared after they suffered an early neonatal death, despite the Trust's 2014 Maternity Service's Risk Management Strategy Version 6.1 stating an SI should have been conducted from the outset. The RCA described the cause of death as a 'sub-acute cord compression leading to acute cord obstruction', but failed to identify why this happened. There was no mention of concerns identified by this review team such as a failure to upgrade intrapartum care to a high risk pathway, and staffing issues and shortages meaning that 1:1 care could not be provided. There was also a failure to monitor the fetal heart rate adequately. This lack of attention to the root cause of the incident meant the systemic issues related to why the incident occurred were not identified and the recommendations that were made did not address the systemic issues within the Trust's maternity services at the time. (2015)*

4.24 In later years there is evidence of improvement in the quality of some SI investigations. In **2017**, a family suffered a similar incident to earlier cases, namely an intrauterine death whilst awaiting an induction of

labour in hospital. The RCA identified multiple systemic and organisational issues resulting in a delay in transferring the mother to the labour ward. The recommendations focused on addressing the issues that created the delay, for example the closure of triage at 8pm putting additional pressure on the labour ward, and how these could be addressed. The report also highlighted that there was *'a culture of normalising long waits for women undergoing induction of labour, who are ready to be transferred to the delivery suite [labour ward] when the delivery suite is busy'*. It should be acknowledged that this was highlighted and multiple recommendations were focused on making improvements. However the review team is of the opinion that the poor investigation of the earlier incident from 2013 represents a missed opportunity to improve and to potentially prevent future incidents, such as this incident in 2017.

c. Lack of learning and missed opportunities to improve safety

4.25 Once investigations were conducted the review team still found there were multiple missed opportunities for the Trust's maternity service to learn, improve and prevent future harm occurring to other women and babies.

4.26 There have been some attempts to improve the safety culture and learn from incidents. In June 2017 the Trust conducted an internal review[66] of maternity services. It considered the history of maternity services between 2007 and 2017, focussed on issues of patient safety, learning, and engagement with bereaved parents. The report further stated that the service must 'create a coordinated approach to the maternity safety improvement plan' and that 'safety in maternity is protected by the efforts of the staff and supported by leaders'. The review concluded that 'all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service'. As of January 2022, the review team has not been provided with this action plan or seen any evidence of its existence in the information provided by the Trust and therefore we cannot comment on the efforts made and any impact of this plan in improving learning and safety at the Trust.

4.27 *In **2010** a woman developed chorioamnionitis[67] and the baby was born in a poor condition, requiring cardiac massage, and subsequently developed brain damage. At the time there was no incident report completed, no review of the care provided, no investigation performed and therefore no learning. In 2018, the Trust asked external experts to review the care provided to the family and they found that the CTG heart monitoring was abnormal for most of the duration of the labour and that there was a lack of obstetric reviews despite midwifery concerns. Oxytocin was started and increased inappropriately when the CTG was abnormal and was also increased despite hyperstimulation in the second stage. They also found that there was a long period of fetal bradycardia not acted upon, and despite performing an instrumental delivery with meconium present the neonatal team were not called to be present at the delivery. This was not one failing in care, but multiple failings. What is clear from the intrapartum section of this report is that issues with the inappropriate use of oxytocin, amongst other failings identified in this case, did continue after 2010.*

4.28 *The lack of investigation in **2010** for a family resulted in a missed opportunity to learn and, due to this it is likely to have resulted in similar situations occurring to other women. Also concerning is that the family were seen a week after the birth of their baby by an obstetric consultant who explained that 'You made good progress in labour and had a very straightforward ventouse delivery for delay in the second stage of labour. Your baby's condition was much unexpected… what is very confusing is that the continuous heart rate monitoring that was performed during labour did not show any signs of your baby becoming distressed and this is unusual'. This was either an unintentional misunderstanding of the clinical situation or a purposeful lack of transparency and honesty. Either way, this follow-up and review was not fit for purpose. The poor governance processes at the time meant that this family waited 8 years to find out there had been significant failings in care that led to their child suffering brain damage. (2010)*

66 Review of Maternity Services 2007 – 2017 by Colin Ovington, on behalf of the Quality and Safety Committee, dated 27th June 2017, provided to the review team by the Trust

67 See glossary

4.29 The review team also found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm. The following three examples over a 12-year period demonstrate exactly this:

4.30 *Firstly, in **2006** a child was born with brain damage (HIE) after the mother developed an infection (chorioamnionitis) due, in part, to multiple inappropriate vaginal examinations after her waters had broken before she was in labour. No investigation was done, no learning identified and therefore no actions were taken to prevent a recurrence. (2006)*

4.31 *Secondly, in **2011** a child developed multiple long term disabilities secondary to inappropriate care in a similar situation (waters breaking before labour). Despite the baby spending 23 days on the neonatal unit there was no investigation performed and again, a missed opportunity for learning. The Trust acknowledged at the time that the 2004 guideline followed at the time was inappropriate and 'very out of date'. Nevertheless, it was still not updated for another three years until 2014. (2011)*

4.32 *Thirdly, in **2015** a very similar incident occurred, with repeated unnecessary vaginal examinations despite the woman's waters having been broken for more than 48 hours before labour and this subsequently led to an infection (chorioamnionitis) and a poor outcome for the baby This poor outcome could potentially have been prevented had investigations been conducted in previous years following competent and appropriate multi-professional governance processes by a team with a willingness to learn. (2015)*

4.33 *In **2016**, the Trust had a second opportunity to review the care provided to a family but this opportunity was again missed. The mother initially made a complaint but after receiving an inadequate response from the Trust, contacted the Parliamentary and Health Service Ombudsman (PHSO[68]), who conducted a review in 2018 and identified failings in care. It was only at this point, three years after this third incident, that the Trust created an action plan to reduce the likelihood of recurrence in the future. The review team however has been unable to find any clear evidence from the information supplied to us by the Trust that the change following the PHSO report has been implemented. (2016)*

4.34 Sadly, the review team encountered many further examples of repeated missed opportunities to learn:

*In **2009** a baby born at the Trust was admitted to the neonatal unit with severe hypoxia and suspected HIE. The baby subsequently died within 12 months of birth due to complications from severe cerebral palsy. There was no investigation performed after the baby was admitted to the neonatal unit with HIE and a missed opportunity for improvement. After the birth the parents met with two consultants who could not identify what went wrong and decided against asking for an external investigation. (2009)*

4.35 *In **2010**, the Trust had a further opportunity to review this case after receiving a complaint letter from the family. However the family have explained to the review team that this response lacked sympathy and compassion and again did not identify any failings in care. The issue of a lack of learning is multi-professional and the neonatal team did not review the care they provided either. Subsequently a letter to the GP from the consultant obstetrician explained that the labour care was 'appropriate' and nothing could have been done differently.*

4.36 *It was only after a second complaint response in **2017**, with a new Chief Executive at the Trust that an external investigation was conducted. In 2018, 9 years after the initial incident occurred, an investigation*

68 See references – various documents on PHSO consulted for this chapter inc:

1. Parliamentary and Health Service Ombudsman (PHSO). Learning from mistakes. 2016.
2. Parliamentary and Health Service Ombudsman (PHSO). A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. 2015.
3. House of Commons Public Administration and Constitutional Affairs Committee. Will the
4. NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. 2017.

identified multiple failings, substandard care and that the delivery should have been sooner. Despite the long delay and the multiple failings, the review team could not find any evidence that this report was shared with the family.

4.37 *In **2011** a woman was inappropriately discharged home with severe pre-eclampsia and subsequently had an eclamptic seizure within 24 hours. No incident form was completed, no investigation occurred (2011)*

4.38 *A mother at 36 weeks gestation with diabetes whose antenatal CTG was persistently abnormal for 3 days whilst in hospital, which should have prompted delivery, was discharged home without a plan in place and subsequently her baby died (2011)*

4.39 In the second case above the review team found the care provided to the mother to be significantly suboptimal, however only a cursory internal review was conducted, (notably the CTGs had disappeared) and no clear recommendations for improvement were made.

4.40 The review team also identified that many governance documents between 2009 and 2019 included the following inappropriate images. These images were found on multiple SI reviews, HRCR reviews, minutes of maternity governance meetings, quarterly maternity safety reports, patient safety events, feedback of learning documents and an external letter to the ambulance service. The review team felt that having such images on governance documents was insensitive and demonstrated a lack of professionalism.

d. Lack of oversight of Serious Incidents by the Trust's commissioners

4.41 When an SI investigation is completed locally, it is reviewed by the local Clinical Commissioning Group (CCG) for approval and closure if the investigation and action plan are deemed appropriate. Previous national reports have highlighted concerns that despite closure of incidents, once external scrutiny is applied to the original investigations they are often found to be of poor quality, thereby questioning the oversight of commissioners in this process[69]. The review team also identified extensive and repeated concerns with the quality of SIs undertaken by the Trust, which may indicate a lack of external scrutiny.

4.42 The Telford and Wrekin, and Shropshire, CCGs undertook a review of the Trust's maternity services which was published in 2013 and found the Trust was *'a safe and good quality service, which is delivered in a learning organisation'*[70]. The commissioners' review of risk management focused on reported SIs and near misses in the period 1 April 2012 to 31 March 2013, which was likely to have underestimated the scale and volume of incidents. It 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,*

69 *Magro M, Learning from five years of cerebral palsy litigation claims.* (2017) NHS Resolution https://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

70 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group, *Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust* (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

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 review team has identified failings in a lack of incident reporting, low levels of SIs being declared, poor quality RCAs and investigations where lessons are not learnt and further harm is caused at the same time. These failings beg the question as to whether the CCG review process was fit for purpose.

e. Persistent failings in incident investigations as late as 2018-2019

4.43 The Trust shared with the review team a selection of self-selected maternity incident investigations from 2019 which the Trust entitled 'Saves and Learning.' These maternity cases were submitted to the review team with the aim of demonstrating improvements in maternity investigation methodology during the latter years and as examples of good practice. There were 12 cases in total. The total number of maternity incidents occurring in the Trust during 2019 are unknown. Improvements in investigation processes have been developed since 2018 and there is now more focus on learning and feedback in different forums, however what is not clear from the evidence seen by the review team is whether these forums are open to all staff groups and whether staff are enabled and encouraged to attend. Extracts from the Maternity and Neonatal Collaboration Survey in 2018[71] demonstrate that staff felt that feedback from incidents was still not disseminated as well as it could have been *'Ensure feedback from any incidents is clearly communicated to staff to ensure continued staff learning and development'.*

4.44 The 'Saves and Learning' investigations demonstrated improvements in asking families to contribute to investigations, they were asked to forward their concerns and recollections or attend a meeting if preferred. There was also improved oversight of the recommendations and actions at governance meetings and when actions were delayed, the review team saw evidence that there was timely follow up with action leads. However, the review team identified from the small sample provided by the Trust that the local processes needed to be further improved, in particular:

- There was a lack of consistency in the seniority and staff groups that attended the rapid review meetings and the panels did not comprise of staff members senior enough to decide on the level of investigation.
- There was no oversight or accountability from the Director of Midwifery nor the Clinical Director for obstetrics or the consultant lead for risk.
- There was still a reluctance to declare an SI and in most cases a HRCR was still conducted, when an SI would be the appropriate investigation.
- Actions did not always correlate with the findings of the investigation.
- Action plans were monitored by the quality improvement midwife however there was no evidence in the cases reviewed that they were overseen by the senior leadership team. During the staff voices meetings in late 2021 a member from the senior Trust team raised concerns to the review on the suitability of staff who were responsible for quality improvement and safety. They explained that staff were promoted to roles without previous substantive clinical experience and without any means of formal support.
- Significant delays in completing all of the 12 Saves and Learning cases from 2019 that were shared with the review team by the Trust.
- Despite families being asked to contribute to the investigation they were not actively involved or empowered to do so. This is in stark contrast to the recommendations from NHS Resolution[72] that

71 Maternity and Neonatal Collaboration survey 2018, provided by the Trust

72 Ibid n11

women and their families should be actively involved in investigations. Best practice from HSIB[73] shows that with a dedicated focus on actively encouraging families to be involved, 86% of families within maternity investigations will engage with investigations.

- In discussing the safety of the unit and the robustness of governance processes, during the time they worked there, some staff showed a willingness to bring in changes to improve safety in an unsupportive system. When asked if the unit was safe they responded: *'I don't … I don't even know if I can answer that. I felt it was safe on a day-to-day business basis, based on day-to-day firefighting and operational exhaustion from people trying to do the right thing'.*

4.45 Despite the improvements the Trust believes it has made, anonymised extracts from the Maternity and Neonatal Collaboration Survey in 2018 demonstrate concerns by their own staff regarding an unsupportive culture and one of blame following SI investigations. One extract included *'I am concerned that midwives who have made errors are treated badly, one midwife was on the verge of suicide due to the way she was treated in her involvement in a SI. More support and care, counselling and help needed in these situations so that the practitioner is not pushed to breaking point or self-harm from intense pressure.'* Another contributor to the same 2018 survey said: *'senior management in care group or above not understanding real issues. Not learning from mistakes'.*

4.46 These findings by the review team differ from the publicly presented findings of two external reviews; firstly, the addendum to the RCOG Review of Maternity Services on 27 April 2018[74]. The original report, which was more critical, had been completed in 2017, but was not presented to the Trust's Board until an addendum had been prepared which highlighted a much more positive situation with risk management than actually existed. This is discussed in more detail elsewhere in this report. The 2018 addendum to the 2017 RCOG report stated that: *'The Care Group has strengthened its risk management structure, risk management meetings are held regularly and rapid review meetings following incidents are executive led' and that 'RCA investigations follow the NHS Improvement SI Framework'.* Secondly, the 2019 CQC[75] report of maternity services at Princess Royal which felt that *'the service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service'.*

4.47 Patient safety relies on maternity services receiving appropriate and timely feedback from regulating bodies to ensure improvements can be made and in these examples above the external systems for review and monitoring of the Trust seem to have failed.

2. Poor complaints handling

4.48 Effective local complaints handling is a part of good clinical governance, enshrined in the NHS Constitution[76]. Done well and in a timely manner, a complaint response can provide patients and families with the answers they deserve, allows areas of concern to be identified and can be used to analyse trends to improve services. In Wales[77] the NHS has published extensively on the benefits of complaints to a service. The review team identified that the Trust performed poorly in all of these areas and identified the following concerns:

a) Lack of senior oversight and input into complaints handling and patient experience

b) Lack of openness and transparency.

73 Healthcare Safety Investigation Branch *Annual Review 2020/21* (2021) https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/HSIB_Annual_Review_Brochure_2020-21_FINAL.pdf

74 Shrewsbury and Telford Hospitals NHS Trust Board Report (2018) outlining the Royal College of Obstetricians and Gynaecologists review of maternity services. https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf

75 CQC report provided by the Trust to the review team, site visits were November 2019 and the report published in January 2020

76 NHS Constitution; NHS Complaints Guide, (updated January 2021). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service [Accessed on 28 October 2021]

77 NHS Wales Using the gift of complaints (2014) http://www.wales.nhs.uk/usingthegiftofcomplaints

a. Lack of senior oversight and input into complaints handling and patient experience

4.49 The review team identified that there was a lack of input from senior members of the leadership team in the writing, review, approval, quality control and trend analysis of complaints. There is no evidence available that the Head of Midwifery, Director of Midwifery and Clinical Director were ever advisory on complaint responses before they were sent to the Trust's Patient Experience Team for the then CEO's signoff. Neither is there any evidence, that complaint themes and trends were analysed and used proactively to improve the service. Even in the latter years of the review period it was unclear what structure was in place for answering complaints and where the accountability lies.

4.50 The review team identified that in 2009, the Trust created a Patient Experience Midwife post. This role was created to provide an effective and timely complaints and claims procedure framework. One of the main objectives of the role was to develop a patient involvement strategy to contribute to the clinical governance agenda and to maternity service development. This role and scope was innovative for the time, however there is no evidence shared with the review team that the objectives of the role were actually ever met. Despite the creation of this role many years earlier there has been no documentation provided of a patient experience strategy or any evidence seen that the Maternity Services Liaison Committee **(MSLC)** or (from 2017) that Maternity Voices Partnership **(MVP)** meetings were included within the terms of reference for clinical governance meetings.

4.51 Whilst the review team acknowledges that the role and job description was forward thinking, the patient experience midwife post lacked the required experience and authority to lead on patient experience, complaints and claims. This meant that from its introduction the post was undervalued. Additionally, it devolved responsibility and oversight from the divisional senior leadership team to members of staff who had no real influence in changing practice.

4.52 Between 2007 and 2013 it appears from information provided by the Trust that complaints were managed between two members of staff who worked part time, one of them a retired member of staff who returned to work one day a week.

4.53 One staff member described the process of responding to a complaint to the maternity review team as: *'[the second midwife] would look up some of the notes or [they] would get information, [they] would start to put a response together and then I would look at it, tidy it up or ask for more information when I came in. The actual complaint came in and we started to look at the notes, look at all the things that had been written down and then talked to the people that were involved in that case. Then from their comments and from what was written and from the patient's letter, we started to investigate what had happened and understand what had happened and then try to put a response together for the patient. Those all had to go, of course, to the Chief Executive office because they all go out in [their] name, not ours'*. There was no evidence that other members of the maternity department contributed, or that responses were reviewed before being sent to the CEO for approval.

4.54 With regards to trend analysis, the review team has seen evidence that complaint trends were identified at maternity governance meetings but there was no evidence that actions were taken to prevent similar incidents occurring. In 2009, the Clinical Director informed the members at the maternity governance meeting about the existence of a separate monthly meeting where complaint themes were discussed and that monitoring of actions would occur at the maternity governance meeting. The review team however has seen no evidence that this forum was ever formed and no evidence of action plans being presented to the governance meeting.

b. Lack of openness and transparency

4.55 There is evidence that complaint responses lacked transparency and honesty, especially with regards to clinical care. The review team has identified families where care was sub-optimal, where different management would likely have made a difference to the outcome, however the complaint responses

justified actions, delays and omissions in care. In addition, they often lacked compassion and in a number of responses it was implied that the woman herself was to blame.

4.56 There are examples of families whose complaint letters were dismissed, only for external investigations, sometimes many years later, to identify failings which should have been evident at the time, had a thorough complaints investigation been conducted.

4.57 *In one example from **2013** a baby was born in a midwifery-led unit and diagnosed with Hypoxic Ischemic Encephalopathy (HIE) secondary, due to a failure to monitor the fetal heart rate (FHR) appropriately in labour. The complaint response from the CEO stated that the fetal heart rate was normal, and that it was recorded at specified intervals of every 30 minutes in labour. The multi-professional review team did not agree that the heart rate was normal and thinks the response to the family is incorrect. (2013)*

4.58 On a number of occasions parents wrote to the Trust find out whether their case had been investigated, often in situations where an investigation should have been conducted and the family involved from the outset; cases range from intrapartum deaths to severe physical and developmental disabilities.

4.59 *After complaining in **2009** a mother reported to the review team that: 'The response to my complaint made me so angry. It didn't address any of my concerns…and was misspelt.' (2009)*

4.60 *In **2009** another family wrote to the Trust pleading for them to open an investigation into the death of their baby, requesting to be involved in the investigation and asked whether if things were done differently the outcome would have been different. In the response received the Trust said: 'The protocols for dealing with CTGs are clear and laid down for all staff. All staff, both midwives and doctors receive updates on the interpretation of CTG traces every 6 months. The loss of X was unexpected therefore difficult to prevent as [the] CTG trace was not indicative of an at-risk fetus that needed immediately delivery. If every dubious or worrying CTG resulted in an emergency caesarean section then ⅓ of all women would be delivered surgically'.*

4.61 The Trust continued: *'Patients cannot demand a caesarean section. They can request one and discuss the issues with the consultant but if the attending medic does not agree that a caesarean is necessary they will not undertake one'.* (2009)

4.62 This is a tragic case of a neonatal death where an independent investigation undertaken in 2018 identified significant failings in care and also a failure of the Trust at the time to learn lessons and recognise that earlier delivery could have altered the outcome for this family.

4.63 *In **2018** an investigation was started without the woman being told an investigation was ongoing or being asked to contribute. This is despite Duty of Candour[78] being well embedded nationally and being a legal requirement. The family received a written complaint response that outlined actions the Trust had put in place and completed but at a subsequent complaint meeting the parents questioned the honesty and transparency of the written response as the actions had not started at the time of the meeting. The family said: 'It's the fact that, when all this first happened, we went through an awful lot…and to be told that you had spoken to Dr X. Dr X had completed some key learns and due to that, you thought nothing was wrong, so you closed the investigation…but since then, obviously, we've found out that none of that actually took place'. (2018)*

3. Local concerns with statutory supervision of midwifery investigations

4.64 The overarching responsibility of the Local Supervisory Authority (LSA) and Midwifery Supervision was to protect the public by monitoring midwives' fitness to practice and instigate remedial actions where necessary.

78 General Medical Council, The professional duty of candour https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour

4.65 From 2001, the Nursing and Midwifery Council **(NMC)** gave powers to the midwifery body, composed of trained Supervisors of Midwives **(SoMs)**, in the form of statutory supervision in accordance with the NMC's rules and standards to regulate midwives. Supervision was subsequently removed from statute in 2017 and replaced by a new model which was based on midwifery education and quality improvement. The review team has considered the role of midwifery supervision in-line with what was current practice from 2000 to 2017.

4.66 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by SoMs at the Trust. From the governance documents the review team has received from the Trust there is minimal evidence that investigations were taking place, however there are some SoM updates within the maternity governance reports which indicate that investigations were taking place. We have received a small number of investigation reports which were of poor quality and which, from their dates, appear to have been conducted many years after the incident.

4.67 A significant number of SoM investigations provided by the Trust to the review team were all dated during one week in December 2016 and written by a single SoM. Some of these investigations related to incidents that occurred over 10 years prior. The review team were informed that this was due to a member of staff recognising that the original investigations lacked objectivity, with gaps in their quality.

4.68 This appears to be a conscious attempt to identify any significant practice issues, however it is unclear whether the midwives involved in the older clinical incidents received feedback - although this would have been out of date given the length of time since many of the incidents took place.

Findings from an RCA review and supervisory records:

4.69 A family experienced an unexpected admission of a term baby to the neonatal unit in **2015**, with the baby subsequently dying aged 5 months. A rapid response meeting was held to review the care and identify any immediate learning. At this meeting there were no identified SoMs present.

4.70 This initial review recommended that, due to the potential for long term harm, the RCA level should be undertaken as a serious incident. The supervision, (SoM) team was notified 2 weeks after the incident and a supervisory investigation was undertaken a month later. The investigation went ahead, however there was no chronology to benchmark the midwifery care against the standards of care at the time. From the initial 72 hour review there appeared to be a primary fixation on the lack of differentiation between the maternal and fetal heart rate, contributing to the difficulty in interpreting the fetal heart rate.

4.71 At this first meeting, it is unclear whether the maternity team considered the overall picture of this mother's labour. A further rapid review meeting was held 3 weeks later. The discussion at this stage still failed to demonstrate a detailed understanding of the 66 minute period when the fetal head was on the perineum, at a time when the umbilical cord will have been compressed. (2015)

How staff members described the SoM team:

4.72 Staff members described to the review team that the culture of the SoM team between 2010 and 2016 was discriminatory and non-inclusive. The review team heard from a midwife, in October 2021 who stated that they '*never felt [they} could fit in with the culture of the unit and were made to feel like an outsider by [their] colleagues'.* Though initially supported upon qualification to undertake the SoM Preparation Course [X] was not appointed into a SoM role because 'the existing SoM team did not want [X] appointed'.

4.73 Another member of staff raised concerns that SoM investigations were not transparent or fair and lacked rigour: *'I started to see gaps and I started to point them out and say, "Well actually, look, we've got the same people. The same people are involved in these reviews. The same people did the supervisory investigations, the same people marked them, the same people in the LSA marked them, we've got these patterns".'* It is evident that staff raised concerns about the quality of the investigations at the time, and

some conscious attempts were made to establish some objectivity, the same staff member added: *'There were reviews from a supervisory perspective and we still just about had supervision then [2016] so we did do that and we did some deep dives into…so we did reviews, but if you like, we were still marking our own homework.'*

External reviews of the SoM function at the Trust

4.74 Information provided to the review team indicates that there have been two external independent reviews of a midwifery supervisory investigation previously undertaken by the Trust's SoMs. The Local Supervising Authority Midwifery Officer (LSAMO) – the senior person who was responsible for upholding the standards of midwifery supervision at a regional level - Annual Report April 2014 – March 2015 stated that a complaint was received regarding the LSA function during the 2014-2015 supervisory year. The complaint related to a family who requested a review of a supervisory investigation in relation to the birth of their daughter in 2009. The family were gravely concerned at the lack of quality and accuracy of the initial investigation.

4.75 The external review concluded that the quality of the supervisory investigation was poor. There were a number of inaccuracies in the timeline and events, the facts of the incident were not established and the principles of the midwifery supervisory investigation were not adhered to. In the period between the initial investigation and the external report in 2015, there was no local learning or safeguarding of the public during a 6 year hiatus. Following the external review, the investigating SoM was found to be unsuitable for the role and they were removed from their supervisory duties by the LSAMO.

4.76 The second independent review was of a case of maternal death and intrauterine death. It was commissioned by the regional Chief Nurse in 2016. From information provided to the review team we found that the original investigation is incomplete, and has focused on the methodology of the investigation rather than the actual investigation of the incident.

4.77 The external investigation identified that two of the nine midwives who cared for the family would benefit from more support and development and the remaining seven should reflect on the care they provided. The original Trust investigation had only reviewed the care of one midwife and found no further learning was required. It had concluded that there were not any serious concerns in relation to midwifery practice.

4.78 The review team considered the language used at times in the reports seem to be inappropriate for the tragic outcomes and impact on the whole family. When discussing a meeting with family members as part of the investigation, they used terms such as the family being 'brave'. The external reviewers thanked the family member for involvement in the second review and described their 'graciousness' for taking part in the investigation.

4.79 The review team's opinion is that the external (or second) investigation also failed to identify that with improved care the outcome for the woman could have been significantly different. The first investigation failed to identify any systemic issues around CTG interpretation and sepsis management, which were relevant, factors. It was also felt by the review team that the few recommendations for improvements made would not have prevented a similar situation occurring in the future. The second investigation relied on the presumed cause of death (amniotic fluid embolism) as 'unavoidable' and therefore did not address salient issues particularly around the identification and management of the critically ill mother, sound escalation plans and multidisciplinary team working.

4.80 Two years after the mother's tragic death, the external assessors acknowledged that some of the recommendations for improved care were still *'in progress'.* It is the review team's opinion that despite being a second investigation the LSA (external) investigation still missed significant points for learning, and improvement, specifically that had the sepsis been treated more promptly earlier, that the outcome might have been significantly different.

Causes of supervisory failings and failure to learn:

4.81 The review team identified the causes of supervisory failings as:

- The supervision function was not independent from the management team, therefore the same people scrutinised clinical incidents regardless of whether this was a supervisory review or not.
- The short staffing levels did not appear to provide supervisors with protected time to carry out supervisory activities.
- A lack of involvement of supervisors in risk management and incident reviews which prevented them from identifying the incidents that warranted supervisory review.
- A lack of integration between supervision and clinical governance.
- A lack of leadership within the maternity governance structure.

4. Concerns relating to clinical guidelines and audits

4.82 The writing, review and use of clinical guidelines to inform best practice and the conducting of clinical audits to monitor compliance with these guidelines is an integral part of ensuring a service is safe. The review team has identified the following concerns:

a) A lack of multidisciplinary input into guideline management and audits

b) A lack of a change in practice and monitoring of compliance in response to clinical incidents

c) The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

a. A lack of multidisciplinary input into guideline management and audits

4.83 Before 2010, and following review of the guidelines supplied to the review team by the Trust, the approach to guideline and protocol management lacked a multidisciplinary approach at the Trust. Guidelines appeared to have been drafted by midwifery staff, with no input or oversight by the obstetric consultants.

4.84 From 2012 onwards the review team identified a named guidelines midwife in post, and identified that subsequent to this, there was a more consistent approach to how guidelines were written, reviewed and then referenced. The review team were unable to find evidence of a named obstetric lead, and obstetric input was not well defined, which meant that there was a lack of multidisciplinary input into guideline management. A member of staff stated '*practice wasn't evidence-based but there was nobody qualified, competent or capable to update guidelines or to even write guidelines. They didn't have very many and what they had weren't evidence-based...I know full well that their guidelines were woefully out of date'.*

4.85 With regard to audits, there is evidence supplied by the Trust of formal registration of women's and children's audits throughout the review period, forming part of the yearly corporate audit plan. This is in line with general practice in maternity units and the majority were conducted by an audit midwife with only a small number, in comparison, having obstetrician involvement. Anaesthetists were involved in audits in earlier years, then no longer featured at the audit meetings and their involvement in maternity audits was not seen in recent years.

4.86 Experience from the multidisciplinary members of the review team is that good practice for most maternity units would be for audit meetings to be multidisciplinary, where all clinicians learn together. The review team noted that the attendance record at audit meetings, especially prior to 2012, demonstrated that, in general, very few midwifery and nursing staff attended, with no midwives present at some. The meetings were often obstetrician-led, attended by the obstetric team and had obstetricians conducting the audits. This shows a culture of exclusion and disparity between the staff groups. After 2012 there was clearly a shift, as most audits were midwife-led, usually by the audit midwife with little involvement by other staff groups. Actions to try to improve obstetric attendance were noted at meetings as late as July 2017.

4.87 For example, in September 2018 the operative vaginal delivery audit was conducted by a midwife and demonstrated that no analgesia was used for ventouse deliveries. The review team felt this was unlikely to be correct, as it would be surprising if none of the women who had a ventouse had an epidural, which is known to increase the risk of instrumental delivery. However, a suggestion was made at audit meetings for this to be investigated and for consultants to supervise future audits with the aim that their presence would promote evidence-based practice and influence a change in practice. The lack of obstetric involvement in the initial audit would have made it difficult for the auditor to develop a robust plan to effect change as it is based on the individual's limited knowledge and experience on the subject.

4.88 Audits were also presented within the maternity governance meetings which to 2012 were mostly attended by midwifery staff. After this time, the review team has noted good attendance by consultant obstetricians and midwives but attendance by junior medical staff was often lacking. The updating of guidelines and leaflets was a regular item on the agenda, however this item was often cancelled when there were more pressing matters being discussed, at the expense of guideline updates.

4.89 Maternity audit action plans were also agreed at these meetings, but discussion when it occurred commonly appeared as perfunctory which was inappropriate as the forum did not have full representation and authority to make decisions. Many action plans merely stated the means of dissemination of findings, rather than addressing the discrepancies identified. Often there was no action plan to improve compliance and then to re-audit. The review team found therefore that management of maternity audits were a significant lost opportunity to improve the quality of maternity care at the Trust throughout the entire period of the maternity review.

b. A lack of a change in practice and monitoring of compliance in response to clinical incidents.

4.90 The review team has identified cases where similar and continuing errors in practice have occurred over the years, which suggests a failure to learn lessons and implement change in maternity practice. When an incident has been investigated and an action plan created, it is vital that these actions are implemented to prevent future harm occurring. The review team has found repeated instances where this has not been the case in maternity services at the Trust.

4.91 *In **2015** a woman with a previous baby on the 5.5th centile was not offered an obstetric review or growth scans. She subsequently suffered a stillbirth at 37 weeks. The baby had a birth weight less than the 3rd centile. The subsequent investigation into this stillbirth recommended that: 'Any previous birth weight between 5.0 and 5.5 centile will be rounded down to 5th centile for the purposes of ascertaining which patients will be offered routine scans at 32 and 36 weeks'. This recommendation however was not written into the Assessment (Antenatal) Guideline Version 11 (2015) nor any versions afterwards. Despite the 2013 RCOG Green Top Guideline[79] recommending use of the 10th centile to determine when ultrasound scans are required, this was not followed at the Trust until 2018. (2015)*

4.92 *In **2016** a woman, for whom English was not her first language, telephoned maternity triage with abdominal pain and was advised to remain at home and sadly attended with a concealed placental abruption and had a neonatal death. The recommendation from the investigation was to update the maternity triage operating procedures to include that women for whom English is not their first language should be invited in for assessment to avoid issues with communication. There is no evidence this occurred. (2016)*

4.93 *In **2018** a woman in early labour telephoned the maternity triage as she believed her 'waters had broken' but she was not invited in for assessment, and the outcome in this case was an early neonatal death. The Latent Phase of Labour and Intrapartum Care on an MLU guideline was updated following this incident and a compliance audit was recorded as being completed, however no evidence of this compliance audit has been supplied to the review team by the Trust. (2018)*

4.94 There is evidence of sharing audit findings at audit meetings. However, there is lack of consistent evidence

79 Royal College of Obstetrics and Gynaecology *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

that practice changed as a result of audits. Of particular note is that the majority of audits did not make reference to previous audit findings, hence the opportunity for comparison and therefore learning to improve the quality of maternity care was lost.

4.95 One example is that an electronic training package used by staff for CTG training was discussed at the maternity governance meeting held in February 2016 and it was said to be in routine use. However, in the July 2017 governance meeting, it is reported that staff were unfamiliar with the aforementioned training package. This is inconsistent with the assurances given at prior maternity governance meetings and to external bodies such as the Commission for Health Improvement as far back as 2007. Poor CTG interpretation leading to poor outcomes for babies was a recurring theme among many cases over the period of time considered by the review team.

c. The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

4.96 The Clinical Negligence Scheme for Trusts, better known as CNST, is an insurance scheme administered by NHS Resolution (previously known as the NHS Litigation Authority), whereby individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence. In the earlier years the CNST standards were met by auditing practice against prescribed standards and identifying evidence of improvement in practice informed by those audits. Successful achievement of Level 1, 2 or 3 resulted in a percentage reduction of trust payments to the NHSLA for indemnity insurance.

4.97 The review team saw evidence that guidelines were amended and updated based on the CNST assessment reviewer's comments and the maternity unit was successful at gaining Level 1. A member of staff stated in a meeting with the review team that as early as 2009 there were significant concerns amongst individuals about standards of maternity care and governance at the Trust.

4.98 In discussing CNST, a staff member told the review team *'…in 2009, there were signs then that governance was not as it should be and I fought a battle even then just with regard to CNST and I was told we're going to get CNST Level 2, and I said, "We're not", and I was told, "We are", and I said, "We're not", and that was the first time that I experienced having a battle with the…leadership at the time, and the Board…but you know what's right and you can't get beyond that barrier. So I considered that I won that battle, in that we did the right thing…we weren't going to get Level 2 unless we fudged it, so those are my words…but it was met with absolute disdain and I remember…being dragged into [X's] office and told, "Sit there with your laptop, we're going to do this action plan for CNST together..." .'*

4.99 This was also confirmed by another member of staff stating: *'I don't think that anybody on the Board expected me to be finding us non-compliant, because obviously that had gone through the Board, so that was a really difficult time as well. …It was a really difficult time, because we were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it, and then obviously we had to look at year one and then we owed a significant amount of money. I think that, you know, that's an example of where they didn't know how much information they should have.'*

4.100 The Trust subsequently gained level 2 in 2012. The review team saw some of the best conducted audits in 2013–2014, with the Transfer of Women Audit being noted as an example of good practice in its structure and findings.

4.101 During 2013/14 the Trust was preparing for Level 3 assessment. The Trust scored a remarkable 48/50 of the required criteria. NHS Resolution **(NHSR)** stated[80] *'the audit reports were in general of a high quality, with readily identifiable measurable standards'* and *'Particularly impressive was the spread of actions that had been implemented as a result of the audit findings…It was clear to the assessors that each deficit identified had been carefully considered and time and effort had been put into drilling down to the root causes and applying meaningful measures to rectify the issues'.* However, there is a distinct disparity

80 NHS Resolution, NHS Litigation Authority. *NHS Litigation Authority Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards 2013-14, The Shrewsbury and Telford Hospital NHS Trust*, Level 3, p23 (March 2014)

between those observations of NHSR and the findings of the review team as in subsequent years the audit reports did not lead to sustainable safety improvements in maternity services at the Trust.

4.102 In 2017 NHS Resolution changed the CNST assessment to become an incentive towards improving safety. Maternity services provided self-assessments which were signed off at Board level on 10 safety actions which it was thought, if achieved, would demonstrate that a Trust was providing safer maternity care[81]. By achieving all 10 safety actions Trusts would recover the elements of their contribution to the CNST maternity incentive fund and also receive a share of any unallocated funds.

4.103 The Trust received its rebate in 2018, but after a CQC inspection report in November 2018 rated the maternity services as inadequate[82] the Trust was obliged to return the money it had received. The review team has heard from a member of staff that it was obvious the Trust would not achieve the CNST standard. This is evidenced by the fact that although the Trust declared in 2019 a 90% or more compliance with the multidisciplinary training target in 2018 and 2019 the maternity clinical governance meeting minutes on 25 February 2019 records that there was discussion of the risk that the Trust would not achieve this target.

4.104 In August 2019 the Training Figures document states that the *'maternity incentive scheme training requirements were achieved'*. However the review team has heard evidence from a member of staff that actions were signed off as *'actions met'* without appropriate evidence being either shared with, or requested by, the executive team and Board.

4.105 A member of staff said to the review team: *'...I have thought a great deal since my interview and how things will not change unless we are prepared to push aside feelings of dismay, anxiety and fear and unless we are prepared to act by the very principles we are expecting from others.'* The staff member stated to the review team that *'X advised me when I was undertaking a review of CNST year 2 submission to "be careful what you find" as it will cause "reputational damage" to the Trust'.*

4.106 The review team has identified multiple and repeated failings in maternity governance throughout the timeframe of this review, spanning poor quality incident investigations, poor complaints handling, concerns with how the Trust implemented statutory supervision of midwifery supervisors and concerns with implementation of the systems for guideline development and clinical audit. The review team feel that these serious failings led to unnecessary harm occurring to mothers and babies over a prolonged time period.

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.107 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

4.109 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

4.110 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

81 NHS Resolution. The maternity incentive scheme year 2 results. Published 13th February 2020. https://resolution.nhs.uk/2020/02/13/the-maternity-incentive-scheme-year-two-results/#:~:text=The%20maternity%20incentive%20scheme%20was%20launched%20by%20NHS,but%20also%20a%20share%20of%20any%20unallocated%20monies.

82 Care Quality Commission, Shrewsbury and Telford Hospital NHS Trusts Inspection report (2018)https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

4.111 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

4.112 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

4.113 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

4.114 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

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

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.116 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

4.117 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

4.118 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.119 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

4.120 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.121 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

4.122 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

4.123 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.124 There must be midwifery and obstetric co-leads for audits.

4.125 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

4.126 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

4.127 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

4.128 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.129 There must be midwifery and obstetric co-leads for developing guidelines.

4.130 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.131 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

4.132 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[83] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

4.133 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

83 NHS England. Maternity self-assessment tool (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

The NHS Patient Safety Incident Response Framework (PSIRF)

4.134 As has been clearly explained within this chapter, there have been many failings in how maternity incidents were investigated in-line with the national frameworks at the time, namely the 2010 National Framework for reporting and learning from serious incidents requiring investigation[84] and the 2013 and 2015 Serious Incident Frameworks[85]. It is also widely accepted that prior to this review, multiple reports, including maternity specific reports, have already highlighted significant shortcomings in the way patient safety incidents are investigated and learned from[86].

4.135 To improve this situation, NHS England published the 2019 NHS Patient Safety Strategy[87] and will be implementing the Patient Safety Incident Response Framework (PSIRF)[88] which is due for gradual implementation across all organisations from spring 2022. Taking into account that at the time of publishing this report there will be more than 20 organisations working within the PSIRF framework[89] who will continue their work after this report is published, the review team has discussed the PSIRF methodology with NHS England. These discussions have helped ensure that the approaches and principles within the PSIRF are aligned with those of this maternity review.

4.136 The PSIRF differs from the current SI framework, which it will replace, in a number of ways and the review team support the fact that it will have a broader scope, moving away from 'hard-to-define thresholds for serious incident investigations' and that it is committed to engaging and supporting patients, families, carers and staff in accordance with a just culture. The PSIRF Introductory framework , published in March 2020, identifies the process currently being used by early adopter sites and has been published 'so that all parts of the NHS, patients, families and other stakeholders can engage with the proposals and help [NHSE] learn how we best ensure our aim is met'.

4.137 The review team has engaged in dialogue with NHS England based on the findings of this review to receive assurances that the PSIRF works effectively for maternity services. The following issues are of key importance:

PSIRF- Resources and expertise:

4.138 The review team discussed with NHS England that the National Maternity Assessment Tool recommends the following minimum staffing levels for governance teams:

- Maternity governance lead (who is a midwife registered with the NMC)
- Consultant obstetrician governance lead (Minimum 2 PAs[90])
- Maternity safety manager (who is a midwife registered with the NMC or relevant transferable skills).
- Maternity clinical incident leads
- Audit midwife - a lead midwife for audit and effectiveness

84 Ibid n4

85 Ibid n2

86 Royal College of Obstetrics and Gynaecologists. Each Baby Counts: key messages from 2015 (2016) https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/rcog-each-baby-counts-report.pdf

Parliamentary and Health Service Ombudsman. Learning from mistakes. (2016) https://www.ombudsman.org.uk/publications/learning-mistakes-0

Parliamentary and Health Service Ombudsman. A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015) https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

House of Commons Public Administration and Constitutional Affairs Committee. *Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England*. (2017) https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf

87 NHS England website. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

88 NHS England. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

89 NHS England. Introductory Patient Safety Incident Response Framework. (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

90 A PA or 'programmed activity' is the unit of currency in a consultant contract, each PA broadly equalling 4 hours – see https://www.nhsemployers.org/sites/default/files/2021-06/consultant-contract-faqs_0.pdf

- Practice development midwife
- Clinical educators, to include leading preceptorship programme
- Appropriate governance facilitator and administrative support within the maternity department.

4.139 The review team is assured that these are key team members who will need to understand PSIRF principles and should be involved in planning preparations locally for implementation of PSIRF.

PSIRF and Training:

4.140 The review team is assured that appropriate training in patient safety incident investigations, and safety science more widely, will be a core feature of the PSIRF and that NHSE&I will set minimum levels of training required for investigation leads.

4.141 The review team strongly supports the notion that training must be available prior to PSIRF implementation and are assured that this will be set out within an investigation training framework which will include a straightforward mechanism for providers to commission the training that their staff need.

4.142 The review team is assured that all relevant tools and templates will be available prior to rollout and should further investigation skills training become necessary over time, the minimum training standards requirement will be adapted as appropriate.

PSIRF- What to investigate and ensuring effective oversight

4.143 Maternity and neonatal incidents which meet the Each Baby Counts and maternal deaths criteria will be referred to HSIB for a HSIB-led PSII (or new statutory body). Organisations will also be required to continue to report to NHSR Early Notification Scheme, RCOG EBC project and MBRRACE-UK as well as the PMRT being used for all stillbirths and neonatal deaths. The review team supports this approach of maintaining set criteria for what must be investigated externally.

4.144 The review team also supports the move away from subjective and hard to define thresholds for SI investigations and towards a proactive approach to safety and learning investigations, which can be based on findings from more than one similar completed incident investigation.

4.145 The review team raised concerns that the PSIRF focuses on trusts determining locally what to investigate and although well intentioned to promote a culture of learning, felt this could lead to similar problems as found at Shrewsbury and Telford Hospital NHS Trust, where incidents were downgraded and not appropriately investigated. The review team has been assured that there will be appropriate oversight built into the PSIRF framework with organisations expected to conduct a gap analysis to assess this, whilst also being assured that a training specification for oversight training will be in place before roll out begins. It is the expectation of NHSE&I that the relevant individuals in oversight roles will have received the appropriate training prior to organisations transitioning to PSIRF.

PSIRF and linking complaints to investigations to aid learning

4.146 The review team has been informed that although this is not part of the PSIRF, providers will be encouraged to bring patient safety and complaints teams together as part of the PSIRF implementation and encourage a collaborative and coordinated process. As stated in the IEAs underpinning this final report all trusts must ensure the maternity complaints process is incorporated within the maternity governance team structure responsible for incident investigations to ensure that complaints are not completed and responded to in isolation. The review team states that **NHSE&I must undertake work to provide those dealing with complaints appropriate training in effective complaints handling**.

PSIRF and reducing variation in investigations

4.147 The review team support the notion of a standardised investigation template and are assured that the patient safety incident investigation (PSII) template has been built on the principles developed by HSIB and that the template will be available prior to PSIRF implementation.

Patient and family involvement in investigations

4.148 The review team has been assured that the active involvement of women and families in investigations is fundamental to the PSIRF and that NHSE&I are currently working with HSIB and a group of independent stakeholders (including academics, patients and patient advocates) to develop an involvement guide that will ensure these requirements are covered in detail.

Chapter 5

Clinical leadership

Introduction

5.1 Safe, high-quality maternity care across England is not an ambitious or unrealistic goal and should be the minimum expectation for all women, their families and their babies. Effective clinical engagement and leadership is critical to improving quality, safety and patient outcomes within the NHS[91]. Frontline teams do not operate[92] in a vacuum; leadership is the key determinant of the organisational culture in which frontline teams operate. 'When things go well, it is down to good leadership and when they don't, who takes responsibility? Does it rest with the 'senior' midwife, the trust's chief executive, the board or the midwife delivering the care?'[93]

5.2 Historically, strategic and operational leadership roles within maternity services were held by the obstetric clinical lead, the clinical director and the director of midwifery[94]. These roles have overarching responsibility for the daily operational delivery and strategic management of maternity services locally and are accountable to the trust board for quality, performance, governance and professional leadership. This responsibility includes making positive changes in the workplace where necessary to shape a fair and positive environment, and encouraging a culture which supports improved clinical outcomes for women and their families. The review team has identified that these responsibilities were not always met within maternity services at Shrewsbury and Telford Hospital (SaTH) NHS Trust.

5.3 During a 'Staff Voices' interview with the review team in late 2021 a member of staff reported how the Trust's board did not have oversight of the concerns relating to patient safety, quality and performance or poor clinical outcomes within maternity services.

5.4 The staff member told the review team: *'I don't think that actually the Board knew what was needed in maternity services. I was giving them information that they'd never had before'.*

5.5 The primary influence of clinical leadership is through the expression of clinical expertise, with direct involvement in patient care. A recent RCOG publication[95] (2021) reiterated how the role of the consultant obstetrician is that of the clinical expert, one who influences both clinical decision-making and standards of clinical practice thereby reducing variation in patient care and optimising clinical outcomes in maternity settings by being physically present and visible[96]. The absence of such clinical leadership has been identified by the review team as a contributory factor in the failure of maternity services at the Trust to provide high quality and safe maternity care to women and their families, and is an overarching theme in this report. This has been widely reported in many national maternity reports over many years[97]. These national maternity reports include those by the Department of Health, Royal Colleges and CEMACH.

91 Joseph & Huber 2015, https://pubmed.ncbi.nlm.nih.gov/29355179/ 2015

92 NHS England: *National Maternity Review: Better Births: Improving Outcomes of maternity services in England* (2016) p72: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

93 Royal College of Midwives (RCM) (2012). Leadership - what's that got to do with me? Midwives Magazine Issue 2 2012 [online]. Available at: https://www.rcm.org.uk/news-views/rcm-opinion/leadership-what-s-that-got-to-do-with-me/ [Accessed 24th November 2021].

94 Royal College of Obstetricians and Gynaecologists (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf [Accessed 01 December 2021].

95 Royal College of Obstetricians and Gynaecologists (2021) *Workplace Behaviour Toolkit.* Available at: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/workplace-behaviour/toolkit/ [Accessed 01 December 2021].

96 Ibid n4 RCOG (2007 and 2021)

97 Department of Health *Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994–1996*. (1998). RCOG, 2004, CEMACH, 2007, Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021]. Knight et al, 2016 and NHS, 2019.

Review of independent reports

5.6 It is acknowledged that the assessment of maternity services has continually evolved over the 20-year span of this independent review, and that different standards and priorities have been expected of maternity services at different times. Key national reports continued to highlight poor leadership as the reason that maternity services were failing women and hampering continued development of the professions[98]. In assessing the quality of leadership within maternity services at the Trust, the review team has considered the most recent external reports reviewing maternity services at the Trust and whether the leadership team were responsive in making effective changes following the recommendations made in those reports.

5.7 A review of maternity services at the Trust was undertaken by the two local clinical commissioning groups[99] (CCG's) in 2013. This was in response to concerns regarding the increased number of serious incidents (SIs) at the Trust, and the safety of the 'hub and spoke' model[100] of maternity care. The findings from the CCG's were favourable, with the overall assessment noting that maternity services provision at SaTH was a safe and good quality service. The Trust board reviewed this report noting: *'There had been concern about some families' experiences but this was in the context of generally good services'.*[101]

5.8 In March 2014, the Trust was reviewed by the NHS Litigation Authority and awarded Level 3, the highest standard under the Clinical Negligence Scheme for Trusts (CNST). The Trust was benchmarked against the requirement to demonstrate good leadership, with an open and supportive culture, providing a service that can fulfil the needs and expectations of women and their families. A maximum score of 10 out of 10 was awarded in 2014, suggesting there were no concerns regarding leadership and management at that time.

5.9 Following the successful submission of CNST data, a staff member explained to the review team that they had voiced concerns regarding the accuracy of the data submitted, suggesting there was no evidence to support that the service was ever compliant in meeting the criteria. The staff member told the review team:

5.10 *'We were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it.'*

5.11 In 2014, a Deanery review of medical training was undertaken. Clinical governance was identified as an area for improvement. The Deanery report stated:

5.12 *'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.'*

5.13 An independent review in 2015 by Debbie Graham which considered the case of a family who had suffered the death of their baby daughter criticised the Trust's response to the family. However the report concluded *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services and the strengthening of the Trust's clinical governance and complaints processes. 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'.* Graham (2015) does not state the basis upon which this conclusion was reached. When considering a number of cases after 2015 and through until 2019 the review team has not seen evidence that this belief came to fruition.

5.14 For instance, in 2018 a family in conversation with the review's Chair described the approach of the Trust at listening to families following critical incidents as *'tinkering at the edges'*. In reviewing the SI report into the

98 RCM 2012

99 See glossary

100 See glossary

101 2014 Trust Board papers supplied to the review team

death of their baby the family (who had significant professional experience in risk management and root cause analysis) said of the Trust's SI report: *'It's not getting down [to the detail]…it says here root cause analysis, they're fine words but the words don't mean anything because they don't understand…and, again with all due respect to them, as I say, from my world I live, eat, sleep and breathe root cause analysis…'*.

5.15 The 2017 Ovington report compiled internally within the Trust stated how *'safety in maternity is protected by the efforts of the staff and supported by leaders'.* It concluded that governance arrangements should be more transparent and open. It also highlighted how learning from incidents and investigations should be improved. No action plan to meet these recommendations in Ovington (2017) has been provided to the review team at the time of writing this report in spring 2022.

5.16 In 2017, there was an invited review of the maternity services by the RCOG. This review found that while there was evidence of strong leadership and good working relationships between the various staff groups, concerns relating to workforce numbers and insufficient numbers of consultants providing obstetric cover were identified. There was evidence of middle grade rotas not always filled by the Deanery, resulting in maternity services relying on overseas trainees and locums. In accordance with other previous reviews, the RCOG report identified a lack of resources and inadequate incident reporting, risk management and governance systems. This report was subsequently not presented to the Trust Board until May 2018. The Trust's 2018 Care Quality Commission report concluded within the 'Well Led' domain that leadership required improvement and also raised governance concerns stating:

5.17 '*Staff were overwhelmingly positive regarding the local management of the service in the hospital. They told us that the senior team were visible and they were approachable and able to raise issues and concerns. However, they were not certain that these issues were then heard at board level. We were not assured that the executive team had engaged well with staff to develop the vision for the service.'*

5.18 *'We found areas of concern that were raised in our last inspection in December 2016, for example service-wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning.'*

Obstetric services, workforce and clinical leadership

5.19 It is clear from the evidence provided by the Trust to the review team that prior to 2012 the obstetric medical staffing at both consultant and junior doctor level at the Trust was inadequate for the size of the unit at around 5,000 births per year. The number of consultants, and the number of women that they were responsible for meant that timely reviews of women on the labour ward, or in other inpatient areas would have been very difficult, if not impossible, to provide at times. Therefore, midwives wishing to escalate clinical concerns would have been regularly working in an environment in which it would have been difficult to obtain a timely senior obstetric review.

5.20 The poor provision of medical staffing resulted or certainly contributed to delays in the instigation of appropriate medical management. This created an environment in which it was accepted within maternity services at the Trust that it was normal practice to wait for an obstetric review, thus leading to clinical risks, which ultimately contributed to poor maternity outcomes. The review team has heard from one member of the medical staff who confirmed that for many years the registrar had to cover both gynaecology and obstetrics clinical areas.

5.21 This staff contributor told the review team:

'One of the problems...in this sort of context that I've been describing, was a very, very overburdened and thinly stretched middle tier in the obstetric team. I was, frankly, flabbergasted at what I was being told, you know, doctors were being asked to cover services that, it was manifestly clear, you couldn't possibly do that on your own.'

5.22 There is evidence within business plans to the Board (provided by the Trust to the review team) that the Trust was working to increase the number of doctors at both middle grade and consultant level. The number of hours of consultant presence on the labour ward subsequently increased from 40 hours in 2011 to 76 hours in 2013. These plans included evidence that solutions were being sought to support this, including better provision of elective caesarean section lists, for example. In spite of these efforts, in 2016 the Trust had difficulty in being able to appoint the required number of middle grade doctors, resulting in the staffing levels being below the recommended standard for both consultant and middle grade staff. At the time of writing this report in early 2022 there has been further consultant expansion at the Trust supporting an increase in resident consultant hours on the labour ward.

Neonatal services, workforce and leadership

5.23 It is clear from the majority of medical records reviewed that involvement of the consultant neonatologists in clinical decision-making, in the provision of neonatal care and in communication with parents and other family members was of a high quality. The medical records suggest that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They often wrote discharge summaries themselves and were also usually involved in the long-term follow-up of their patients, providing continuity of care for their parents. For some of the clinical cases reviewed, the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This may compromise the availability of skilled care, and, given the size of the neonatal service at the Trust, it would be important to have separate consultant cover for the neonatal and general paediatrics services. This has now been achieved.

5.24 Advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick infants on the NNU and of babies on the postnatal ward. As far as can be judged it appeared that their practice was appropriate and likely to have made an important contribution to neonatal practice within the Trust. For some of the cases reviewed it was clear that, out-of-hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care in both units. The employment of ANNPs has undoubtedly provided some mitigation of this but it was not clear whether the service was adequately covered to this level at all times.

5.25 The review found some evidence of senior neonatal leadership within maternity and perinatal governance processes, and on occasions in raising concerns about individual cases in the perinatal service. We heard evidence of attendance by a neonatologist at Perinatal Mortality and Morbidity (M&M) meetings. In interviews with the review team, we were told of neonatologists attending joint mortality meetings from the early 2000's. Neonatologists contributed data to the national neonatal audit project, which collects important neonatal outcomes. Neonatologists and obstetricians told the review team that they usually met bereaved parents independently, but the review team found some evidence of correspondence between them, including selected cases where a neonatologist wrote to the consultant obstetrician requesting a case review after an adverse outcome.

5.26 Some of the neonatologists told the review team that they raised concerns in the early 2000s about a perceived higher than expected incidence of hypoxic ischaemic encephalopathy (HIE). They also raised concerns about lack of recognition of IUGR and of trauma secondary to instrumental delivery. At interview members of the neonatal team told the review team that these concerns were raised with clinical colleagues and the divisional management team, however the outcome remains unclear.

5.27 A staff member told the review team: *'We have been always very closely involved because we have regular monthly perinatal mortality reviews, meetings every third Wednesday, third Friday of every month and we would actually attend all the late fetal losses, stillbirths, everything, it's not just neonates…so we would robustly challenge them…and those were very well attended meetings, including midwives, obstetric, neonatal teams, perinatal pathologist and geneticist etc.'*

5.29 They continued:

'I think the consistent feature from the neonatal side for us for many stillbirths etc. was the lack of recognition for fetal growth restriction and I think that's another part we repeatedly brought out. I think that led to the introduction of the customised growth centiles as well as the GROW programme.'

Midwifery roles, workforce and leadership

5.30 Frontline midwifery leadership incorporates a myriad of midwifery roles across maternity services including midwives[102], matrons, senior midwifery managers, labour ward coordinators, community clinical leads and specialist midwives. It is notable that, in spite of the RCOG safety recommendations from 2007 on standardising an approach to clinical leadership roles, the Trust did not have any consultant midwife posts for all of the time period considered for this review. The Trust has informed the review team that their first consultant midwife is due to take up employment in early 2022. The national recommendation remains that midwifery-led units (MLU) have one full-time consultant midwife post and obstetric-led units have one additional full-time consultant midwife post to every 900 births, based on 60 per cent low risk women receiving midwifery-led care[103].

5.31 The review found no evidence that there was a consideration of developing the role of the consultant midwife, during the time period under consideration. In conjunction with the consultant obstetrician, the consultant midwife could have provided the balance of professional and effective clinical leadership to ensure the improvement of both quality and safety across maternity services.

The labour ward co-ordinator

5.32 The role of the labour ward coordinator is multi-faceted and central to ensuring the safety of pregnant and labouring women and babies. It encompasses the role of midwifery clinical expert; to inform and challenge practice, and to escalate clinical concerns whilst prioritising and managing the complex demands of contemporary midwifery and maternity care in the high-risk clinical setting of the labour ward.

5.33 Maintaining oversight and knowledge of the management of all clinical cases, the coordinator acts as a source of clinical support for junior midwifery and obstetric staff and a professional conduit across multidisciplinary teams thereby ensuring appropriate use of resources to enable the effective and safe provision of care. While there were some examples of good midwifery leadership seen, staff within maternity services at the Trust shared with the review team their own lived experiences of when this was not always the case.

5.34 A staff member told the review team:

'I was, I think, three months into my labour ward rotation and I kept pressing the call bell saying she's bleeding a lot quicker than I'd like, you know, I think we're up to 500mls now, and the coordinator kept coming in saying I'm on [the] ward round, it'll have to wait…I felt like I'd let that woman down because my skills weren't good enough, that's how I was made to feel when, actually, that was a situation I should have had help in…if she was bleeding that much I should have had help.'

5.35 Each labour ward must have a team of experienced senior midwives rostered as labour ward coordinators, who have supernumerary status; this is defined as having no caseload of their own during a shift and is fundamental to the effective running of the labour ward, which is a high risk clinical area. This is also a recognised requirement in the CNST safety standards[104].

102 Ibid n4 RCOG (2007) & Kings Fund, 2008https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/safe-births-everybodys-business-onora-oneill-february-2008.pdf

103 Ibid n4 RCOG (2007) RCM, RCA, RCPCH, 2007 and Kings Fund, 2008

104 NHSR, 2020

5.36 The review team found that the Trust allocated one band 7 labour ward coordinator per shift who had overall responsibility for coordinating the care throughout a clinical shift, and for the allocation of staff (Labour Ward Staffing v2, 2015). Out-of-hours in the absence of the management team, the coordinator was also responsible for overseeing the clinical activity across the whole of maternity services, including the distant MLUs, and community activity across Shropshire, with escalation to the on-call manager at home, according to the Future Model of Care, 2016 document, shared with the review team by the Trust.

5.37 Reports by the CCG in 2013 and the RCOG in 2018 found that due to midwifery staffing shortfalls, the coordinator was supernumerary for only 50% of the time (RCOG, 2018). This mirrored the findings of the review team who identified that, in many instances, the coordinator had their own women for whom they were responsible for providing clinical care and were therefore not able to fulfil their required role, in particular the provision of support for junior midwives and doctors. Nor were they able in these circumstances to achieve and maintain the necessary 'birds eye' view of the labour ward.

5.38 A staff member told the review team:

5.39 *'The shift leader was constantly having a patient and from the time that I was working on their labour ward, ...you sometimes couldn't get hold of the shift leader because she was in looking after a woman.'*

5.40 Another staff member told us:

5.41 *'I was frightened about putting in…being put into an area that I just, just wasn't my area of expertise and not having support. But it wasn't just lack of support, it was actually, I was just frightened of going past a labour ward; I didn't want to do it, it wasn't my area of expertise and at the time if you voiced those concerns that was probably going to mean you were going to go there full time…'*

Midwifery matron

5.42 The role of the midwifery matron is deemed to be the cornerstone for improving the quality of clinical care through visible, compassionate and inclusive leadership and management. The role has evolved considerably since the publication of The Matron's 10 Key Responsibilities in 2003, and the Matron's Charter in 2004. However, the fundamental aspects remain the same: this includes promoting professionalism in the workplace, ensuring good patient safety and service-user experience, control of infection responsibilities, and monitoring the cleanliness of the clinical environment. It is widely acknowledged that midwifery matron roles also encompass workforce management, budgetary responsibilities and effective resourcing of equipment and maintenance of estates. The recommended minimum requirement for presence is one full-time equivalent, with additional on call and out-of-hours cover, ensuring 24-hour managerial cover[105].

5.43 The review has identified that as late as 2015 the Trust did not meet these recommendations, as the labour ward manager was found to be a hybrid of roles consisting of two shifts working as a labour ward coordinator and three shifts as a matron according to Labour Ward Staffing v2, 2015. In addition, the lead midwife/clinical risk co-ordinator role for consultant inpatient service also had responsibility for leading midwifery care and management on the labour ward. This combination of roles would have resulted in a workload that was not manageable and would have led to key issues being overlooked.

Statutory supervision of midwifery

5.44 Prior to its removal as a statutory function in March 2017, the West Midlands Local Supervisory Authority (WMLSA) had overarching responsibility for statutory supervision of midwifery at the Trust. While there were many professional principles for midwifery supervision, in terms of clinical leadership its purpose was to maintain and improve quality, and to protect women and babies by actively promoting a safe standard of

105 bid n4 RCOG (2007) and RCM, RCA, RCPCH, 2007

midwifery practice, which contributed to the protection of the public. The role of a supervisor of midwives (SoM), who was appointed by the WMLSA was intended to play an important part in providing expert, professional leadership for midwifery at both local and regional level[106].

5.45 A SoM timeline produced by the review team consisting of information extracted from documentation provided to the review including WMLSA audit reports, identified a high level of confidence in the supervisors of midwives at both Trust executive and clinical levels. The supervisors were said to be 'cohesive', had a 'very good team dynamic', and were said to be actively involved in staff training, which included participating and leading in obstetric emergency drills.

5.46 In 2012, a WMLSA visit reviewed the Trust's SoMs' investigation process, which concluded that the team would benefit from further support and guidance around report writing. This training was said to be provided in a supplementary visit to the Trust, however there is no evidence in the documentation provided to the review team that the WMLSA ever returned to the Trust to ensure improvement had occurred.

5.47 Until 2017, the caseload numbers of SoMs at the Trust were repeatedly identified as being above the then recommended ratio of one SoM to 15 midwives. To address these concerns, four of the current supervisors held a double caseload (i.e. 30 midwives) and received double financial remuneration and 15 hours of time in which to manage the additional workload. Similarly, appropriately qualified staff who had retired or previously left the Trust were recruited on a bank basis to provide further support to the supervisory team. There is also evidence which suggests the SoMs were supporting the CNST team; while the context of this is unclear, this may have given rise to a perceived conflict of interest as documented in the Midwifery Regulation in the United Kingdom report (Kings Fund 2015).[107]

5.48 In response to a complaint from a family, an external review was commissioned by the Trust to review an original investigation, which had been conducted by the Trust and signed off by the Local Supervisory Authority Midwifery Officer (or LSAMO) in 2009. The external review concluded that the quality of the supervisory investigation was poor, noting that the principles of root cause analysis were not applied, resulting in key events not being investigated. A repeat investigation by two midwives independent of the Trust made a number of recommendations relating to midwives involved in the clinical care; these included consideration of supervised practice, development support and referral to the Nursing and Midwifery Council (NMC). Furthermore, a significant number of systems issues were identified, that had not been identified in the original investigation including the escalation of staffing issues during times of increased activity/emergency. The absence of a systematic root cause analysis and the lack of support available to the investigating SoM, in particular when interviewing midwives, was also highlighted.

5.49 An independent review was instigated of WMLSA governance and assurance arrangements to determine whether the management and oversight of midwifery supervision was adequate. The review, which was carried out by NICHE patient safety[108] identified a lack of rigour around oversight of the investigative process, best practice was not followed and the quality of reports was not sufficient to prevent reoccurrences. With the purpose of statutory supervision of midwifery being to maintain and improve quality, and to protect women and babies by promoting a safe standard of midwifery practice, these were lost opportunities to achieve these objectives over a long period of time.

5.50 In late 2016, the WMLSA instructed the Trust to review a number of its cases internally. These appear to be some of the cases of the original 23 families, from 2000 onwards which make up the cohort that was highlighted to the Secretary of State and began the process of this review. This task appears to have been undertaken by one SoM at the Trust. The Trust found that none of the nine case investigations, which have been made available to the review required further investigation, thereby missing valuable opportunities for wider organisational learning and further improvement to processes. None of the families were contacted to be involved. Despite the complexity of some of the cases, this was a single professional review, failing

106 NMC, 2015

107 https://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom

108 NICHE 2016 Independent Review of West Midlands local Supervising authority (LSA) Supervisory Investigations Governance arrangements dated 31st August 2016, ref 2031-16, supplied by the Trust

to involve other key colleagues who could have potentially provided significant assistance; for example obstetric, neonatal or anaesthesia colleagues. The review team believes that the WMLSA's instruction to undertake a further internal supervisory review of the investigations is questionable as we have not been able to evidence that assurance had been sought arising from the LSA's initial concerns regarding the quality of supervisory investigations, originally identified several years before.

Concerns regarding governance and concerns from families

5.51 Independent reports into maternity services at the Trust, including Graham (2015), identified governance issues, concerns from families and failure to learn from incidents and investigations. There is often a clear disconnect between the issues raised by the families and the findings in the subsequent investigations report. It is also clear that the maternity department, the Trust and the CCG were aware of these issues raised by families. The governance chapter of this report reviews this in more detail, but the evidence available and seen by the review team is that whilst the various reports made recommendations these did not translate into consistent improvements. As indicated in the first Ockenden Report (page 15) there were examples in 2016 and 2017 of families' dissatisfaction with investigation reports. Further examples were found in multiple interviews with families by the review chair throughout 2018 and 2019.

5.52 The RCOG undertook an invited review of maternity services at the Trust during July 2017, which was commissioned by the Trust's Medical Director to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services.

5.53 The review team was provided with documentation updating on the progress of actions against the recommendations of the RCOG review; including an addendum to the report received during June 2018. This addendum had been prepared following a visit to the RCOG in London by a Trust team. The RCOG had not returned to the Trust to assess the accuracy of the evidence submitted. Quotes from the 'addendum' include the following: *'Review had been undertaken of the manager on-call rota and the rota is now "working better". The escalation policy is firmly in place and was referred to on many occasions, particularly during times when an MLU is closed and services are diverted to another unit.'*

Team working, culture and civility

5.54 The complexities and challenges of team working are not exclusive to healthcare settings, however unlike in some specialities, the effect of poor relationships and collaboration can have catastrophic long-term consequences for individuals, teams and organisations[109].

5.55 National reports into failing maternity services over a number of years have highlighted conflicting agendas and poor teamwork as significant contributory factors towards adverse maternal and neonatal outcomes[110]. Whilst there was some evidence of multidisciplinary team working at the Trust, there was often a notable lack of leadership, accountability and situational awareness.

5.56 *'In **2015** a woman in labour with a twin pregnancy at 36 weeks gestation did not receive an obstetric review on arrival to the labour ward. The neonatal unit were not informed of the admission. No progress in cervical dilatation was escalated to the labour ward coordinator, however there was no change to the management plan or escalation for obstetric review.'*

5.57 *'At full dilatation, an obstetrician attempted to perform a ventouse delivery of twin two. The ventouse cup came off after four pulls. Keilland's forceps were subsequently applied and five pulls were attempted. Neville Barnes forceps were then applied and the baby was delivered in poor condition with one further pull (ten with an instrument in total). The baby had moderate to severe hypoxic ischaemic encephalopathy.' (2015)*

109 Fatolitis, P. and Masalonis, A. 'Human Factors in Aviation and Healthcare: Best Practices, Safety Culture and the Way Ahead for Patient Safety', Journal of Ergonomics vol 11 issue 5. (2021) Available at: https://www.longdom.org/open-access/human-factors-in-aviation-and-healthcare-best-practices-safety-culture-and-the-way-ahead-for-patient-safety.pdf [Accessed 01 December 2021].

110 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021].

5.58 Due to the requirement for 24/7 cover of a significant proportion of service provision, teams within maternity units increasingly involve various practitioners of different clinical expertise[111]. Teams are also rarely constant, resulting in a number of individuals practising their specific roles within interchangeable groups. As such, training should enable maternity practitioners to function effectively in whichever team or environment they find themselves working in.

5.59 Furthermore, the labour ward can be a particularly challenging environment for even the most cohesive teams or groups due to its acute, unpredictable and specialist nature.

5.60 A staff contributor told the review team in late 2021:

'The fear was being pulled to somewhere else in the middle of a nightshift or being on-call for homebirths or midwife-led units. Being on-call perhaps having worked the day before, working the next day and then being called in to the labour ward to work a whole night shift because it was lacking in staff and that was very fearful…'

5.61 *'Yes, I certainly wasn't equipped because I was a community midwife…those were my areas of expertise, and I was expected to go in and act as a manager on labour ward and I was terrified. I was terrified and much stressed, and very emotional all the time about it.'*

5.62 Throughout the years, there have been multiple reports and research detailing the intricacies of team working and its direct relationship with safety outcomes and patient experience[112]. Additionally, there have been recommendations from leading organisations over a long period of time with the aim to improve safety through the standardisation of minimum multidisciplinary staffing requirements[113]. Despite this, the overall team working at the Trust remained suboptimal, which contributed towards many preventable incidents and adverse outcomes.

5.63 A staff contributor told the review team in autumn 2021:

'Culture is a big thing because I feel there's a reluctance to change there. Yes, they do need to change because this has resulted in lots of families having a terrible event happen in their lives that shouldn't have happened and I'm a midwife, and I know that things don't always go to plan. I don't believe that anybody has set out to go to work to cause harm or anything like that, but I think that probably some processes, some attitudes have definitely been a reason as to why things have not gone to plan.'

5.64 Another staff member said the following to the review team in early 2022:

'If I could say anything to the families it would be that there were people who tried to make changes, we tried to escalate our concerns and be heard but every process we used was set up not to acknowledge our voices or the problems we were highlighting. We were ignored and made out to be the problem but ultimately we failed to make ourselves heard....'

5.65 Many different factors affect the dynamics of team working which are well illustrated within various national programmes including Each Baby Counts. The following feature as contributory factors in adverse incidents:

- Individual human factors (present within 58 per cent of cases)
- Team communication issues (present within 53 per cent of cases)
- Lack of team leadership (present within 24 per cent of cases)
- Poor intra- or inter-professional communication (present within 43 per cent of cases).[114]

111 Flin, R., O'Connor, P. and Crichton, M. Safety At The Sharp End. (2008) CRC Press; Florida.

112 Ibid n20 and Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and Dixon-Woods, M. (2019) *How to be a very safe maternity unit: An ethnographic study*. Available at: https://www.thisinstitute.cam.ac.uk/research-articles/safe-maternity-unit-ethnographic-study/ (Accessed 01 December 2021).

113 National Institute for Health and Care Excellence Safe *midwifery staffing for maternity settings*. (2015) Available at: https://www.nice.org.uk/guidance/ng4 [Accessed 01 December 2021] and Ibid n4

114 Royal College of Obstetricians and Gynaecologists (2020) Each Baby Counts. 2020 Final Progress Report.

5.66 Similarly, Civility Saves Lives (2017)[115] articulates how negative behaviour such as rudeness or bullying results in a significant decrease in a clinician's performance and/or cognitive ability. Furthermore, incivility is recognised to not only affect an individual recipient, but also bystanders, patients/relatives and the wider team within healthcare settings[116].

5.67 A staff member told the review team that:

'There is culture of bullying on labour ward 24. Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it. I was told that I was a band 6 midwife so I should have no problems. I also got told by one shift co-ordinator that I was qualified longer than her and why was I asking her to support me with what was a difficult delivery?'

5.68 Whilst the identification of human factors will always remain integral to patient safety, there is more recent emphasis on addressing and preventing such issues from occurring in the first instance. Consequently, there is an increasing recognition of the importance and value of workplace culture and civility.

5.69 Workplace culture can be defined as 'shared ways of thinking, feeling and behaving within an organisation'[117]. The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013).

5.70 It is imperative to ensure the 'culture' within all healthcare settings is one that promotes openness, transparency and the psychological safety to escalate concerns. Yet the review team found evidence of disempowerment, with staff encouraged not to complain or raise awareness of poor practice within both personal and professional capacities.

5.71 A staff contributor told the review team that:

'You feel like you're penalised constantly in this organisation. I'm keeping my head down now. I have raised it before, I went to HR and it was almost as though I was causing trouble.'

5.72 Another staff member told the review team:

'Whilst reviewing the governance and assurance processes, I was approached by a consultant [obstetrician] who said be careful what you find.'

5.73 Reflecting on the harm caused to families a current staff member told the review team in early 2022:

'I am sorry and I know that sorry is not enough but by engaging with this review we hope that our voices will finally be acknowledged and that change will happen so that there are robust and independent places for clinicians to speak out that acknowledge what we are saying, what needs changing and act on this without fearing reprisals..'

5.74 Positive behaviour strategies have been designed to address negative cultures within healthcare, to improve the working environment for staff and so promote the delivery of safe and compassionate care for patients. Some of these strategies include the implementation of a Workplace Behaviour Toolkit (RCOG, 2021), Civility Toolkit (HEE, 2021) and the creation of national patient safety movements such as Civility Saves Lives (2017) and Learning from Excellence (2014).

5.75 Whilst it is of equal importance for all staff within maternity settings to demonstrate positive behaviours in their everyday practice, it is vital that leaders, such as the labour ward coordinator and senior obstetricians,

Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/ebc-2020-final-progress-report.pdf [Accessed 01 December 2021].

115 Civility Saves Lives (2017) Civility Saves Lives. Available at: https://www.civilitysaveslives.com/ [Accessed 01 December 2021].

116 Youngson, G. and Flin, R. Patient safety in surgery: non-technical aspects of safe surgical performance (2010). doi: 10.1186/1754-9493-4-4.

117 Mannion, R. and Davies, H. Understanding organisational culture for healthcare quality improvement, British Medical Journal (2018) doi: 10.1136/bmj.k4907.

are acutely aware of their own behaviour and how this influences other members of the wider team. Where negative workplace practices or behaviours are identified, leaders should ensure they take proactive steps to support individuals, address concerns and prevent the creation of a systemic negative culture similar to that described by staff at the Trust.

5.76 During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.

5.77 A staff member told the review team:

'At a study day in 2016/2017, following the Kirkup report, a senior manager made the comment "we (SaTH) are not a Morecambe Bay". I made the comment that we absolutely were a Morecambe Bay - a trust full of unhappy staff with ineffective poor leadership, looking to hide or ignore poor care and poor management. I have worked for [another NHS Trust] which learned from its mistakes and supported its staff for the past [number of] years'.

5.78 *'I didn't realise how bad things were in SaTH until I left. The bullying culture from top down breeds bullying. I used to be proud to work there, but that changed from 2006.'*

5.79 Another member of staff told the review team of events within maternity services in 2019:

5.80 *'SaTH was managed with a big…stick from behind, there was no forward thinking leadership. We had changes in policy imposed on us, we did not contribute to changes. We were bullied, everything was done under the guise of 'clinical need' or 'your contract says.' We had issues with pay being withheld, managers not happy to reconcile hours/wages. The on-call rotas and change lists were both used as bullying tools. [An] entire team of five experienced midwives left the Trust in less than 18 months…I tried to raise a concern and instead of being listened to I was referred straight to occupational health. It seemed that as I dared raise a concern I must obviously be mentally unwell (this was in 2019)…this whole conversation was held in public unbeknown to me. Other midwives sitting in the office were listening to the way the manager spoke to me. I was and am still absolutely appalled by that action. I resigned…There are a lot of, I would say, home grown midwives, there are cliques there and, you know, they are Band 6s, Band 7s, Band 8s and they are a little gang, and, yes, they will make your life hell'.*

5.81 They continued: *'It's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work…'*

5.82 The staff interviews with the review team also highlighted that there was a lack of respect and role appreciation between the consultant unit staff and the community teams.

5.83 A staff member told the review team that *'There was a…bit of a feeling that because they were the consultant unit, they knew better than you, but actually, we're in the outlying units because we're experienced and we know what we're doing, but…we didn't feel like that respect was always there. Often our decisions were questioned as to, "Well, try this, try that", "Well no, actually, I'm sending her... [the mother in]" '.*

5.84 They continued:

5.85 *'Actually, they need to know our role; they need to know what it's like half an hour, 45 minutes. ...Nearly an hour away from the consultant unit, and they forget that you have to think that far ahead because of what might happen. We don't have an emergency buzzer to have the whole team in, so we have to think ahead and I think they forget that.'*

Conclusion

5.86 External reviews of the maternity services at the Trust between 2013 and 2017 gave the overall message that this was a safe maternity service. This review is concerned that some of those messages gave false reassurance and as a consequence opportunities were lost to have improved maternity services at the Trust sooner. For example, there were a number of concerns arising from these reports regarding governance issues and concerns raised by families, however these issues did not appear to have been prioritised.

5.87 The workforce is a cause for concern, and there were missed opportunities to address the shortfalls in staffing. It is clear that there were insufficient numbers of consultant obstetricians and junior obstetric staff and that there was inadequate anaesthetic support to the maternity unit. It is clear that the midwifery staffing across the service was poor and resulted in the service constantly working in escalation. This impacted on staff confidence and morale, creating a culture of fear and anxiety. There is also evidence of a lack of role appreciation across the service, particularly with those providing maternity services in the community.

5.88 The review team found evidence from documents provided by the Trust (2013-2016) that the local leadership had identified and escalated workforce issues and business plans had been drawn up to increase consultant and middle grade staffing. In recent times there has been a significant expansion in consultant obstetrician staffing.

5.89 Overall, there is a picture of external, independent and internal reports not being critical of clinical leadership at the Trust. However, the review team is concerned that even where recommendations were made, there is no evidence of who was accountable for their implementation or who, within the context of leadership, was responsible for maintaining oversight of these. Because of this, there was no effective strategy for meaningful change within maternity services at the Trust which further perpetuated the cycle of harm to women and families accessing maternity services at the Trust over an extended period of time. Staff who are currently employed in maternity services at the Trust and who engaged with the maternity review team as recently as early 2022 told us of a fear of speaking out in maternity services that persist to the current time. This is of very significant concern to the review team and has been shared with the Trust in advance of publication of this report.

Chapter 6

Our findings following the review of family cases

6.1 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.

6.2 The review was intended to span the years 2000-2019. However, as discussed in previous chapters, 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.

6.3 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	FAMILIES	CLINICAL INCIDENTS
Pre-2000	170	181
2000-2019	1,305	1,393
Post-2019	15	18
Totals	**1,486***	**1,592**

** Four families had clinical incidents that fell both within the 2000-2019 years and outside these years. Therefore there are 1,486 unique families in total.*

6.4 In line with the terms of reference underpinning this review we reviewed all 1,592 clinical incidents and analysed two aspects. Firstly, we graded the care provided by the Trust as set out overleaf. Secondly, 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

6.5 All the clinical incidents were reviewed by members of the review team which comprised obstetricians, midwives, neonatologists, and 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), which was similarly used in the Morecambe Bay investigation report by Dr Bill Kirkup, OBE. Further details on the findings and the Immediate and Essential Actions recommended by this review are described in the accompanying chapters.

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

6.6 Table 3 shows the grading of care for the major incident categories. For the incident categories HIE, neonatal death and cerebral palsy / 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.**

Table 3: Clinical review findings for each of the major incident categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS*	GRADING OF CARE SCORE				PERCENTAGE OF CARE AT GRADE 2 AND 3
			0	1	2	3	
Maternal Death		12	0	3	6	3	75.0%
Stillbirth		498	193	174	93	38	26.3%
Hypoxic Ischaemic Encephalopathy	Mother**	44	10	5	16	13	65.9%
	Baby***	41	26	13	2	0	4.9%
Neonatal Death	Mother**	251	107	74	38	32	27.9%
	Baby***	237	182	38	13	4	7.2%
Cerebral Palsy/ Brain Damage	Mother**	147	35	47	45	20	44.2%
	Baby***	139	99	30	8	2	7.2%

**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).*

***Review of the care provided to the mother*

****Review of the neonatal care provided to the baby after birth*

Maternal deaths

6.7 There were 12 maternal deaths reviewed and in nine of the 12 cases (75 per cent) the review team identified significant or major concerns in the care received. Maternal deaths are further discussed in chapter 10.

Stillbirth

6.8 498 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.

Hypoxic Ischaemic Encephalopathy (HIE)

6.9 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 per cent) 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

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

Cerebral palsy

6.11 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 per cent 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

6.12 Within this group were families who did not meet the incident categories identified in the NHS England and Improvement (NHSE&I) 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, women who had had a caesarean hysterectomy, women who 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 one in four women in this group. The care provided to the baby was considered appropriate in more than 90 per cent of records reviewed.

Combined category

6.13 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 and 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

6.14 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. 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 etc.) 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.

6.15 The tables below show the results for stillbirths and neonatal deaths for the period 2011-2019. The maternal death investigations are discussed more fully in Chapter 10. 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 (2011-2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
168	100	36%	49%	15%	85	32.9%	40.0%	27.1%

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

Table 6 Neonatal Deaths (2011 – 2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
77	44	54.5%	34.1%	11.4%	41	41.5%	31.7%	26.8%

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

6.18 In the hypoxic ischaemic encephalopathy group there were 12 cases reviewed for the period 2011-2019 and of these eight were investigated by the Trust. This group was considered too small to draw conclusions on the quality of the investigation.

OCKENDEN REPORT - FINAL

Section 3

Our findings of what happened to the families

Chapter 7

Antenatal care

7.1 Safe and individualised antenatal care must be the foundation underpinning a woman's pregnancy and birth journey. From the point at which a woman notifies her pregnancy, often to her GP, and then attends a booking appointment with a midwife, a detailed and thorough risk assessment must be undertaken. Comprehensive, individual and woman and family-focussed questioning permits an accurate risk assessment so that care can be personalised and women can be signposted to the most appropriate antenatal care pathway.

7.2 For many women antenatal care is provided by a wide group of professionals including midwives, doctors and sonographers, as well as individuals from external agencies such as social care. This relies upon the sharing of accurate information between primary care and hospital maternity services and on occasion other medical specialities. Throughout antenatal care provision there is a necessity for close interdisciplinary working between these groups to ensure optimal and safe antenatal care is delivered. This chapter focuses on aspects of antenatal care that were not previously addressed in the first report and aims to highlight areas within the maternity service provided by the Trust which the review team felt warranted further attention.

Good practice in antenatal care and missed opportunities for learning

7.3 Throughout the time period of the review our multi-professional review team found a number of examples of good practice, of compassionate and safe antenatal care. However, also throughout the entire period of the review our team found poor standards of antenatal care, showing a lack of consistency and significant opportunity for improvement. Unfortunately there were significant numbers of poor standards of investigation when things went wrong or investigations that should have taken place which did not. Overall, the Trust continued to miss significant opportunities for significant learning throughout the entire time period of the review.

Care of vulnerable women

7.4 Pregnancy is a well-documented catalyst that may increase maternal vulnerability and inequalities already present in the lives of some women[118]. Vulnerability can be seen in women that have previously or are currently experiencing poverty, homelessness, domestic abuse, learning difficulties, seeking asylum, substance misuse, poor mental health, complex co-morbidities and teenage pregnancy. It is widely recognised that pregnancy carries a great deal of uncertainty. Women who are vulnerable in pregnancy are more likely to be exposed to additional harm, stress and anxiety.

7.5 The review team found evidence of missed opportunities to further investigate women from vulnerable groups. There was a lack of professional concern and in some cases a lack of appropriate referral in cases where further exploration was warranted. It is recognised that vulnerable women who receive appropriate support and intervention have improved outcomes[119].

7.6 *In **2009** a young woman in her first pregnancy was booked for consultant-led care due to her age and was diagnosed as having a baby with fetal gastroschisis[120]. She was not referred for additional support from the teenage pregnancy midwives but instead was seen by multiple midwives. As a result there were missed opportunities to explore her possible complex social needs as her care continued to be focused largely on the fetal gastroschisis (2009).*

118 NHS England. Better Births (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

119 Centre for Maternal and Child Enquires. Perinatal Mortality 2008 (2010) https://www.publichealth.hscni.net/sites/default/files/Perinatal%20Mortality%202008.pdf

120 See glossary

7.7 *A very young woman was booked for her first pregnancy in **2013**. There was no referral to the teenage pregnancy service nor any further exploration relating to her social circumstances, particularly as her partner was significantly older than her. She was not offered appropriate additional support and care. (2013)*

7.8 *In **2013**, a young teenage woman presented with a history of three previous pregnancies, all of these ending in miscarriage. Whilst she was appropriately referred to the teenage pregnancy midwife there was a lack of professional exploration or questioning around her social background, support networks and mental health. Appropriate signposting and referrals were not made in the pregnancy, and she did not receive the necessary additional offers of care and support. (2013)*

7.9 National guidance for women with complex social factors was updated in 2010[121] and emphasised the need to improve support for women with additional needs. The Trust has guidance available with care pathways and referral processes for specialist practitioners such as the safeguarding team and teenage pregnancy midwife. The review team considered many cases where guidance was followed and referrals had been appropriately made

7.10 *In **2018**, the review team had concerns around a lack of appropriate safeguarding and domestic violence screening- not completed at the booking visit. There were a number of missed opportunities to follow up the questions about domestic violence. It is appreciated there is always a possibility that an individual may not disclose any concerns. Following what was thought to be a domestic violence incident there was significant maternal morbidity and stillbirth. The review team subsequently saw evidence of learning from the Trust and changes to practice following this case. (2018)*

Good practice

7.11 *In **2008** a young teenage woman in her first pregnancy received appropriate input and referrals from the teenage pregnancy midwives and additional input and investigation from the fetal medicine consultant. Bilateral talipes[122] were identified on an ultrasound scan. The baby was born at term and had an extended stay on the neonatal unit for nearly 1 month due to its inability to feed and the need for nasogastric feeding. There were extensive investigations for a possible neuro-muscular disorder and the family were counselled and supported by a geneticist about this. (2008)*

7.12 *A young woman in her first pregnancy in **2016** was appropriately referred to the teenage pregnancy team. The review team observed use of interpreters and the offer of a comprehensive assessment which would have resulted in an holistic consideration of the family strengths and needs. This was declined by the mother and the family (2016).*

7.13 Whilst highlighting these examples of good practice, the review team found that overall there was a lack of consistency, potentially exposing women and their babies to increased risk and potentially unnecessary harm.

Fetal growth assessment and management

7.14 Monitoring fetal growth is an integral component of safe and effective antenatal care. Over the last 20 years there has been increasing evidence that fetal growth restriction (FGR) is associated with stillbirth, neonatal death and increased perinatal morbidity. The Perinatal MBBRACE report in 2015[123] on term antepartum stillbirths found that 'about one in three term, normally formed, antepartum stillbirths are related to abnormalities of fetal growth'.

121 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010) https://www.nice.org.uk/guidance/cg110

122 See glossary

123 MBRRACE-UK. Perinatal Confidential Enquiry. *Term, singleton, normally-formed, antepartum stillbirth* (2015) https://www.hqip.org.uk/wp-content/uploads/2018/02/perinatal-confidential-enquiry-term-singleton-normally-formed-antepartum-stillbirth-report-2015.pdf

7.15 In November 2015, the Department of Health[124] announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. The National Maternity Review, Better Births[125] (2016) highlighted a range of measures which can enhance the safety of care for women and babies, and identified a 'care bundle' as good practice in reducing stillbirths.

7.16 NICE (2003, 2008)[126] and RCOG (2013)[127] guidance advocates the use of symphysis fundal height (SFH) measurement and plotting these on a growth chart in the maternity handheld notes as essential to the care of low risk women. A referral for an ultrasound growth assessment is indicated where thresholds are reached or for women who are deemed to be high risk.

7.17 In 2016 NHS England produced the Saving Babies Lives Care Bundle Toolkit for maternity units to reduce the risk of stillbirth. The 'toolkit' was a range of measures that could be deployed to improve safety for mothers and their babies. One element of this has been the detection and surveillance of fetal growth restriction (FGR); (version 2 published 2019)[128]. However, it must be acknowledged that historically, national guidance for monitoring of fetal growth has been conflicting and this has been a contentious issue across the UK over the last 20 years. There remains extensive regional variation in the adoption of guidance and practice.

7.18 In 2007-2008 the Trust introduced customised growth charts as part of the national Growth Assessment Protocol (GAP)[129] and Gestation Related Optimal weight (GROW)[130] programme with the West Midlands being one of the first regions to introduce the programme. Prior to this time the non-customised SFH and ultrasound growth charts were in use within the Trust's handheld antenatal notes.

7.19 The review team found many instances where fetal growth restriction occurred but was not identified. Whilst it is recognised that despite following guidance it is not always possible to detect FGR (given the limitations of available methods including ultrasound) there were definite themes that emerged from review of these cases:

- The SFH measurement was not always completed and documented at each antenatal visit from 24 weeks.
- The SFH measurements taken were both inconsistently and inaccurately plotted onto the growth chart.
- A lack of appropriate referral when SFH measurements would have triggered an ultrasound scan.
- Failure to monitor growth by ultrasound in babies at high risk of FGR (e.g. women with underlying hypertension).
- Lack of recognition, action and wider learning by the Trust when babies were born growth restricted, including those who died.

7.20 *In 2017 a nulliparous[131] women was assessed at her an antenatal visit at 27 weeks and it was noted that the symphysis fundal height (SFH) plotted above 90th centile when plotted on the customised growth chart. Following this fetal growth appeared to be reducing in trajectory. According to local guidance a fetal growth scan should have taken place .This did not occur. At 35 weeks gestation a stillbirth occurred of a grossly fetal growth restricted baby (birthweight at delivery on the 1st centile). The Trust recognised that*

124 https://www.england.nhs.uk/mat-transformation/saving-babies/

125 Ibid n1

126 National Institute for Health and Care Excellence. Antenatal Care Clinical Guidance 6 (2003) https://www.nice.org.uk/guidance/cg6 and Antenatal Care for uncomplicated pregnancies Clinical Guidance 62 (2008) https://www.nice.org.uk/guidance/cg62

127 Royal College of Obstetrics and Gynaecologists *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

128 NHS England. Saving Babies' Lives Version 2: a care bundle for perinatal mortality (2019) https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

129 Clifford, S., Giddings, S., Southam, M., Williams, M., Gardosi, J., *The Growth Assessment Protocol: a national programme to improve patient safety in maternity care.* (2013) https://www.perinatal.org.uk/wwwroot/pdf/nz/GAP_article_MIDIRS_Dec_2013.pdf

130 Gestation Network. Growth Charts GROW https://www.gestation.net/growthcharts.htm

131 See glossary

there were missed opportunities to detect IUGR and refer appropriately. There was confusion from staff about guidance and when a woman should be referred for a scan. Had this severe IUGR been detected earlier delivery may have been expedited prior to stillbirth occurring. (2017)

Staff voices on fetal growth:

7.21 A staff contributor told the review that that they had encountered problems with women being referred for growth scans and had found that some clinical colleagues were uncertain of SFH measurement technique:

'When I was doing some of the clinics, I would be seeing antenatal women who should have had a scan… and in one clinic session, there were three women who should really have been referred for a growth scan and obviously, I did refer them, but I mean even the one partner had plotted the growth on the chart because they said the midwife hadn't plotted it…'

7.22 *The staff member continued: 'I was even asked the one time, "How do you measure fundal height?" by a midwife? I don't know, having a joke or something, I says, "How do you mean?" and [midwife] said, "Well…" literally [they] described how they measure the fundal height, I said, "Well, it's clear on the growth chart how to measure it you know, this is how you do it; it's on the growth chart itself how to measure it," and [they] says: "I do it the opposite way", which wouldn't give you the correct measurement'.*

7.23 Incorrect assessment of fetal growth was repeatedly observed by the review team. Some examples of this include:

*In **2011** a woman had continuity of care with the same midwife during her antenatal care, however the SFH measurements were incorrectly documented at some visits (not written in centimetres), and were incorrectly plotted in their position and mark used on the growth chart. The plots, if correct should have alerted referral for an ultrasound scan to assess growth. The pregnancy ended in a stillbirth of a baby with growth restriction. (2011)*

7.24 The Trust's initial investigation in June 2011 did not recognise that there had been missed growth restriction. The governance documentation reviewed was poorly completed and there was no indication that any of the actions had been achieved. Following a complaint from the family in October 2011 a further investigation took place and it was acknowledged that the growth measurement and plotting did not identify growth restriction. An action plan was made and evidence subsequently supplied to the family that the actions had been completed. However the learning only took place after a family complaint and not before. Families consistently told the review team of investigation only commencing after receipt of a complaint or commencement of litigation. The review team has seen this was a regular feature during the whole time period of this review. (2011)

7.25 *At 36 weeks' gestation in **2013** a woman experienced an intrauterine death. Following birth it was found the baby was significantly growth restricted. On case review it was established the SFH was not plotted on the GROW chart. The SFH was persistently measured as >90th centile (when retrospectively plotted) but the baby was profoundly growth restricted, and weighed 1.53kg at birth (1st centile). This case highlights poor SFH measurement techniques by several different antenatal care providers. (2013)*

7.26 Governance documents supplied by the Trust to the review team for the above case recognised that growth was not plotted appropriately and there had been missed FGR. Actions stated by the Trust were to ensure GROW training was being accessed by all, including GPs. GAP training was due to start in 2014. A further meeting in 2015 found that the CCGs had not progressed these actions and the GPs had not accessed the GAP training. Following this meeting the action was for the patient safety manager to highlight the need for the GAP training with the CCGs in conjunction with the recent MBRRACE report. The target date was February 2016, 3 years after the case. The review team has not been provided with evidence by the Trust to demonstrate this actually happened despite the significant passage of time.

7.27 *In **2015**, a woman became pregnant who had previously had a small baby with a birth weight just above the threshold in the local guideline to merit referral for an ultrasound scan. She was a current smoker and in this current pregnancy missed antenatal appointments due to issues with scheduling and non-attendance. Despite these risk factors, in the pregnancy in 2015 the complete clinical picture was not considered and she was not appropriately referred for an obstetric review or serial growth scans. (2015)*

7.28 *Her baby was stillborn at 37 weeks, with a birth weight less than the 3rd centile. The investigation by the Trust recommended a change to guidelines, to clarify exactly which centiles must be included in the risk assessment guidance for referral for scans in a subsequent pregnancy. The following two versions of the guidance did not change and the antenatal risk assessment was not updated until **2018**, a gap of 3 years following the incident.*

7.29 *A woman who was known to have large uterine fibroids had midwifery-led care throughout her pregnancy in **2016**. There were errors in the interpretation of the baby's growth, fetal and growth restriction was not detected and an obstetric opinion on the ultrasound scan was not obtained. The baby was born at 31 weeks and was severely growth restricted with a birthweight less than the 1st centile. The baby died the same day from a severe hypoxic birth injury. Local investigation recognised there was a missed opportunity for earlier specialist ultrasound scanning. (2016)*

7.30 Staff interviews undertaken during late 2021, as part of the Staff Voices initiative, supported the view that the Trust remained slow in implementing recommended changes. A staff member told the review team: *'so we're going to put that into our protocols and policies and before it was just 'mañana', we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.*

Specialist antenatal care

7.31 Some aspects of antenatal care require the input of specialised services. The review team identified the following areas of concern with specialist services that were being delivered at the Trust.

Fetal medicine care

7.32 A number of cases were considered where fetal medicine care was provided at the Trust. The review team identified incidences where a baby was born with an abnormality which was not detected until after birth or where a fetal abnormality was detected during the pregnancy and the review team had concerns about the care provided. From review of clinical records, in most cases the quality of fetal medicine care at the Trust appears to have been appropriate or good for the year that the pregnancy occurred. Some fetal abnormalities would not necessarily have been expected to be diagnosed antenatally and for those diagnosed it was evident that appropriate, kind and compassionate care had been provided both during the pregnancy and following a pregnancy loss.

Good care

7.33 *In **2007** a woman had a pregnancy complicated by multiple abnormalities found on the anomaly scan. She was seen by the fetal medicine consultant at the Trust and counselled regarding the increased chance of a chromosomal abnormality and she had an amniocentesis. The baby was confirmed to have a chromosomal abnormality and a referral to the genetics team was made. The parents decided to terminate the pregnancy. There was documented evidence of good communication with the parents and GP antenatally and postnatally and evidence of compassionate antenatal and bereavement care. (2007)*

7.34 *In **2012**, a baby was diagnosed with a significant brain abnormality at the anomaly scan. There was referral to the tertiary centre and the parents were counselled by the geneticists and paediatric neurologists at the tertiary centre and the neonatal and fetal medicine team at the Trust. The woman had regular scans and thorough investigations during the pregnancy with good multidisciplinary antenatal care and*

communication noted. The baby was delivered at 37 weeks and the baby died at a few hours of age. There was appropriate follow-up with the neonatal and genetic teams. (2012)

7.35 *A woman had a pregnancy in **2016** complicated by multiple fetal abnormalities identified at the anomaly scan at 19 weeks. She was seen by a fetal medicine consultant and offered an amniocentesis (invasive testing) and possible termination of pregnancy which she declined and had a stillbirth at 36 weeks. She was seen regularly by the midwives and obstetricians throughout the pregnancy and offered bereavement support. (2016)*

7.36 These cases demonstrate that there was often appropriate multidisciplinary care, support, counselling and bereavement care for the parents, including care at the tertiary centre where appropriate, following the diagnosis of a significant fetal abnormality.

Poor care

7.37 However, the review team found a number of cases where care was substandard. For fetal abnormalities such as cardiac abnormalities, babies that require surgery immediately post birth, babies with multiple abnormalities suggestive of a genetic syndrome or babies with severe early onset FGR, then referral to a tertiary fetal medicine centre during the antenatal period is the appropriate care pathway expected. This would ensure multidisciplinary counselling and expert care and for many babies birth in a unit with a Level 3 neonatal unit would be appropriate. There appeared to be a reluctance by some clinicians to refer some women for tertiary centre fetal medicine care for advice and counselling, or to transfer care to a Level 3 centre as a more appropriate place for birth. In cases where a fetal abnormality was detected postnatally or a baby died with abnormalities there was often no Trust investigation of the screening process or care. Thus opportunities for learning were lost.

7.38 When interviewed by the review team a member of staff at the Trust agreed that there was sometimes a reluctance to refer fetal medicine cases for an external review.

7.39 The contributor told the review: *'I think I'd probably, in retrospect, agree…to some extent. I think there was a degree of fetal medicine clinical overconfidence…but there are other things that you thought perhaps ought to have been referred elsewhere earlier on, yes'.*

7.39 *A woman booked in her third pregnancy in **2015**; although the 20/40 week anomaly scan was normal, significant fetal abnormalities were diagnosed at a later scan, which were likely to be associated with a poor outcome for the baby. She was counselled by a Trust fetal medicine consultant; although documentation of the discussion and possible outcomes were poor. The plan was made for the baby to be delivered at the Trust and for the neonatal team to be at the birth. The baby was delivered at 36 weeks and died within the first 24 hours of life. (2015)*

7.40 This case highlights the importance of appropriate antenatal communication and consideration for best place for birth. Although in cases, such as this, where the outcome is likely to be poor and the pregnancy is continuing, the outcome may be unchanged by referral to a tertiary centre, appropriate practice would be offering referral to a tertiary fetal medicine unit to ensure the provision of detailed counselling regarding the prognosis, including counselling from the wider multidisciplinary specialists. The specialist team would comprise geneticists, neonatal surgeons and speciality paediatricians to plan appropriate antenatal surveillance and postnatal care and ensure informed decision making by the parents.

7.41 Ongoing antenatal care following referral can be shared between the local and tertiary centre but at least one visit to the tertiary centre will ensure that key expertise is sought. Consideration must also be given to birth in the tertiary centre in complex cases, where the abnormality is likely to require early surgery and where level 3 neonatal care may be required to ensure optimisation of care at birth. With all of this information provided to the woman and her family they are then able to make an informed choice.

7.42 *In **2008** a women in her sixth pregnancy was identified as having a baby with a significant congenital abnormality at the anomaly scan. She was counselled by a Trust obstetric consultant, the neonatal team and neonatal surgeons at the tertiary centre. She decided to continue her pregnancy and delivered her baby at the Trust. The baby was transferred to the tertiary centre postnatally and died aged four days. Following review of this case it was agreed that referral to tertiary fetal medicine service should have been made and consideration given to the appropriate place of birth. (2008)*

7.43 *In **2019**, a woman had a pregnancy affected by severe early onset fetal growth restriction. There was no referral to a tertiary centre for specialist review, counselling or advice, particularly when the woman was reluctant to consider local advice regarding birth. The review team found there was limited evidence, pointing to inadequate counselling, and fetal medicine management was not in keeping with best practice. (2019)*

7.44 In the chapter focussing on neonatal care the review team discuss the change in designation of the neonatal unit in 2006 from level 3, (neonatal intensive care unit or NICU) to level 2, or a 'local' neonatal unit. Staff interviews supported the culture of reluctance to transfer women in utero or neonates to a Level 3 tertiary unit following the Royal Shrewsbury Hospital being designated a Level 2 or local neonatal unit, (LNU) in 2006. Staff described a gap of circa 8 years before the changes introduced in 2006 were actually implemented, but some were reluctant to be quoted within the report. Some staff members from the Trust stated that there was a lack of capacity at the designated level 3 units in the surrounding area, leading to the Royal Shrewsbury Hospital continuing to care for babies outside its designation. However this was disputed by the neonatal network.

7.45 One staff contributor told the review: *'Part of the sense of futility is that we have raised concerns, you know, sometimes we've actually had quite heated debates about…if on the obstetric side they feel that they don't want to send to Stoke or Birmingham, and…want...to keep the patient, and you're made to feel that you're letting the side down by not agreeing to proceed…I think for some of them there is a reluctance, and I don't know if that is a cultural thing because I think for a long time, particularly while based at RSH, there was a feeling that it was a very standalone unit and it did its own thing. So I think culturally there's been that feeling…'.*

Multiple pregnancies

7.46 About 1 in 60 pregnancies is a twin or triplet pregnancy (NICE 2015). A unit with approximately 5,000 births a year such as the Trust would expect on average 65-75 pregnancies resulting in multiple births a year. Multiple pregnancies are known to be at greater risk of adverse obstetric outcomes and so additional antenatal care is required.

7.47 NICE guidelines on twins and triplet pregnancy were first published in 2011 and have since been updated in 2019[132]. Guidance has emphasised the importance of detailed antenatal counselling for women with twins or triplets especially with regards to intrapartum management. This is best facilitated through a specialist clinic. The review found multiple cases where limited or no counselling was evident with regards to management of twin pregnancies.

7.48 *In **2013**, a multiparous[133] woman booked with a DCDA[134], twin pregnancy. At 31 weeks she was seen by a registrar and requested birth by caesarean section. She was told this was not necessary but there was no documented discussion regarding the risks associated with vaginal birth for the second twin. Twin 2 experienced a complicated birth and suffered HIE Grade 3. The child is now profoundly disabled and the mother suffered post-traumatic stress disorder. (2013)*

132 National Institute for Health and Care Excellence. Twin and triplet pregnancy NICE Guideline NG137 (2019) https://www.nice.org.uk/guidance/ng137

133 See glossary

134 See glossary

7.49 *In **2014**, a 41-year-old first time mother who conceived through assisted conception was advised an induction of labour at 36+ weeks as her twins were small. There was no evidence of any antenatal counselling. Labour was induced and she required an assisted vaginal birth for both twins in theatre. The second twin had a very complicated birth and as a consequence suffered HIE. (2014)*

7.50 *In **2017**, a primiparous[135] woman was induced at 37 weeks and 5 days as she had a DCDA[136] twin pregnancy, this was in accordance with local guidance. There was inadequate documented antenatal discussion with regards to the process of induction of labour, consideration of epidural analgesia and the potential risk of caesarean section for twin 2. Furthermore, at the time of induction prostaglandin (medication given to start the labour) was given without an obstetric review or an ultrasound scan to confirm presentation of the twins. An emergency caesarean section was undertaken for a fetal heart rate abnormality. There was a postpartum haemorrhage of 2500mls which was appropriately managed. (2017)*

7.51 Further cases of concern regarding the management of multiple pregnancies were seen by the review team. In conclusion, the review team found that multiple pregnancy management at the Trust gave cause for concern across the entire review period.

Diabetic Care

7.52 The care of women with diabetes encompasses women with both pre-existing diabetes and women who develop diabetes during pregnancy, known as gestational diabetes mellitus (GDM). UK rates of GDM have steadily increased over the last decade with Diabetes UK estimating that about 1 in 16 women will develop GDM. Women with pre-existing diabetes make up a smaller proportion of the women requiring diabetes care, but pregnancy complications are greater in this group.

7.53 UK guidance for the management of diabetes in pregnancy was first published by NICE in 2008 (revised in 2015 and updated 2020)[137]. Prior to NICE guidance CEMACH[138] published a landmark report in 2007 that highlighted women with pre-existing diabetes had a fivefold increased risk of stillbirth and a threefold increased risk of perinatal mortality. All these reports emphasise the importance of multidisciplinary care for women with diabetes and that women must have ready access to specialists with expertise in the care of diabetes in pregnancy.

7.54 Diabetes care at the Trust must be led by a named consultant obstetrician who acts as a lead for the service. This lead consultant must have sufficient time in their job plan to lead the diabetes service effectively. This can be benchmarked against other similar sized trusts. The lead consultant must work in conjunction with a consultant diabetologist, specialist nurses, midwives and also a diabetes dietician. It is imperative that these individuals work together in a collaborative manner. The diabetes service at the Trust was created in 1999 and has increased in size over the last 20 years. The number of women presenting with diabetes has been increasing significantly.

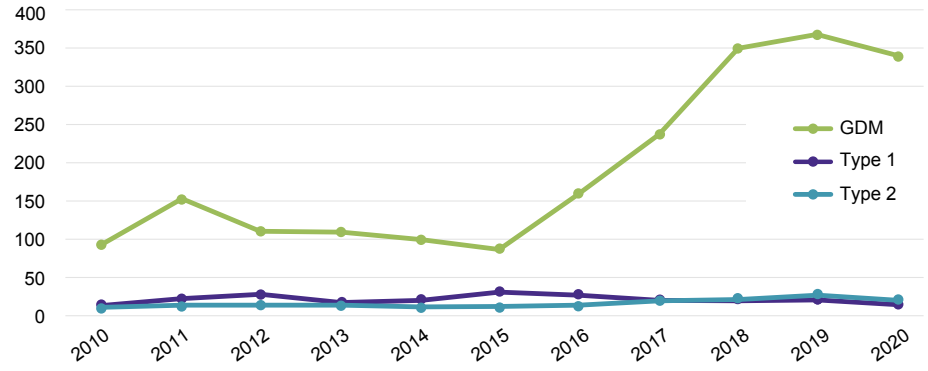
135 See glossary

136 See glossary

137 National Institute for Health and Care Excellence. *Diabetes in pregnancy: management from preconception to the postnatal period NICE guideline NG3* (2020) https://www.nice.org.uk/guidance/ng3

138 Confidential Enquiry into Maternal and Child Health. Diabetes in pregnancy: are we providing the best care? (2007) https://www.publichealth.hscni.net/publications/diabetes-pregnancy-are-we-providing-best-care

Diabetes yearly breakdown



Source: Shrewsbury and Telford Hospital NHS Trust

7.55 *In **2016**, a woman had appropriate multidisciplinary team antenatal care that involved senior obstetric, diabetic specialists and midwifery input. However there was failure not to act or further investigate increasing ketonuria[139] and fetal macrosomia[140] in a diabetic smoker all of which are individual risk factors for intrauterine fetal death. An antepartum stillbirth occurred at 34 weeks and 6 days. There was no evidence provided to the review team that this case was discussed at a governance meeting or that any learning was identified. (2016)*

7.56 *In **2016** a women with Type 1 diabetes who had poor control prior to pregnancy, suffered a stillbirth at 34 weeks' gestation. There were multiple missed opportunities to improve diabetic control and care sometimes seemed fragmented. The risks of the pregnancy were not shared with the patient. The patient had a pregnancy the following year where the care was much improved with evidence of better multidisciplinary team working. (2016)*

Staffing of the maternity diabetic service at the Trust

7.57 The Trust has advised the review team that the present diabetic service consists of two consultant obstetricians, and two endocrinologists. There is one Band 7 midwife and two band 6 midwives who both provide less than 0.5 full time equivalent cover. The service also has access to diabetes nurse specialists. The review noted current problems with staffing and capacity within the diabetic service, especially given the increasing workload. Firstly, there is no current provision for consultant cover during periods of annual leave, study leave and other absences, meaning women have limited access to the correct specialist during their antenatal care.

7.57 Furthermore, from the documentation provided to the review team there appears to be only one fortnightly clinic run for women with GDM. This is inadequate for the number of women managed with GDM in the service, which is on average 29 women a week (based on the Trust's data for the last 3 years). Having such limited appointments available for complex pregnancies means that an appropriately detailed assessment is unlikely to be made, which increases the likelihood that omissions will occur and errors will be made.

Good practice

7.59 Whist the review had concerns regarding the maternity department's ability to support the diabetes service it saw good practice, in that the department had invested to develop a midwifery non-medical prescriber. This model of care means a specialist midwife has a greater depth and understanding of diabetes and also continues to manage women with gestational diabetes when medical therapy is required.

139 See glossary

140 See glossary

Preconception care and diabetes

7.60 An important facet of diabetes management is access to preconception care for women with pre-existing diabetes. Women with very poor diabetic control must be advised against becoming pregnant until better diabetic control is established and must have access to appropriate advice on contraception and medications to avoid when embarking upon pregnancy. The review found evidence of numerous cases of women with pre-existing diabetes who had not had access to preconception care. This includes the case below, which is relatively recent.

7.61 *In **2019** a woman with underlying type 2 diabetes and an elevated BMI booked with an average blood glucose level of 117 prior to pregnancy (desired upper level for pregnancy is 48). Whilst she was first seen prior to 10 weeks of gestation, she unfortunately suffered an intrauterine death at 16 weeks, which may have been related to her pre-pregnancy diabetic control. (2019)*

7.62 Cases such as this evidence the disconnect between diabetes care, general practice and maternity services and the need for greater emphasis on preconception care. With better access to preconception care and provision of appropriate contraception services, this will help reduce or minimise cases of pregnancy loss associated with a woman's diabetic status.

7.63 As pregnancies in women with underlying diabetes are at elevated risk of poor fetal outcome it is imperative that women undergo thorough clinical and risk assessment at all antenatal visits. This includes assessment of blood pressure, urine and measuring and plotting the SFH.

7.64 A further important component of antenatal care for women with diabetes is that of birth planning. Women with diabetes are far more likely to require induction of labour or birth by planned caesarean section, particularly in the presence of fetal macrosomia or fetal growth restriction. There was evidence that this failed to occur in several cases leading to poor fetal outcome at the Trust.

7.65 *In **2014** a woman with type 1 diabetes was seen at 35 weeks and a plan was made for induction of labour at 38 weeks. There was no assessment of fetal growth beyond 35 weeks, but it was noted the abdominal circumference plotted above the 95th centile. At the time of induction, it was noted that the SFH measured 46cm and yet this was not acted upon. The patient underwent induction of labour which culminated in a vaginal birth complicated by a shoulder dystocia and abnormal fetal blood gases. Unfortunately, an early neonatal death occurred which was related to fetal hypoxemia at birth. (2014)*

7.66 When planning the place and mode of birth, maternity team members must provide women with evidence-based advice and recommendations. This will enable women to make an informed choice about their pregnancy and birth. This discussion must be fully documented in the maternity notes.

Good practice

7.67 There is evidence within the diabetes service that the Trust has made efforts to enhance antenatal care for diabetic women. The Trust has invested in the use of smartphone technology to allow remote reviews and telephone consultations for women with gestational diabetes. Additionally, NHS England recently mandated funding for all women with type 1 diabetes to have access to continuous glucose monitoring (CGM) in pregnancy. This funding stream has commenced after the period of the review but it is nevertheless important that the Trust ensures women have equity of access to CGM early in pregnancy.

Hypertension management

7.68 Gestational hypertension (also referred to as pregnancy induced hypertension) is a common disorder and may affect up to 1 in 10 pregnancies. It describes new onset hypertension in pregnancy occurring after 20 weeks gestation where maternal blood pressure is greater than 140/90 on two separate readings more than 4 hours apart. Hypertension identified prior to this point is known as chronic hypertension and affects about 1-2% of women. Gestational hypertension as well as chronic hypertension are known to be

risk factors for the development of complications in pregnancy and so women must undergo assessment of blood pressure at every antenatal visit. Furthermore, women who develop hypertension may require antihypertensive treatment during pregnancy to reduce the risk of developing severe hypertension.

7.69 National guidance for hypertension management was first published by NICE 2010 with collaboration from the RCOG and the RCM. It has since undergone revision in 2019[141]. Prior to 2010, the UK confidential enquiry in maternal deaths (CEMACH)[142] emphasised the importance of treating severe hypertension which may have contributed to cases of maternal death. Given how common hypertension is, all healthcare professionals working in maternity services must be aware of the need for monitoring and onward referral of woman with hypertension for obstetric review.

7.70 The Trust shared with the review team its first guidance for hypertension in pregnancy. This appears to have been created in 2006. The document is entitled Hypertension Severe (it has no implementation date but was due for review in 2008). It is noteworthy that the guidance stated that the initiation of antihypertensive medication for high blood pressure was only required if the systolic was 170 or greater, and they acknowledge that the Confidential Enquiry recommendation (published 2007) stated a lower blood pressure of 160 systolic required treatment. This potentially indicates a reluctance within the Trust's maternity service to treat severe hypertension according to national guidance. It must be noted these thresholds are much higher than the current guidance set out from NICE where blood pressure requires treatment when it is 150/100 or greater.

7.71 This review covers an extended period over 20 years and underpinning the review is a methodology acknowledging that assessment of cases must utilise the national guidance in use at the time. When reviewing the management of hypertension, the review team has focused on cases from 2009 onwards so that maximum learning could be established for the Trust as regards current service provision from the cases reviewed. Nevertheless, it must be acknowledged that there were many significant cases that were encountered where there was suboptimal management of hypertension prior to 2009. One example is:

7.72 *In **2001**, a woman developed severe hypertension with a blood pressure 165/100 and proteinuria at 36 weeks' gestation. A 24 hour urine collection was raised at 0.5g/l. No treatment was started, instead her elevated blood pressure was attributed to anxiety, despite clinical signs of severe hypertension. Over a week later induction of labour was finally decided upon when she developed epigastric pain and felt very unwell. There was no long term harm to mother or baby in this case. (2001)*

7.73 Following publication of the 2010 NICE guidance the review team found continued deviation from NICE guidance in the treatment of women with hypertension at the Trust.

7.74 *In **2011** a woman developed hypertension at 38 weeks' gestation in her first pregnancy, despite multiple elevated blood pressure readings that would have justified treatment, no treatment was started. She suffered an intrapartum stillbirth during the induction of labour, (IOL) process. The review team felt this was a high risk case, and a scan should have been carried out prior to IOL. In addition, assessment should have been made by an experienced midwife, not a student. If the CTG had been normal at the beginning of induction, then it is more likely than not that with adequate and ongoing observation and assessment, the outcome would have been different. (2011)*

7.75 *A woman developed hypertension and proteinuria at 33 weeks gestation in **2011**. She was admitted to the antenatal ward and started on treatment and given intramuscular steroids in anticipation of early birth. She had persistent vomiting and an ongoing headache. A consultant review occurred and it was decided she could have outpatient management. The woman was discharged but had an eclamptic seizure at home and was transferred and delivered by emergency caesarean at another hospital. The review team have not been provided with any documentation by the Trust that indicated any investigation or subsequent learning occurred as a result of this case. (2011)*

141 National Institute for Health and Care Excellence. Hypertension in pregnancy: *diagnosis and management NICE guideline NG133* (2019) https://www.nice.org.uk/guidance/ng133

142 Confidential Enquiry into Maternal and Child Health. *Saving Mothers' Lives 2003-2005* (2007) https://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005

7.76 *In a **2013** pregnancy a woman with type 1 diabetes was reviewed as an inpatient at 37 weeks as she had developed hypertension and proteinuria. Her blood pressure was elevated at 162/98mmhg. Her case was escalated to a consultant who despite clinical signs of hypertension and proteinurea indicated that no treatment was required. The review team found had concerns that such a high risk case had induction of labour started on the antenatal ward. There was poor management of her pre-eclampsia; earlier medication/treatment for pre-eclampsia would be recommended in this case. The review team notes with concern the management of a high risk IOL on the antenatal ward. Due to the complexity of this case, IOL should have been managed on the labour ward. There were also concerns regarding the management of this woman's diabetes with a delay in starting an insulin 'sliding scale'. (2013)*

Chronic hypertension

7.77 Another key element to managing hypertension in pregnancy is the recognition of women who have chronic hypertension. This cohort of women are at greater risk of developing severe hypertension in pregnancy as well as pre-eclampsia, having a preterm birth or a baby born small for gestational age. Women identified with chronic hypertension must be cared for throughout their antenatal period on a consultant-led care pathway. Current evidence suggests women should be advised to take aspirin from 12 weeks' gestation[143]. Additionally, women may require additional fetal growth scans to assess for growth restriction, which is more common in this cohort of women.

7.78 *A 42-year-old woman with a history of previous pregnancy affected by pre-eclampsia had a booking blood pressure of 140/80 with dipstick proteinuria in **2015**. She was appropriately referred to see a consultant at 11 weeks. However, there was no consideration that this might be chronic hypertension with an underlying renal disease. Unfortunately, the woman developed superimposed pre-eclampsia and experienced a stillbirth at 27 weeks' gestation. (2015)*

Inpatient antenatal care

7.79 It is estimated that about 12 per cent of all pregnant women are admitted to the antenatal ward during their pregnancy[144]. Women admitted for hospital care antenatally are more likely to need extra surveillance for an existing or new condition during their pregnancy. As a review team we acknowledge that there is an absence of national guidance that sets thresholds for when a woman must be admitted. Nevertheless, when women are admitted to the antenatal ward a clear consultant obstetrician-led plan of care is required as a standard.

Obstetric ward rounds

7.80 The Trust's Maternity Clinical Operation Policy (2015) describes the cover and support for the wards (wards described as labour ward; antenatal ward; postnatal ward and other pregnant women in hospital such as ITU) with a consultant on site from 08.30 to 20.30 from Monday to Friday and 08.00 to 16.00 on weekends and bank holidays. However, there is no clear description of what this 'support' entails. There is no mention of dedicated ward rounds on the antenatal ward. The RCOG Roles and Responsibility of a Consultant[145] (published 2009 and updated 2021) has identified that obstetric ward rounds enable staff to monitor, anticipate and respond in a timely way to emerging problems. They permit women to voice their concerns and enable them to ask questions and receive answers with regard to their care.

143 Ibid n25

144 Tracy, K. et al. *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO*, A randomised controlled trial. (2013) Lancet. Vol 382, Issue 9906 p1,723-32

145 Royal College of Obstetrics and Gynaecologists. Roles and Responsibilities of a Consultant – Workforce Report (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

7.81 Handovers must also include high risk women in the antenatal ward, enabling the out of hours team to be aware of concerns and possible reviews needed during their shifts (RCOG 2010[146], NHS1 2019[147]).

7.82 The review team found many incidents of high-risk women admitted to hospital not being reviewed by consultants. There was a lack of consultant presence on the antenatal ward and no evidence seen of a structured antenatal ward round. Medical assessments of antenatal inpatient women seemed to happen when a midwife asked for a clinical review rather than being part of the daily routine in maternity services.

7.83 When a plan for treatment or intervention was decided, documentation of detailed discussions with the women and their partners was rarely found within the records supplied to the review by the Trust.

7.84 *In **2005**, a woman with a complex pregnancy had an amniotic fluid drainage (removal of excess amniotic fluid around the baby) on the ward. There was no mention of a discussion of the procedure with the woman or any record of the procedure itself. The only documentation in the medical records provided to the review team by the Trust is the amniotic fluid biochemistry. (2005)*

7.85 During the staff voices interviews in autumn 2021, staff were asked about inpatient care and if registrars couldn't get hold of consultants to see high-risk antenatal patients, whether they would make it known that it was a concern. A staff member replied: *'No, they wouldn't, they would just act on whatever... they would just do whatever they can'.*

7.86 *In **2017** a woman was booked in for low risk midwifery care, but placed on aspirin as there was a family history of pre-eclampsia. The woman presented as large for her dates, had oedema and reduced fetal movements on presentation at 39 weeks and 6 days gestation. She was booked for an induction of labour. Following Propess[148] times 1 and Prostin[149] times 3, when ready for artificial rupture of membranes (ARM) the labour ward was too busy to accept her transfer, so the mother remained on the antenatal ward. Approximately 12 hours later, she was transferred to the labour ward. However, on attempting to auscultate the fetal heart, intrauterine death was identified and confirmed on ultrasound scan. (2017)*

7.87 Additionally, the review team encountered multiple instances where women who were admitted for induction of labour did not have a clinical review at all prior to commencing the induction process.

7.88 *A woman was admitted for induction of labour at 40+1 weeks in **2013**. Through the documentation provided by the Trust to the review team the indication for induction was not clear. Prostaglandins were given as the cervix was unfavourable. No obstetric review is documented in the notes until 48 hours after admission. Baby was born delivered by emergency caesarean section. Parents report their experience around induction, labour and the immediate postnatal experience being 'horrific.' (2013)*

Escalation of concerns

7.89 The RCOG Each Baby Counts (2020)[150] documented that 'failure to escalate/act upon risk/transfer appropriately' occurred in 36 per cent of reviewed reports. Factors affecting escalation nationally included site-based or professional team alliances, and skill gaps within specialisms and wider teams.

7.90 The review team identified many cases where midwifery staff appeared reluctant to escalate their concerns regarding care and treatment to obstetric and neonatal colleagues. High risk and complex cases were not escalated to the right person in a timely manner. Sometimes, there was recognition by the midwifery team of the need to escalate but as the junior doctor was often busy, they just waited despite their concerns.

146 Royal College of Obstetrics and Gynaecologists. Improving patient handover: Good practice no. 12 (2010) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-12/

147 NHS Improvement. Implementing huddles and handovers 0- a framework for practice in maternity units (2019) https://www.pslhub.org/learn/patient-safety-in-health-and-care/transitions-of-care/handover/nhs-improvement-implementing-huddles-and-handovers-%E2%80%94-a-framework-for-practice-in-maternity-units-25-march-2019-r136/

148 https://www.medicines.org.uk/emc/files/pil.135.pdf

149 https://bnf.nice.org.uk/drug/dinoprostone.html

150 Royal College of Obstetrics and Gynaecologists. *Each Baby Counts: 2019 progress report* (2020) https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2019-progress-report/

In other cases, they did not recognise a sick or deteriorating women and failed to escalate. The cases below are examples from across the timespan of the review. In addition, frequently women with confirmed preterm pre-labour ruptured membranes were not given antibiotics in keeping with national guidelines.

7.91 *In **2002** a woman was admitted with repeated episodes of antenatal bleeding. Her waters then broke at 25 weeks' gestation. She reported tightenings but was asked to go for a walk and given some analgesia. It was eventually realised that the so called tightenings were labour and she experienced a vaginal breech birth just 75 minutes later. (2002)*

7.92 *A woman with a history of ruptured membranes for 3 days in **2011** was admitted feeling unwell and had a raised pulse. Despite raised inflammatory markers on her admission bloods, there was a delay in recognising how unwell the woman was and she was transferred to labour ward with overwhelming sepsis 14 hours later. (2011)*

7.93 *In **2016**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation. Antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously even though the baby was breech. She experienced an intrapartum stillbirth with evidence of E.coli sepsis. (2016)*

7.94 The review team also saw multiple cases where women who were considered high risk were admitted to the antenatal ward to commence an induction of labour when induction should have occurred (or it should at least have been considered) on the labour ward. Lack of senior review or awareness meant that care provision happened in the wrong place and often without full consideration of the clinical risks involved in the care provided.

7.95 *In **2010** a woman was transferred from the midwife-led unit, (MLU) by ambulance to the consultant-led unit. There was high clinical activity at the time and yet there was no escalation to the labour ward consultant. The registrar was unable to make a full assessment because they were conducting a twin delivery with another patient at the time. This case sadly resulted in the baby needing to be cooled and developing HIE. (2010)*

7.96 *In **2012**, a 25-year-old mother with a history of previous caesarean section for breech decided to attempt vaginal birth after her membranes ruptured at 36 weeks. Prostaglandin was given on the antenatal ward. There was no documentation in the records provided by the Trust with regard to information given on the increased risk to the mother or her baby. The mother suffered a uterine rupture and the baby was born in poor condition. The baby died at 7 days of age. (2012)*

7.97 *In **2014**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation however antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously, even though the baby was breech. Her baby was born showing no signs of life. Resuscitation was initiated, but neonatal death was confirmed at 27 minutes of age. (2014)*

7.98 *A woman who was 25 weeks' gestation in **2016**, was admitted to the antenatal ward with preterm pre-labour ruptured membranes, she developed a MEOWS score of 7 indicating that she was severely unwell. The midwife contacted the registrar who was busy, but there was no escalation to another clinician until almost an hour later. At this point the women was severely unwell and a decision was then made for an emergency caesarean section. (2016)*

7.99 *In **2019**, a 35-year-old woman in her third pregnancy was induced as her baby was severely growth restricted, with absent end diastolic flow[151]. She also had gestational hypertension. A decision was made to commence the induction on the antenatal ward. The CTG was deemed suspicious on admission and she was transferred to the labour ward. The consultant review was at first to prescribe prostaglandin, but*

151 See glossary

fetal monitoring remained suspicious and a category 2 caesarean section was performed. The review team is of the view that induction should have been started on the labour ward in the first instance due to consideration of the mother's known hypertension and a severely growth restricted fetus (placental pathology). This baby therefore needed frequent monitoring. (2019)

Delay in transfer of women to the labour ward

7.100 The review team found many incidences where there was a delay in transfer of women in established labour to the labour ward. Women were frequently not monitored appropriately despite being identified as high risk. There were also several cases of women experiencing induction of labour where following delays in transferring to labour ward an intrauterine death occurred. In other cases, the delay subsequently led to a category 1 caesarean section.

7.101 *In **2003**, a 28–year-old woman was admitted to the antenatal ward at 29 weeks with abdominal pain. On the ward she collapsed with a tender abdomen. It took nearly 50 minutes to transfer her to the labour ward and conduct an emergency caesarean where a placental abruption was confirmed along with the death of her baby. (2003)*

7.102 *In **2013**, a woman undergoing induction of labour on the antenatal ward was delayed in transfer to the labour ward. When the family requested for the fetal heart to be monitored as it had not been for an hour, the fetal heart could not be located. The midwife asked the woman to go for a walk and have a drink as it was handover. An intrauterine death was diagnosed on her return an hour later. (2013)*

7.103 *A type 1 diabetic mother had a high risk pregnancy in **2013** and was admitted having evidence of pre-eclampsia. There was delay in planning induction of labour (IOL). When IOL commenced it was conducted on the antenatal ward and transfer to labour ward was not arranged until the mother had reached 4cm cervical dilatation. The baby was born by emergency caesarean section and initially responded well to resuscitation, but required transfer to the neonatal unit at seven hours of age. The baby remained an inpatient for three weeks, and is now doing well. However, as well as a delay in transfer to the labour ward the review team also has concerns regarding the care provided in labour once transfer occurred. (2013)*

7.104 *In **2015** a woman who experienced an antepartum haemorrhage in late pregnancy was inappropriately advised by the consultant obstetrician that her plans to birth in a midwifery led unit (MLU) did not need to be reconsidered or changed. When problems were identified in labour there was a delay in transfer to the labour ward, and fetal wellbeing was not adequately monitored during the transfer period. The baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation and correspondence with the Trust. (2015)*

7.105 *In **2017**, a woman whose transfer to labour ward was delayed during the induction process as the unit was very busy experienced an antepartum stillbirth whilst on the antenatal ward. During their investigation into what happened, the Trust through their Root Cause Analysis (RCA) recognised there were delays in transfer primarily due to maternity unit activity. In the RCA analysis section of the report the causes were identified as a lack of capacity on the labour ward, increased activity and emergency caesarean sections being undertaken. It also found that there was a 'culture of normalising long waits for women undergoing induction of labour when labour ward is busy'. (2017)*

7.106 Various versions of the Trust's Escalation of Maternity Services policy have been provided to the review team by the Trust since version 1 from June 2010 to version 5 in 2018. The policy repeatedly states that if the labour ward is busy, this must be escalated to the highest level and if women are waiting more than eight hours to be transferred to continue induction of labour then a senior obstetric review must occur. The review team found numerous cases where the trust did not follow its own escalation policy.

Misinterpretation of the antenatal cardiotocograph (CTG)

7.107 Fetal well-being assessments are a significant component of antenatal inpatient care and this will frequently be through CTG monitoring. Typically, women admitted to the antenatal ward may need enhanced fetal monitoring so it is imperative that CTG monitoring is undertaken appropriately and interpreted correctly. Delaying action or misinterpreting an antenatal CTG may lead to a poor fetal outcome. This is especially true in high risk women, such as those with pre-eclampsia, diabetes or severe fetal growth restriction.

7.108 The RCOG 'Green Top' guidelines Reduced Fetal Movements[152] advises that all women have an antenatal CTG from 28 weeks (pre-computerised CTG) if they are not in labour. CTG monitoring for at least 20 minutes provides an easy and accessible means of detecting fetal compromise. The presence of a normal fetal heart indicates a healthy fetus with a functioning autonomic nervous system. Interpretation of the CTG must be according to the NICE classification of fetal heart patterns.

7.109 The review team found there were many cases where an antenatal CTG was incorrectly classified, or there was a delay in acting upon a clearly abnormal CTG leading to poor fetal outcome.

7.110 *In **2003**, at 37+4 weeks gestation, a woman reported to the maternity triage unit with reduced fetal movements. The CTG was reported as having a baseline rate of 90 beats per minute (grossly abnormal) but there was no escalation made to an obstetrician, an intrauterine death was confirmed 30 minutes later. (2003)*

7.111 *In **2011**, a woman at 34 weeks' gestation attended the day assessment unit with reduced fetal movements and symptoms of pre-eclampsia. She was sent home and informed to return at a later time. When she was eventually seen by a locum registrar four hours later the CTG was interpreted as being abnormal but was not correctly classified and immediate escalation did not occur. Even when the case was reviewed by the consultant there was a delay in expediting birth to a category one caesarean section, instead, opting to perform an obstetric ultrasound scan. The baby was born requiring admission to the neonatal unit and was later diagnosed with hypoxic ischaemic encephalopathy grade 3. (2011)*

7.112 *In **2010**, a woman with a complex social history was admitted to the antenatal ward with preterm pre-labour ruptured membranes, (PPROM) at 29 weeks gestation. The review team found a failure to obtain adequate CTG's and a failure to perform additional fetal wellbeing tests such as a fetal biophysical profile whilst the woman was an inpatient. The review team also found no use of prophylactic use of antibiotics once there was confirmed PPROM, which may have reduced the risk of maternal infection and its complications. There was a lack of communication to the woman and her family and a lack of a clear obstetric plan. An intrauterine fetal death occurred 4 days after ruptured membranes occurred. Examination of the placenta showed there was histological evidence of acute chorioamnionitis[153] and funisitis[154]. There was a complaint made by the family regarding treatment and plans were made with lessons to be learned but there is no evidence from the documentation shared with the review team by the Trust of these actions having been put in place. (2010)*

152 Royal College of Obstetrics and Gynaecologists. Reduced fetal movements: Green top guideline 57 (2011) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

153 See glossary

154 See glossary

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.113 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.114 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

7.115 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.116 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

7.117 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.118 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.119 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD AND CLINICAL REVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.120 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

7.121 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.

7.122 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.123 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

7.124 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

7.125 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Chapter 8

Intrapartum care

Multidisciplinary working

Failure to escalate and lack of senior obstetric input

8.1 Effective communication between healthcare professionals and women is an integral component of safe maternity care, this is absolutely vital during intrapartum care. Maternity services should foster a team approach based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication[155].

8.2 In our first report[156], which was a review of 250 cases across the timespan of the review, evidence was provided that concerns were not appropriately escalated, leading to direct impact on the safety and quality of care provided to women. In this second report the review team has selected vignettes from more recent years to highlight both a failure to learn and a lack of progression at the Trust in terms of governance and learning.

8.3 All midwives and medical staff have a duty to call for help if they consider that a clinical situation requires the direct input of a consultant. The consultant should be responsive and attend in person in complex situations such as the cases outlined in the vignettes below[157].

8.4 *In **2014**, a pathological CTG in the second stage of labour failed to attract the attention of the obstetric team for too long. The trainee was busy but even during the daytime, there was no apparent attempt to call the consultant obstetrician despite a complicated operative delivery of a baby in the operating theatre. This baby now suffers cerebral palsy and no governance review was conducted. (2014)*

8.5 *In **2016** a woman was taken to the operating theatre for an attempted forceps delivery. The baby's head was in the posterior position and the delivery was undertaken by a junior registrar. No attempt was made to rotate the baby's head to the correct position and during the forceps delivery the woman sustained a 4th degree tear. There was no evidence of duty of candour being performed and the issue does not appear to have been raised with the junior doctor as a training issue. (2016)*

Consultant presence on labour ward

8.6 The requirement for consultant obstetricians to be directly involved and lead in the management of all complex pregnancies, labour and delivery, with planned twice daily consultant-led ward rounds was identified as a local action for learning for the Trust within our first report. As the review team has continued to review all of the cases for this report we have found little evidence of planned consultant level reviews throughout the time period of this review. There were many cases which demonstrated that the supervision of trainee doctors during day and night time did not meet the required standards. Many high risk women received minimal obstetric care during the induction of labour and intrapartum period, until a point of midwifery request for review.

155 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. *Safer Childbirth Minimum Standards for the organization and delivery of care in labour (2007)* https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf

National Institute for Health and Care Excellence Safe midwifery staffing for maternity settings (2015) https://www.nice.org.uk/guidance/ng4

156 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.* (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

157 Royal College of Obstetricians and Gynaecologists Safe Staffing (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing/

8.7 *In **2007**, in the death of a woman who was a practicing Jehovah's Witness and who laboured and gave birth to twins, no middle grade or more senior review was received until the final stages of her second stage of labour. Consultant input into her care was only sought when an extensive perineal haematoma was discovered many hours after the birth. (2007)*

8.8 *In **2012** a woman who did not initially want a vaginal birth after a previous caesarean section birth was advised to undergo an induction of labour after pre-labour preterm rupture of membranes with signs of infection. The registrar advised oxytocin to be administered after 2 hours of pushing and the woman pushed in the second stage of labour as the oxytocin continued to be increased for over 4 hours until she suffered a uterine rupture and her baby died. No consultant input was evident within this birth or during the immediate postpartum period. Oxytocin was prescribed by the registrar during advanced labour when there were signs of obstructed labour without first performing a medical review. No apology was given for the mismanagement of this case and the conclusions of the subsequent Trust risk review were not appropriate or relevant to the real issues at the time. (2012)*

8.9 One midwife spoke to the review team in autumn 2021, describing that in a previous trust they had been familiar with a system in which a senior trainee, anaesthetist and obstetric consultant would lead a ward round after handover twice a day. The midwife was concerned that there were no ward rounds at the Trust however when questioning this, the response they received was: *'No, no, no, you are the Band 7 coordinator, you should know when the doctor needs to see the patient'.* The midwife described to the review team how she was laughed at and ridiculed for suggesting that multi professional ward rounds were necessary.

8.10 Evidence was found by the review team that when care was escalated at the Trust there was a failure of the senior clinical team to respond appropriately:

*In **2016**, a woman was admitted to the labour ward with evidence of excessive uterine contractions with a reassuring CTG and severe hypertension. This was escalated to the registrar who decided upon no further intervention. The midwife's written statement indicated unhappiness with this response however these concerns were not escalated further. The CTG was pathological for one hour before delivery of a large for dates baby with significant shoulder dystocia and postpartum haemorrhage (PPH). The baby was later diagnosed with grade 3 hypoxic ischemic encephalopathy (HIE). Escalation and obstetric involvement in this case was poor throughout. (2016)*

8.11 *In **2016**, a woman spent approximately 8 hours on the labour ward, where she received minimal medical input despite midwifery requests for a medical review of her raised blood pressure (BP). At numerous times during the late first and second stages of labour the woman's BP was recorded as 160/105 mmHg or higher which is a medical emergency. Repeated attempts to have the woman reviewed due to her high BP were unsuccessful and when the consultant was informed, nothing was written in the notes and the consultant did not review the woman, instead prescribing an anti-hypertensive which had little effect. During a subsequent major postpartum haemorrhage this same consultant attended, advised on drug use and again documented nothing. The governance review failed to address these issues of lack of consultant review and action. (2016)*

Midwifery leadership and culture on the labour ward

8.12 A lack of documentation regarding decision-making by the labour ward coordinator was often evident when the labour ward coordinator was asked to attend a room for review of a case. Although the role of the coordinator is challenging, with contemporaneous documentation sometimes difficult when dealing with emergency situations, many cases reviewed have failed to demonstrate even any good quality retrospective documentation. The verbal and written communication between the coordinator and obstetrician is paramount and there is evidence that it failed in numerous cases.

8.13 *In **2015**, a woman with a raised BP had her labour augmented with oxytocin for 12 hours without an obstetric review. The labour ward was so busy that the labour ward coordinator was caring for another*

labouring woman and did not perform a 'fresh eyes' assessment on a CTG when asked. The midwife had previously attempted to escalate clinical findings of raised maternal BP, significant proteinuria and an abnormal CTG with no documented evidence that she was supported by senior obstetric or midwifery staff even when the emergency buzzer was pulled due to fetal bradycardia. Eventually a decision was made to expedite the delivery using forceps and the baby required admission to the neonatal unit for suspected infection. (2015)

8.14 It is not ideal for the coordinator to be caring for a woman in labour, although the review team appreciates this can happen occasionally in an emergency situation. This role must be supernumerary so that the labour ward remains safe and there is senior presence available to assist midwives and to facilitate escalation to the obstetric team[158]. Midwives also have a duty to escalate care and challenge decisions when there is a concern about safety[159].

8.15 *In **2016**, a woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

8.16 There is evidence that over a long period of time midwives may have been reluctant to ask for help when working on the Trust's labour ward. One midwife explained to the review team in late 2021 how *'you just tried to keep your head down...asking for help was seen as a bad thing. People were derided for asking for help. Even something simple like a junior midwife asking for support suturing, they were like … [ridiculed]...'.*

8.17 Midwives providing intrapartum care outside the labour ward described facing reproach from labour ward colleagues when they telephoned regarding a possible need to transfer the woman to labour ward. One midwife outlined the challenges midwives faced when transferring women into labour ward or planning ahead when the clinical picture of the woman they were caring for started to change stating that there was *'a bullying culture'* on the labour ward.

8.18 The same midwife explained to the review team how the general culture on the labour ward was to joke that the transferring midwife did not know how to look after a woman in labour, for example, *'Do you not know how to look after a woman in labour? So that was the culture. It started off as being a little bit more of a jokey sort of thing, then it became really quite insidious so that I used to dread it, I would dread ringing. In the end I would say…this is the situation I am bringing the lady up, expect me in an ambulance in forty five minutes, and then I would always get, well if you bring her up, you would have to look after her yourself'.*

8.19 Another midwife told the review team in autumn 2021 of a culture of bullying on labour ward. *'Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it.'*

8.20 A further example was provided by a midwife who described being belittled when asking for support on the midwifery-led unit due to an excessive and complex workload. *'I said: "I can't accept somebody in labour because there are nine women, nine babies, a midwife who's not familiar that needs my support as well and I don't feel it's safe…" [A manager] came storming down and said, "You've got no authority to close this MLU", and I was like, "I'm not closing the MLU, I'm saying that we need further support to be able to safely do this." [The manager] belittled me in front of a group of staff there and told me, "You're taking this woman".'*

8.21 The same midwife also commented on how midwives were belittled when transferring women to the labour ward: *'You'll hand over care to somebody on the consultant-led unit and the comments that they make*

158 Ibid n1 and Royal College of Midwives. *RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings* (2016) https://www.rcm.org.uk/publications/publications/rcm-guidance-on-implementing-the-nice-safe-staffing-guideline-on-midwifery-staffing-in-maternity-settings/

159 Nursing Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* (2015, updated 2018) https://www.nmc.org.uk/standards/code/

in front of the woman, can be very belittling and degrading to your face in front of a family and that's not cohesive. That's not putting the woman first'.

8.22 It is evident from considering numerous reviews and hearing staff voices throughout the autumn and winter of 2021 that there continues to be some major issues relating to the culture of intrapartum care at the Trust. Influencing factors include human factors, leadership from senior clinicians, lack of escalation, locum doctors working for many years with little supervision, lack of robust governance processes and a lack of multi-professional working.

8.23 The culture of intrapartum care at the Trust may have resulted in harm to mothers and babies due to failure in escalation to the most appropriate professional in a timely manner. This starts with the allocated midwife not escalating to the labour ward coordinator. The coordinator in turn fails to escalate to the consultant, when the trainee is either busy or is performing practice against guidance (for example unsafe operative delivery and, in particular, a number of inappropriate breech deliveries). These examples continue throughout the period of the review to the very end. Examples of these are detailed throughout this report.

8.24 The direct links between incivility and patient safety have been well documented. Civility Saves Lives[160] sets out the detrimental impact uncivil behaviours have on team functioning, decision-making, performance and safety. The consultant obstetrician and labour ward coordinators have an integral role to play in role-modelling the professional behaviours and personal values that are consistent with positive team working, including the demonstration of respect for colleagues and women[161].

Use of medical locums at obstetric middle grade

8.25 The review team found that there appeared to be a high reliance on the locum medical workforce working at middle grade at the Trust without evidence of documented supervision and governance.

8.26 *During the birth of twins in **2015**, a family told the review team the doctor was 'so aggressive, he was shouting. The midwives didn't like him; that was obvious'. The doctor conducted a poorly managed twin delivery and walked out of the room (not to return) during a postpartum haemorrhage and episode of extreme hypotension. The Trust has not shared any evidence of learning or the development of actions following this case with the review team. (2015)*

8.27 *In **2016** a locum doctor failed to recognise or intervene during a 40 minute terminal bradycardia resulting from acute intrapartum hypoxia. After alienating both the midwife and woman, he was told to leave the room and did so without any further delivery of care. The baby was born with HIE and severely acidotic cord blood results. The Trust risk review process was not robust and there was no evidence of internal reflection. The RCA report failed to investigate and recognise that this incident occurred due to gross lack of team working, failure in escalation, failure to monitor the actions of locum staff, failure to recognise acute bradycardia in labour and failure to document to an expected standard. The report concluded that, 'it is difficult to understand the team dynamics'. (2016)*

8.28 The review team found several examples where locum doctors acted unsupervised, leading to poor outcomes for mothers and babies. Equally it appears that there were not clear escalation plans to the consultant or midwife in charge. In cases of adverse outcomes there is evidence that these were not investigated in line with the incident framework utilised at the time and individuals were not held to account.

8.29 Consultants must be visible, approachable and demonstrate effective leadership skills, enabling other team members to speak up when something is wrong, ensuring good information flow and clinical prioritisation[162].

8.30 The widespread shortage of suitably qualified obstetricians who can safely undertake the role of senior resident doctor out-of-hours with indirect supervision from a consultant who is non-resident has been well documented. The RCOG has highlighted the need for adequate support and supervision of locums

160 Civility Saves Lives. Civility Saves Lives (2017) https://www.civilitysaveslives.com

161 Ibid n3

162 Ibid n3

who enter the workplace and has recently released guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales[163].

8.31 Locum doctors are employed to cover staffing shortfalls and trusts should have appropriately robust recruitment processes in place including assessment of their skills and knowledge, with structured feedback and support before they are released to work independently.

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.32 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

8.33 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

8.34 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

8.35 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

8.36 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out and feel able to speak out when they have concerns about safe care.

Fetal Assessment and Monitoring

8.37 National intrapartum guidelines[164] recommend intermittent auscultation (IA) of the fetal heart rate (FHR) in low-risk pregnancies and continuous FHR monitoring if there are abnormalities such as tachycardia or decelerations, meconium, bleeding, or interventions such as epidural analgesia or oxytocin administration.

8.38 Intrapartum monitoring of the baseline FHR, presence of decelerations, and visually determined FHR variability are used to assess the risk of fetal acidaemia[165] via a set of clinical guidelines. However, FHR abnormalities during labour rarely correlate with fetal compromise because the FHR is highly sensitive to hypoxaemia/hypoxia (both common during labour), but lacks specificity for fetal acidosis, the end point of intrapartum hypoxia.

8.39 On the one hand this mismatch results in increased operative delivery of non-acidotic babies; whilst clinicians on the other hand may miss fetal compromise because current guidelines remain silent on the adverse role played by intrapartum factors, which impair fetal adaptation to the challenges of labour such as fever, chorioamnionitis, meconium, abnormal fetal behavioural states, and excessive head moulding. National perinatal audits and quality improvement programmes such as the Confidential Enquiries into

163 Royal College of Obstetricians and Gynaecologists *Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales*. (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/safe-staffing/rcog-guidance-on-the-engagement-of-long-term-locums-in-maternity-care.pdf

164 National Institute for Health and Care Excellence *Intrapartum care for healthy women and babies* (2017) https://www.nice.org.uk/guidance/cg190

165 See glossary

Stillbirths and Deaths in Infancy (CESDI) and Each Baby Counts (EBC) have highlighted the significant contributions of these conditions to adverse perinatal outcomes.

8.40 In our first report we found significant problems with the conduct of intermittent auscultation and the interpretation of CTG traces. The review team found problems with intermittent auscultation of labour throughout the entirety of the review period right up to the very end of the review timeline. Vignettes from the cases considered by the review team are presented below which continue to illustrate significant knowledge gaps and examples where the care of complex cases was left in the hands of inexperienced staff.

Failure to recognise and/or escalate the abnormal CTG in early labour

8.41 *In **2012**, a woman presented to the MLU in labour. A CTG was performed on admission, which was reassuring, and early labour was diagnosed. The woman described her pain as constant, but the midwife did not perform an abdominal examination. Intermittent auscultation (IA) showed a significant drop in the baseline fetal heart rate (FHR) although remaining within normal parameters. The FHR was not auscultated for 1 full minute following a contraction. The FHR was auscultated prior to the lady entering the pool and found to be 90bpm. There was a delay in escalation. The baby was born in very poor condition and was later diagnosed with cerebral palsy. The family had concerns that the FHR was not listened to enough. The Chief Executive's letter to the family incorrectly stated that the FHR would be auscultated every 30 minutes during labour. (2012)*

8.42 Fetal bradycardia should be reviewed urgently by an experienced obstetrician to exclude irreversible obstetric emergencies (abruption, cord prolapse and uterine rupture) and to correct reversible causes such as supine or epidural hypotension and uterine hyperstimulation due to excessive oxytocin use. Urgent delivery should be undertaken where indicated if the bradycardia does not improve.

8.43 *In **2012**, a multiparous woman with an uneventful pregnancy had a membrane sweep at 41^{+2} and at 41^{+4} weeks and later admitted to the MLU contracting regularly. The woman presented with a temperature of 37.7^{0}C, maternal heart rate (MHR) 120bpm, and cervix 3cm dilated. Following concerns the woman was transferred and arrived on the labour ward 2 hours later. A female baby was delivered in poor condition by ventouse with an Apgar score of 1[166] at 1 minute and 1 at 5 minutes. Despite intensive resuscitation the baby died after 40 minutes. Post-mortem findings were consistent with infection as a cause of the death. (2012)*

8.44 Clinicians should always consider factors which can influence the fetus. Antenatal factors such as placental insufficiency, intrauterine infection, meconium aspiration, hypoglycaemia, recreational substance abuse or fetal brain injury can all influence fetal heart rate patterns. Where suspected, these cases should all be escalated urgently to make an appropriate plan for delivery.

8.45 *In **2018**, a woman in labour had meconium stained liquor and fetal tachycardia. The family were given the option to 'carry on' with the labour or opt for immediate caesarean. There is no evidence of discussion with the consultant regarding an appropriate plan of care. The CTG was not considered pathological by the maternity review team and therefore to give the woman 'an option' to have a category 1 caesarean is not the standard practice. There is also no evidence that a further vaginal examination was performed prior to the caesarean to exclude or confirm full dilatation, in which case an emergency caesarean may not have been necessary. (2018)*

8.46 Fetal heart rate tachycardia associated with meconium staining of the amniotic fluid raises the likelihood of fetal infection significantly. The team should involve a consultant in the management as soon as possible to set out a plan of care, and the family should be involved in a Montgomery[167] compliant manner.

166 See glossary

167 https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/december-2016/montgomery.pdf

Augmentation

8.47 Augmentation of labour is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour. This can be achieved either by intravenous oxytocin infusion and/or artificial rupture of membranes.

Use of oxytocin

8.48 Oxytocin can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and to facilitate cervical dilatation and vaginal birth.

8.49 Many examples of the injudicious use of oxytocin were highlighted in our first report. The review team has found further examples of inappropriate oxytocin use which impacted upon fetal wellbeing and neonatal outcomes suggesting that sufficient learning from previous cases had not occurred. A common theme identified by the review team was the inappropriate commencement and continuation of oxytocin despite evidence of deterioration of the baby's condition.

8.50 Oxytocin should only be used when there is a valid indication and potential benefit for its use and appropriate guidelines and equipment available to support its safe administration. One-to-one midwifery care must be provided and the FHR rate and maternal contractions must be closely monitored. The identification and escalation of any concerning features relating to CTG changes should occur promptly and oxytocin reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns.

8.51 Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour. Decision-making regarding the plan of care and mode of birth should consider any additional risk or intrapartum factors which impair fetal adaptation to the challenges of labour and the stage of labour that has been reached.

8.52 *In **2012** a woman presented in spontaneous labour at 30 weeks' gestation. After an hour of pushing in the second stage, the fetus remained high in the pelvis with a pathological CTG. An oxytocin infusion was commenced. After a further hour of pushing, the woman consented to a trial of instrumental delivery in theatre. A manual rotation was undertaken followed by the application of Wrigley's forceps with a presenting part level with the ischial spines. No descent was noted after one pull. An emergency caesarean section was undertaken, and the infant was delivered in poor condition. The infant was resuscitated, but later died due to complications of severe hypoxic ischaemic injury and massive hypoxic damage to multiple organs. (2012)*

8.53 *In **2014**, a woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken by the Trust but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change future clinical practice. (2014)*

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.54 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

8.55 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

8.56 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors

Midwifery-led units

8.57 There are five Midwifery-led-units (MLUs) that have provided antenatal, intrapartum and postnatal care in addition to the consultant maternity unit at the Trust, during most of the time period of this review. The Royal Shrewsbury Hospital, (RSH) in Shrewsbury, provided consultant-led care until 2014. Consultant obstetric services were relocated to the Princess Royal Hospital (PRH) in Telford in 2014. An overview of births by each MLU is provided in table 1 below. The review team is advised that Wrekin MLU has recently moved to a new location adjacent to the Shropshire Women and Children's Centre at the PRH.

Table 1: Births by MLU Overview (Source: SaTH Clinical Dashboards)

MLU	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bridgnorth	69	68	75	68	82	77	26	4	0
Oswestry	87	72	74	69	83	52	15	4	0
Ludlow	86	71	62	49	51	36	12	4	0
Shrewsbury	478	421	367	235	207	142	120	69	15
Wrekin	435	401	362	336	359	337	351	285	224

8.58 Issues relating to MLU closures and staffing availability have been highlighted within the local press and Telford and Wrekin CCG's Quality and Safety Report in 2013. Staff shortages within maternity are also raised as an issue within the Trust's 2021 CQC report[168] and remain an urgent wider issue for maternity care on a national basis.

8.59 Evidence from staff who have contacted the review team suggest that there was an expectation for midwives working on the MLU to manage with reduced staffing. A midwife who had worked at the Trust until 2021 commented that: *'historically, whilst working in the MLU, there was an expectation to stretch the boundaries of what was considered normal…MLU staff are seen as less important, less valuable, and less skilled. There can be poor conversations between teams frequently but teams working together stick together and support one another. This remains to this day. There is a very toxic culture within the place and it seems impossible to break despite some individuals trying to raise as an issue - myself included and part of the reason I have now left'.*

8.60 Another long term community midwife reflected on the impact this had on safe care provision on the MLU where there were *'...incidents where we are caring for a woman and the second midwife has been told to leave the unit to move to another area. This is unsafe practice as there should be two midwives on the unit when a woman is birthing at all times'.*

168 Care Quality Commission Inspection (2021) https://www.cqc.org.uk/provider/RXW?referer=widget3

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.61 Midwifery-led units must complete yearly operational risk assessments.

8.62 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

8.63 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

Delay in escalation and taking appropriate action

8.64 The review team found evidence of failure to appropriately document the FHR and undertake continuous electronic fetal monitoring (CEFM) using a CTG when abnormal FHR changes were detected on the MLU. Evidence of this has also been presented above. Information gained from any investigations performed after a birth were not always shared with women and families, and evidence of appropriate governance and shared learning from such incidents is frequently unavailable.

8.65 *In **2006**, a multiparous woman was noted to have an abnormal FHR whilst in labour on the MLU. This was not acted upon, a CTG was not performed nor was the case escalated. The woman suffered a stillbirth. In the bereavement follow-up appointment the consultant gave incorrect information and initially withheld information from the parents about the possible cause for their baby's death. (2006)*

8.66 *In **2010**, a primiparous[169] woman attended the MLU in labour. Intermittent auscultation (IA) was started, however there was a delay in starting CEFM when this became abnormal. Eventually the CTG was started and a further examination was undertaken which revealed a cord prolapse. Emergency transfer was arranged and delivery by caesarean section. The baby was born in poor condition and required cooling. There were missed opportunities for earlier transfer. (2010)*

8.67 *In **2010** there was a failure to appropriately document intermittent auscultation (IA) of the fetal heart and commence CTG monitoring for a woman labouring in the pool with meconium. There was a significant delay from the time of decision to transfer to the Royal Shrewsbury Hospital (RSH) to calling the ambulance for transfer. The midwife failed to ascertain the fetal wellbeing during transfer. Following admission to labour ward a CTG was commenced and was abnormal. The midwife escalated her concerns to the registrar and prepared the woman for an emergency caesarean section. Due to the workload of the labour ward the registrar was called away to attend a twin birth and there should have been escalation to the on-call consultant, who should have attended. The baby was born in poor condition, intubated and received cardiac compressions before receiving hypothermic cooling. (2010)*

8.68 A number of the MLU cases reviewed by our team reflected some of the wider issues found on the labour ward relating to failures in appropriate escalation and consultant obstetric review once transfer to the consultant-unit was achieved. In a number of cases there was inappropriate risk assessment and management of labour when women presented with a history of reduced fetal movements. The wider clinical picture was not always appropriately assessed and acted upon. Evidence of poor teamwork and communication during transfer has also been presented elsewhere in this and other chapters of this report.

169 See glossary

8.69 *In **2010** a mother self-referred to Wrekin MLU with absent fetal movements and abdominal pain. There was a failure of the two midwives working there to recognise the evident clinical signs of placental abruption: an obstetric emergency. There was no attempt to cannulate the mother and it took 80 minutes to assess her and order a "blue light" ambulance transfer from Telford to Shrewsbury. No paramedic crew were requested. Arrival time at the consultant-unit from initial admission was 1 hours 45 minutes. Following arrival there was appropriate assessment and whilst the baby's death appeared unpreventable there are many care delivery issues that suggest that learning from this event was required. Postnatal care was not appropriate and there was no obstetric documentation in the notes until 09.45 the next day. There is no evidence of a governance review or learning from this case by the Trust. (2010)*

8.70 *In **2013** a woman with a history of multiple miscarriages attended the MLU for a post-term membrane sweep at 40+5 weeks gestation. A fetal bradycardia was noted prior to the procedure and the woman walked over to the consultant-unit and was in theatre within 20 minutes for a category 1 caesarean section. There followed a delay of 17 minutes after the consultant arrived in theatre where he discussed the possibility of not performing a caesarean section. The parents opted to proceed and the baby was born in poor condition and developed severe cerebral palsy. Neonatal care at all points within this case was excellent. The SI investigating team was solely made up of midwifery staff with no evidence of inclusion of an obstetrician, neonatologist or Trust executive all of whom would be expected to have involvement in this level of investigation. (2013)*

8.71 *In **2016** a primigravid[170] woman called Wrekin MLU at 09:18 stating that she did not think things were right as her baby was not moving as much and the pattern of movements had changed. She was advised to lie on her side, have a cold drink, and focus on the baby's movements over the next two hours. The woman responded that she had done all of that already and still had reduced fetal movements. The MLU staff member responded that they had a lot on that morning so to wait until lunchtime before coming in. On arrival there was difficulty ascertaining the FHR, an ultrasound scan (USS) performed and urgent transfer to the consultant-unit was arranged where a category 1 caesarean section was performed. The baby was born in poor condition and died the following day. The parent's comments suggest that they were put off attending the MLU earlier that day when they phoned with concerns because the unit was busy. The parents expressed many concerns about the bereavement care, the lack of information and their belief that the emphasis was on damage limitation for the hospital. (2016)*

8.72 A midwife employed at SaTH for many years who left in recent years[171] told the review team that: *'The MLU's practice needed to be standardised and updated as practice was not evidence-based. There was nobody competent to update guidelines, what guidelines they had were not evidence-based'.* In relation to learning from incidents the midwife emphasised that there was a reluctance to rotate staff to different clinical areas for updating for fear of upsetting people and *'When an incident happened, once the cause had been identified and the actions agreed it took too long to implement change'.* The review team notes that many guidelines have since been reviewed and updated.

8.73 Recent findings from national perinatal surveillance data which focussed on intrapartum stillbirths and intrapartum-related neonatal deaths in planned births at freestanding MLUs and those alongside consultant-led units found that in 75 per cent of deaths improvements in care were identified that might have made a difference to the outcome for the baby[172]. The authors conclude that these findings do not address the overall safety of midwifery-led settings for healthy women with straightforward pregnancies, but suggest areas where the safety of care can be improved. Issues with care were identified around risk assessment and decisions about planning place of birth, intermittent auscultation, transfer during labour, resuscitation and neonatal transfer, follow-up and local review.

170 See glossary

171 Date of leaving provided to review team but not stated to maintain confidentiality of staff member

172 Rowe, R, Draper, ES, Kenyon, S, Bevan, C, Dickens, J, Forrester, M, Scanlan, R, Tuffnell, D, Kurinczuk, JJ. I*ntrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry*. (2020) BJOG 127

8.74 Findings published from a national cross-sectional survey of all 122 UK maternity services found that 92 per cent of local admission guidelines varied from national guidance[173]. These findings suggest that variation in admission criteria for MLUs exists nationally which presents a potentially confusing and inequitable basis for women making choices about planned place of birth. An earlier study also found that local guidance for transfer of women from MLUs to consultant units were of poor quality[174].

8.75 *In **2018** a woman made numerous contacts with Wrekin MLU triage throughout her pregnancy and early labour due to concerns about reduced fetal movements, bleeding and spontaneous rupture of membranes (SROM). Based upon national guidance it would have been appropriate for the woman to have been transferred to the consultant unit. Local Trust guidance did not align with national guidance. The baby was born in poor condition on the MLU and despite extensive resuscitation and neonatal support a decision was made to withdraw care and the baby subsequently died. (2018)*

8.76 National guidance recommends that when there are maternal concerns about fetal movements, the woman and the baby should be assessed (NICE, 2021). It is important that this assessment takes into consideration the full clinical picture and previous history of reduced fetal movements.

8.77 The importance of ensuring that women undergo a risk assessment at each contact throughout the pregnancy pathway was presented as an essential action in report 1. The review team continued to find evidence that this did not always happen. 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 which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.

Vaginal breech birth

8.78 Further evidence of poor escalation, failure to involve the consultant obstetrician and to respect women's wishes in relation to mode of birth were evident within the vaginal breech cases reviewed across the timespan of the review. Women reported to the review team that they were persuaded to have a vaginal breech birth without the associated risks being explained or there was a failure to make decisions regarding mode of birth in a timely way. There is a lack of evidence that governance processes were fully implemented which may have provided the Trust the opportunity to refine its decision-making processes, define the personnel needed for a safe breech vaginal delivery and refine the escalation pathways on the labour ward.

8.79 *Request for consultant advice or attendance was never made for the vaginal breech birth of a woman at 36/40 weeks gestation in **2003**. There was a lack of formal documentation regarding the mother's birth wishes and advantages and disadvantages of mode of birth. The middle grade doctor was asked by the midwife to examine for footling breech but declined to do so. It was inappropriate for the most inexperienced member of the medical team (SHO) to be conducting a footling breech delivery alone in the labour room without registrar or consultant attendance. During the birth an emergency caesarean section was arranged. There is no documentation of involving the consultant in any way and when the consultant attends in theatre [they] appear surprised in [their] notes at the impending situation. The baby was born with no signs of life and after extensive resuscitation died at approximately 3 hours of age. (2003)*

8.80 *There was a failure to appropriately plan and escalate care for a woman at 31 weeks' gestation in labour with prolonged premature rupture of membranes in **2011**. On the day of delivery, there was a failure to escalate for consultant decision-making, failure to make definitive decisions regarding the mode of delivery, failure to have adequate and highly trained individuals at the delivery, and failure to understand that a footling breech delivery at 31/40 weeks is relatively contraindicated by local and national guidelines. There was also no internal investigation of this case and so no evidence of lessons learned. (2011)*

173 Glenister C, Burns E, Rowe R. *Local guidelines for admission to UK midwifery units compared with national guidance: A national survey using the UK Midwifery Study System (UKMidSS)*. (2020) PLoS One. Oct 20;15(10):e0239311. doi: 10.1371/journal.pone.0239311. PMID: 33079940; PMCID: PMC7575094.

174 Rowe RE. *Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality.* (2010) Quality and Safety in Health Care19 (2):90-4.

Management of twin pregnancies and births

8.81 Some of the issues within this section reflect the findings presented previously in this chapter, namely unsafe operative delivery, inappropriate use of oxytocin and a failure to escalate care with the added complication of a twin delivery to consider. The review team found significant concerns with the management of twin labour and births throughout the whole of the review period right to the very end of the review.

8.82 *In **2013**, a primiparous woman with an IVF conceived twin pregnancy was induced at 36+5 weeks gestation as the second twin was found to be small. After one hour of pushing a decision was made for trial of instrumental delivery in theatre under spinal anaesthetic by a consultant and registrar. The first twin was born in good condition following a Keilland's forceps rotation. The second twin was born 37 minutes later by Neville Barnes forceps, after a total of 9 attempts at delivery by ventouse and Keilland's forceps. The baby was born in very poor condition and required resuscitation and transfer to the NNU where he underwent cooling and had multiple blood transfusions. He was subsequently diagnosed with moderate to severe HIE, subgaleal and subdural haemorrhage with depressed bilateral skull fractures. The administration of second stage oxytocin did not follow any guideline or regime. There was no concluded Trust investigation provided to the review team. (2013)*

8.83 *Inappropriate use of oxytocin and poor CTG management was noted with no escalation during the labour of a woman with a twin pregnancy at 35+4 weeks gestation in **2013**. The second twin's birth was not expedited when it should have been and the baby was diagnosed with HIE 2. There was no obstetrician or neonatologist in the room for the birth of twin 1 despite twin 2 being breech, they were called to assist with twin 2 following a placental abruption and the baby required a vaginal breech extraction. (2013)*

8.84 *A woman was admitted to hospital in **2014** at 34+6/40 weeks gestation with a suspected urinary infection with uterine tightenings. It was found that that both twins had died in utero. Placental abruption was noted at birth, with partial dehiscence of the uterine scar. Brown liquor was also noted which was mildly offensive. (2014)*

8.85 *The antenatal care was complex as the woman had numerous admissions to hospital for abdominal pain and tightenings, urinary symptoms and back ache. It was noted that the CTGs during admissions often had loss of contact or poor quality interpretation that was not escalated. The woman's voice was not heard as it was documented that there were reduced fetal movements but no action was taken. The woman met with the Trust who made promises around improving bereavement support, but the mother told this review that it felt that this was not actioned. (2014 until 2020)*

8.86 *In **2016** a woman who had a twin pregnancy, complicated by twin to twin transfusion syndrome, developed pre-eclampsia and was allowed to go home despite signs of evolving pre-eclampsia. Subsequently one twin died and the governance review documentation leans towards blaming the woman for the outcome, as she decided to go home rather than accept the 'offer' to remain in the unit as an inpatient. (2016)*

Management of high-risk and complex mothers

8.87 In a significant number of cases the review team found evidence that the poor outcomes in mothers and babies were caused mainly because clinicians failed to recognise women at high risk of medical complications. They failed to respond adequately to problems arising during labour, failed to make appropriate clinical decisions and failed to respond in a timely manner to signs of impending serious complications such as severe hypertension and significant antepartum haemorrhage. There were many instances of poor communication between doctors and midwives which led to inappropriate and delayed clinical decision-making.

8.88 *A woman presented on multiple occasions around term with hypertension and proteinuria in **2009**. There were missed opportunities to manage hypertension appropriately with the woman returning at least four times for assessment of blood pressure, when there could have been consideration for delivery. During this time she saw a relatively junior member of medical staff and there was a failure to consider the worsening*

picture of pre-eclampsia and no involvement of the labour ward coordinator. There appeared to be no urgency to treat the severe hypertension and there was little thought as to whether to give magnesium when this was appropriate. The baby was born in poor condition with Apgar scores 1 at 1 minute and 6 at 5 minutes. (2009)

8.89 *In **2017** a primigravid woman in spontaneous labour developed mild intrapartum hypertension. She required emergency caesarean delivery and received ergometrine intraoperatively. Subsequently, she developed significant postnatal hypertension and required treatment. Her medical records and subsequent correspondence indicate significant friction between the midwives and the registrar over the administration of ergometrine and its subsequent effect. The parents' concerns and communication about investigation of the drug error were poorly handled, leading to a formal complaint. (2017)*

Psychological birth trauma

8.90 The degree of life-long psychological trauma revealed by families in this report is harrowing and profound. Women and families have given graphic written and verbal accounts describing their recollection of events that have led to long-term depression, anxiety, distressing memories and post-traumatic stress disorder (PTSD). Some have sought psychological treatment, whilst others have remained silent until now.

8.91 Descriptions of physical trauma, pain, lack of attention, vulnerability, unkind words, swearing, sarcasm and bullying towards women as well as unkind treatment of colleagues, amongst midwives and obstetricians have been found to be widespread throughout the review period.

8.92 *A woman who gave birth in **2009** told the review team: 'I was lying on the table and was prepared for surgery but they couldn't find the anaesthetist. The senior midwife said to the assistant who was there "If this baby dies it's on his head". I reminded her I was still awake and she said "sorry no it will all be fine...". After the anaesthetist was found I was put under. My husband who was waiting outside was told 'go and walk round the car park for 45 minutes. But I have to prepare you don't hold out much hope for the baby' I had counselling after the experience but still felt I needed to complain as I knew how lucky we had been that our daughter was not only alive but well. I wrote my concerns down and the response I had just made me so angry. It didn't address any of my concerns…it was so bad that to be honest I gave up and just tried not to think about it.' (2009)*

8.93 There were many cases reviewed in which the care provided aligns with national standards and where there is evidence of the maternity team at the Trust going above and beyond the usual expectations in an attempt to support women. It is evident that for many women, any deviation from the expected progress of events, such as passage of meconium, bleeding of any degree or suspicious features on CTG is recalled by them years later as a failure of appropriate care.

8.94 Sometimes, despite documented good quality care and reassurances, the woman's recollection is terror, guilt, suspicion and feelings of Trust cover up. In addition, many women perceived any deviation from normality to be an indicator that a caesarean section was needed and that this was subsequently denied to them by the Trust. Despite this, the review team has seen many cases of meconium stained liquor, marginal placental abruption and mild infection that were managed appropriately with a trial of labour and outcomes that have been satisfactory.

8.95 *In **2017**, a woman whose baby presented in the occipito-posterior position laboured for 15 hours having experienced a small antepartum haemorrhage. The woman received very good care during labour with ongoing and appropriate efforts to address her anxiety and analgesia requirements. A caesarean section was performed within a standard timeframe and both mother and baby were well following this. Despite good care, the woman's recollection of labour has developed into ongoing treatment for PTSD. (2017)*

8.96 Formal diagnosis of PTSD is a common finding in the review and despite the evidence of some good care as detailed above, there were also many cases reviewed that demonstrate poor management in labour that resulted in ongoing physical and psychological harm for women as detailed in the following vignettes.

8.97 *In **2011**, a woman suffered psychological harm after being accused of 'being lazy in labour'. Also, as an employee of the Trust, she was advised against making a complaint. (2011)*

8.98 The review team has heard recollections from women relating to feelings of loss of control and power, **(2016)**, excessive and painful vaginal examinations **(2003)**, not being listened to **(2002; 2004; 2015; and 2016)** which resulted in psychological trauma for themselves and on occasion their birth partners.

8.99 *In the case of a forceps delivery and a missed recto vaginal fistula in **2009**, a woman told the review team: 'Following my daughter's birth by forceps, I was passing wind through my vagina. My wound was never checked whilst I was a patient in the hospital. It was only when I got home that a midwife asked me how I was and I said I felt something wasn't right. She did then check me at home but found no problem. A couple of weeks later I went to see my GP about it and I was referred back to the hospital.*

8.100 *I saw a consultant obstetrician. After examining me the doctor informed me that I'd had a large baby and that had caused in her words "a baggy fanny". To say I was upset is an understatement and despite telling her that I could tell the wind was coming from my back passage and passing through to the front, she said no further investigation was required. My issues got worse and the anxiety of going outside and embarrassing myself by having no control of passing wind meant I became nervous, anxious and depressed which seemed to exacerbate the situation. All of which resulted in upset stomachs and loose stools which resulted in my passing faeces through my vagina. Feeling that I should have pushed this matter further in the hospital made me feel inadequate as a mother. With the fistula causing personal care issues for me, the depression got worse. It wasn't diagnosed for quite some time. The emotional effects of all this still affect me 10 years on.' (2009 -2019)*

8.101 *A consultant said to a woman with physical disabilities in* **2008***: 'How do people like me get pregnant, who would do that [have sexual intercourse] to me, and did I know what I was doing?'. (*2008*)*

8.102 *Many women describe how they moved to different units for subsequent births or even to other countries. One woman in **2013** described to the review team how she could never contemplate giving birth in the UK again and found her experiences in the USA far more acceptable. (2013)*

8.103 *After not feeling listened to in **2016** another woman described: 'not having the courage to stand up and advocate for herself'. (2016)*

8.104 The few cases of maternal ICU admission for life-threatening illness are strongly associated with ongoing psychological morbidity and PTSD and women have expressed their strong desire for professional psychology services to be available to them.

8.105 *In a case of chorioamnionitis and failure to act on a pathological CTG in **2012** a woman told the review team: 'They spent half an hour trying to resuscitate my daughter in the corner of the room, didn't say anything to us until it was: "I'm sorry, but we couldn't save her". [I said] "But you were telling us everything was fine". On top of that, the aftercare was absolutely appalling as well. They left us in the [delivery] room for I don't know how long and then they put me in a wheelchair, gave my daughter to me, put us in a room and left us there basically. What was even worse, they put us on the maternity ward so we could hear babies crying. We could hear people being congratulated'. (2012)*

8.106 *Following a cardiac arrest in **2014**, a woman still finds it difficult to come to terms with her condition and feelings she could still die. She described to the review team unhelpful comments from an unknown doctor saying, ' "Hi, I was the guy that restarted your heart". I couldn't cope with that. I was really struggling with the gratitude I felt for the people that had saved my life but also needed some counselling.' (2014)*

8.107 *There were failings within the MDT in **2014** to manage a woman's history and experience of childhood sexual violence. There was evidence of a disconnect between the midwifery notes and the woman's recollection of events. Following her birth experience, the mother contacted the review team to help her to determine if her PTSD, and a birth injury which took years to heal, and left her unable to work is 'normal and acceptable'. The woman explained to the review team that she had been unable to leave the house between 2014 and 2018.*

8.108 Evidence that staff at the Trust often try to settle fears and anxieties is present in many case reviews yet long term psychological harm has still occurred. Postnatal discussion meetings have routinely been offered to women at the Trust over many years but a debrief with a midwife is often not enough for women who have harboured deep seated anxieties and memories and have complex clinical questions that require answers. Most midwives in the UK are not trained to provide professional counselling and may not have the clinical knowledge to adequately explain clinical scenarios that require the input of an obstetrician, neonatologist or anaesthetist.

8.109 It would seem that women receiving their maternity care at the Trust may require the opportunity to review their birth experience more often and in a different way than is currently provided, even if the care was perceived as good. In cases where clinical care was below optimal or complications occurred, ongoing psychological support for women is necessary.

8.110 The NHS Long Term Plan[175] renewed the commitment for the NHS to improve specialist perinatal mental health services. The Perinatal Mental Health Programme and the Maternity Transformation Programme are working together to fulfil this ambition to enable maternal mental health services to be improved by establishing nationwide Maternity Outreach Clinics by 2023/24. This service will help provide support for women with moderate to severe complex mental health problems resulting from their maternity experience and is expected to address issues such as PTSD, perinatal loss and tocophobia (fear of childbirth).

8.111 In July 2020, NHS England and NHS Improvement invited proposals for pilot areas for the testing and development of a maternal mental health service. Shropshire Telford and Wrekin were selected as an early implementer and have revised and updated their Maternity Mental Health guidance. There is evidence that the Trust is working towards improving access to perinatal mental health services.

Conclusion

8.112 This second report builds upon our first report[176] published in December 2020. In that first report, evidence was provided that concerns were not appropriately escalated, leading to a direct impact on the safety and quality of care provided to women and their babies. In this second report which concludes our review of family cases the review team has highlighted both a failure to learn and a lack of progression at the Trust in terms of governance and learning across the timespan of the review.

8.113 In this chapter the review team has highlighted the essential need for effective communication between all healthcare professionals providing maternity care and the women they provide that care for. We have highlighted numerous examples where communication was not at the standard expected or required. As with other chapters in the report there is an ongoing concern from maternity staff at the Trust feeling unable to speak out and raise concerns about care at the Trust. This is an issue that requires urgent action and resolution at the time of publishing this report.

175 NHS England. *The NHS Long Term Plan* (2019) https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

176 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*. (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Chapter 9

Postnatal care

9.1 There is a need for continuing midwifery and multi-professional observation of the mother and her baby during the postnatal period since serious events or deterioration of already known conditions can occur in this time. The time after the birth of a baby is often when new mothers report they feel most vulnerable, with vulnerability increased where a woman already experiences social disadvantage or pre-existing medical co-morbidities. It is essential, therefore that postnatal care is safe, supportive and compassionate.

9.2 The importance of senior (consultant) involvement in acute care, including postnatal care, was emphasised by the RCOG 2021[177] when it noted that 'consultants must ensure that they fulfil the standard that all women should be reviewed within 14 hours of admission' and that 'this standard also applies to postnatal admissions'. This is not new advice, and reiterates Keogh[178] standard 2 first published in 2015 and emphasised by MBRRACE UK 2019[179]. MBRRACE advised a 'review of guidance [was] needed to ensure that deviation from the usual clinical pathway, with unexpected, or unexplained, symptoms [then] triggers a consultant review'. MBRRACE also noted 'These enquiries have emphasised repeatedly the importance of senior review in relation to abnormal postnatal symptoms'.

9.3 Overall improvements in postnatal care across the wider maternity system require significant investment in both workforce, and technology, especially the improved availability of information technology on postnatal wards and across the community too. Midwifery and support staffing on postnatal wards is often poor, and across England maternity teams will recognise that staff are moved from postnatal wards and the community when there are staff shortages in those areas considered to be more acute, such as the labour ward. Across postnatal care the staff at the Trust have described to the review team how they are stretched beyond capacity. This can then lead to poor physical, social and emotional care provision for mothers and their babies.

9.4 Early postnatal discharge from hospital to home is not always appropriate, despite pressure (which can be from families or the maternity service) for women to leave hospital soon after birth. It must therefore only occur if clinically appropriate, and there must be appropriate support in the community after discharge. Across England, improved midwifery and support staffing levels in postnatal care will improve the safety of that care and lead to an increase in family satisfaction. Consultant job planning must also be considered to ensure that postnatal reviews are a timetabled activity.

Lack of consultant involvement in the management of complex postnatal cases at the Trust

9.5 The review team noted many cases where there was no consultant review, or inadequate consultant involvement, in the management of complex postnatal problems in maternity services at the Trust. For example:

9.6 *In **2002** a woman spent 17 postnatal days in critical care, and sadly died. During that time she was only reviewed on four occasions by an obstetric consultant. There should have been greater consultant obstetrician input into her ongoing care. (2002)*

9.7 *In **2006** a woman with known cardiac problems was discharged home soon after birth without consultant review, despite having been fluid overloaded in labour requiring treatment with diuretics and oxygen. She was admitted some three weeks later in significant heart failure and died. (2006)*

177 Royal College of Obstetricians and Gynaecologists, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

178 Keogh B, *Seven Days a Week*, NHS England (2015) https://www.england.nhs.uk/seven-day-hospital-services/the-clinical-case/

179 Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17.* Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019). https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

9.8 *In **2007** there was no postnatal consultant review after a difficult caesarean section, even though the registrar who performed the surgery informed a consultant that they were concerned that there might have been bladder damage during the operation. The consultant simply advised an indwelling catheter for 14 days, however, after the woman was discharged home on day five she was readmitted on day 12 but was not reviewed by a consultant until day 15 when she was finally diagnosed with a ureteric injury which occurred during her caesarean section. (2007)*

9.9 *In **2011** a woman with known pregnancy induced hypertension, who required a prolonged postnatal stay in hospital because of labile blood pressure, had no postnatal consultant review. Earlier consultant review could have identified seriously deteriorating HELLP[180], from which the mother subsequently died. (2011)*

9.10 *In **2018** a woman who underwent a caesarean hysterectomy because of a placenta accreta[181] had her surgery performed by a consultant, who also reviewed her the day after surgery, but there was no further consultant involvement in her care after this. (2018)*

Complex postnatal care requiring readmissions

9.11 Postnatal readmissions, for maternal complications, are uncommon, and are by definition complex. Management should therefore include review by a consultant. However, there were several cases where timely consultant review did not occur:

9.12 *In **2006** a woman was admitted with postnatal faecal incontinence, but was not seen by a consultant until 4 days after admission. (2006)*

9.13 *In **2009** a woman remained on the postnatal ward for 15 days after a caesarean hysterectomy for placenta accreta. In the first week she had regular obstetric review, including consultant reviews on days 1, 3 and 8. In the second week recording of maternal observations was very ad hoc and all the reviews were by very junior doctors. This woman was discharged home on day 15 by a junior doctor but was readmitted later the same day with severe sepsis, requiring ITU admission. Adequate observations, and thorough review before discharge, should have alerted clinicians to the developing sepsis, and would have allowed more timely management, possibly avoiding the need for ITU care. (2009)*

9.14 *In **2018** a woman was admitted with postnatal endometritis[182], but did not have any consultant reviews. In this case the management was not timely, as it was not recognised that she had retained placental tissue requiring removal under anaesthetic until 3 days after admission. (2018)*

Observations and appropriate responses

9.15 Observation of vital signs, and appropriate response if they are not normal, underpins the provision of safe maternity care. This should occur at all stages of pregnancy, including the postnatal period. The review has noted many cases where this did not occur across the timespan of the review.

9.16 *In **2000** there were very limited postnatal observations recorded of a woman who had experienced a stillbirth, with abruption, and a 3 litre blood loss, which required a blood transfusion. (2000)*

9.17 *In **2008** there had been abnormal observations recorded but the midwife simply discontinued observations without explanation. This resulted in a delay arranging the blood transfusion this woman required. (2008)*

9.18 The review team has also noted a number of cases where women with known pregnancy-induced hypertension either had few postnatal observations recorded, or had hypertension recorded but there was no response to the abnormal readings (both on the postnatal ward and in the community). These cases include examples seen in **2008** and in **2011**.

180 See Glossary

181 See Glossary

182 See glossary

9.19 *In **2008** when a woman reported severe rectal pain after a forceps delivery there was little consideration that she may have a serious complication. She was given analgesia, but very few observations of her vital signs were made, even when it was noted that she had only passed small volumes of concentrated urine. It was eventually realised, when it was noted that her heart rate was 140–160 bpm that an internal haemorrhage was likely, and her management was discussed with the on-call consultant who advised examination under anaesthetic (EUA) in theatre. Initially no plans were made for the consultant to attend theatre, but as the woman had still not gone to theatre 90 minutes after the decision for EUA, the consultant did attend. The woman went on to have a laparotomy[183], and drainage of a large retropubic haematoma[184]. She also required a 6 unit blood transfusion. Earlier recognition of her blood loss should have led to more timely management. (2008)*

9.20 Shock in the postnatal period should be recognised by all members of the multidisciplinary maternity team. The team must be aware that as most pregnant women are fit and healthy they can compensate for blood loss, and therefore may not show all the classic signs of hypovolaemia[185], which are an increasing heart rate with a fall in blood pressure, usually secondary to blood loss. The review team noted a number of cases where there was a significant delay in either recognising postnatal shock, or a slow response to the situation by clinicians. These are discussed below:

9.21 *In **2006** a woman was admitted with a significant secondary postpartum haemorrhage (PPH). Fluid resuscitation was slow, as was the decision for an examination under anaesthetic (EUA) during which the mother required a hysterectomy. (2006)*

9.22 *In **2006** the midwife noted excessive blood in the drains after an emergency caesarean section with an associated tachycardia and fall in oxygen saturation. The midwife did inform both the registrar and consultant of her concerns. A litre of colloid fluid did not improve the mother's tachycardia, and her oxygen saturation deteriorated, but the obstetric team did not appear concerned as the blood pressure remained normal. It was not until approximately 2.5 hours after leaving theatre that a bedside blood test was performed which revealed a life threateningly low haemoglobin level of 3.3g/dL. She was then rapidly transfused and returned to theatre where she underwent repair of a bleeding left uterine artery. (2006)*

9.23 *In **2008** a woman with known severe pre-eclampsia developed pulmonary oedema some 36 hours after an emergency caesarean section. This is a recognised potential complication, which is why her postnatal care should have been multidisciplinary (obstetrics and anaesthetics) and should have included a clearly documented postnatal MDT[186] management plan of fluid restriction, careful monitoring of fluid balance and regular MDT clinical review including chest auscultation[187]. In this case the care was not multidisciplinary, and did not involve appropriate fluid management. Had this occurred she would certainly have been better managed, and the pulmonary oedema possibly avoided, or managed earlier, so that admission to the medical HDU where her pulmonary oedema was well managed might have been avoided. (2008)*

9.24 *In **2016** a consultant obstetrician ignored clinical signs suggesting an ongoing problem. After a normal birth a woman had a high uterus and ongoing bleeding, this was managed with an oxytocin infusion but the heavy trickle of blood continued. She developed symptoms of light headedness, as well as a fast heart rate, and low blood pressure. Her blood loss was recognised, and managed with one unit blood transfusion. As her bleeding was still ongoing 7 hours after birth the registrar planned for her to have an examination under anaesthetic (EUA) to check for any retained placental tissues, or unrecognised tears. When she was reviewed by a consultant, some 9 hours after the birth, the consultant decided that EUA was not needed. The woman was transferred to the postnatal ward, where she had a further 3 unit blood transfusion the*

183 See glossary
184 See glossary
185 See glossary
186 See glossary
187 See glossary

next day, and was discharged home on day 3. She was readmitted 20 days later with heavy bleeding, and when she did undergo the EUA a large (9 x 5 x 3cm) piece of placental tissue was removed. Clearly the initial management controlled the immediate symptoms, but did not treat the underlying cause of retained placental tissue. Had the EUA occurred 7–8 hours after the birth, as planned by the registrar, then this woman would not have been exposed to the increased risk of infection and secondary haemorrhage. (2016)

Escalation

9.25 The review team has noted many cases where abnormal findings by midwives have then not been escalated to the midwife in charge of the ward/unit or to appropriately senior medical staff.

9.26 *In **2008** a postnatal woman, with known pre-eclampsia, had her blood pressure taken 5 times over a 20 minute period with all readings showing significant hypertension with no further escalation. A junior doctor came to review, but on attending found the woman asleep so the review did not occur until she woke up very confused, and with a headache about 2.5 hours after the hypertension was first noted. She was subsequently managed with a magnesium infusion and antihypertensive medication. (2008)*

9.27 In some cases midwives appropriately escalated concerns to medical staff, but the response to the escalation was poor.

9.28 *In **2019** a midwife escalated concerns about a woman's one-sided weakness the day after a manual removal of placenta was performed under spinal anaesthetic. The midwife's concerns were raised after the woman had been reviewed by an anaesthetist on a routine ward round, when no issues had been identified. The anaesthetist had not documented their clinical review in the medical records. The midwife's concerns led to a further review by an anaesthetic registrar who concluded that the woman's weakness could be explained as "prolonged effects from spinal". This was incorrect as spinal anaesthetic does not cause one-sided weakness. The midwife again raised her concerns, and the woman was then reviewed by a consultant anaesthetist who arranged a head CT scan which diagnosed a subarachnoid haemorrhage. In this case there was a delayed diagnosis of a serious condition. (2019)*

What Trust staff have told the review team

9.29 In late 2021 a number of maternity staff from the Trust, including current and past employees, spoke to the review team:

9.30 One contributor told the review team that '*There wasn't really much working together at all, it was very much we're midwives, they're obstetricians…if you knew certain obstetricians were on [duty] you would be fearful of calling them…because of their way with women…not very nice to the women'.* Another contributor, also noted *'A midwife couldn't ring the consultant on-call…afraid to ring with any concerns'.* A further staff member told the review team: *'It seems to be [with] processes, protocols, guidelines, some are using it, and some are not…policies and guidelines are all there…but not being followed'.*

9.31 A staff member described *'a very, very overburdened and thinly stretched middle tier in the obstetric team… doctors were being asked to cover services that you couldn't possibly do on your own'.*

9.32 Another staff contributor described: *'There were one or two, or even three, consultants that would intimidate the midwives and junior doctors, and make sure they were not approachable…many registrars have been intimidated not to contact the consultant during the night, and if they contact they get told off'.* The same contributor also commented on the relationship between consultants and midwives: *'They don't get on well…there is a barrier'.* Another contributor, commented on the relationship between consultants and midwives and said: *'Some you were seriously on your guard with… [would] bite your head off…I wouldn't have phoned a consultant lightly… [They] weren't particularly approachable'.*

9.33 Some staff also shared with the review team the lack of a supportive culture for junior or inexperienced staff that they had experienced very recently but declined to have their words used directly. It was explained to the review team that asking for help was seen as a bad thing and that junior staff at the start of their careers were often too frightened to ask for support when needed.

9.34 Overall staff feedback to the review team in late 2021 describes poor team working, failure to follow guidelines and an overstretched middle tier of obstetricians. This undoubtedly influenced the ability of postnatal ward midwives and junior doctors to be able to escalate potential clinical complications appropriately. These issues with lack of escalation were found within our first report and feedback directly to the review team from current maternity staff supports the findings in report 1.

9.35 There were however some encouraging reports from staff that the culture has started to change within maternity services at the Trust over recent years. A member of staff, interviewed in October 2021, who had only been with the Trust for a short period reported: *'Overall I think the culture is good…on the postnatal ward'.* The same contributor reported: *'Two new consultants [are]…trying to update the MEWS (modified early warning system) charts'* in reference to escalation from the postnatal ward, a recommendation from our first report.

9.36 Another staff contributor, referring to previously poor escalation at night commented *'Doesn't happen now…consultant now covering labour ward at night'.* The same contributor also commented that the relationship between doctors and midwives was *'improved now'*. Another member of staff, commented on the appointment of an individual consultant in 2018 who changed the culture *'in terms of consultant engagement…is engaged, approachable, woman-centred…and was the start of potentially the tide turning with what was quite an old and staid consultant body…it's much better now…24/7 consultant cover on labour ward'.* The same contributor said *'that is a good thing to come out of all this scrutiny'.*

Clinical follow-up in the postnatal period:

9.37 Clinical follow-up is comprised of two main aspects: firstly, follow up of results of investigations with potential amendments to already existing plans of care. Secondly, follow-up discussion and debriefing of care especially for families who have experienced perinatal loss, or a serious adverse event. This is essential to help women and their families understand, and begin to come to terms with, what has happened to them.

9.38 Follow-up discussions should address ongoing care needs, and discussion about any implications that events within the current/most recent pregnancy may have for care in a future pregnancy. In some cases it may be appropriate for this discussion/debrief to occur before discharge from the postnatal ward, but in others a formal follow-up appointment is required.

9.39 Such discussions require effective and timely communication with both the mother and her GP. It is therefore vital that the appointment occurs in an appropriate setting, within a reasonable timescale and is accurately documented and that the appointment is with a senior doctor who gives the family time for adequate discussion. The doctor also needs to listen to the family, who may hope that any investigation of their case could lead to learning and changes that might avoid another family experiencing a similar event. When a stillbirth occurs MBRACE-UK 2017[188] advised that *'All parents should be offered a follow-up appointment, in an appropriate setting, with a consultant obstetrician to discuss events leading to their baby's stillbirth, the actual or potential cause, chances of recurrence and plans for any future pregnancy'.* The same report also advised that *'A summary of their follow-up appointment, written in plain English, should be sent to the parents, and their GP'.* The review team found many examples where this did not happen:

9.40 *Failure to address the mother's ongoing care needs were noted by the review team when in **2007** a woman was discharged from maternity care still on antihypertensive medication, which had been started during the pregnancy, but with no instructions to either the GP or the woman, about ongoing blood pressure management. (2007)*

188 MBRACE-UK Perinatal Mortality Surveillance Report: *UK Perinatal Deaths for Births from January to December 2015* (2017) https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

9.41 *In **2014** a mother's membranes ruptured well before 24 weeks, and she went on to have a very pre-term birth and neonatal death after a few hours. In her pregnancy she had been informed of a positive test result, and advised to collect a prescription for treatment, which she did not do. This test result was noted when she was admitted, and appropriate treatment prescribed, but it was never given. This information was not relayed to the GP, nor was it addressed when the mother saw the consultant for follow-up. (2014)*

9.42 Similarly there are cases of women who experienced serious physical trauma at birth with potential implications for future births, where they and their GP do not appear to have been advised about these implications. One example is the following:

9.43 *There was a lack of information given to a mother in **2018** when a woman had an 'inverted T incision' on the uterus at caesarean section for the birth of the second very pre-term twin (25 weeks gestation). Sadly both twins died in the neonatal period. In the records provided by the Trust there was no evidence that the parents were made aware of the unusual incision on the uterus which does have implications for a future pregnancy: if this woman were to labour in the future there is a high risk of uterine rupture, which can be catastrophic for both mother and baby. The discharge summary to the GP did not include any information about the 'inverted T' incision. (2018)*

9.44 The review noted many perinatal loss cases where there was no evidence in the medical notes that the family had been offered a follow-up appointment; this was noted across the years of the review (2000–2019). For most of the last 20 years the majority of maternity units have arranged that these follow-up appointments take place away from any clinic associated with maternity care, but the Trust was still seeing these families in the gynaecology clinic as late as 2014.

9.45 These appointments are often distressing for the families, and must therefore be conducted sensitively. The written summary of the discussion must also be both sensitive, accurate and easily understood by the family. This was often not the case for the families considered by the review team.

9.46 *A family told the review that they felt that the consultant was 'unprofessional' during their post-stillbirth appointment in **2006**, as he was ill-prepared, had not read the post-mortem report, and sent a letter with multiple factual errors after the appointment. The family explained to the review team that the consultant exacerbated their distress in an already extremely difficult situation, and they then had to write back to the consultant to get the factual errors in the letter corrected. (2006)*

9.47 *A family described their post-stillbirth consultant appointment in **2011** as 'very brief in and out in less than five minutes, and 'did not give [them] any answers'. The consultant was described to the review team as 'inattentive' and he is said to have 'sat on the table swinging his legs'. (2011)*

9.48 *A family who suffered a neonatal death in **2013**, after a traumatic birth, reported that at the follow-up appointment the consultant 'showed no compassion or understanding of the trauma experienced'. (2013)*

9.49 In some cases the letter sent to the family after the follow-up appointment did not offer condolences, or was written using a lot of unfamiliar medical terminology. The review team has seen examples of this in both **2016 and 2018**. In other cases the letter used inaccurate wording that the family found upsetting for example in **2018** the consultant's letter after a stillbirth noted that the mother had *'gone through labour and delivered a very healthy girl'* which is inappropriate given that the baby was stillborn. (2018)

9.50 It is expected that families are given complete and honest information both before discharge from the hospital and at the follow-up appointment. The review team found a number of instances where the information given was either incomplete, or misleading:

9.51 *In **2002** after an intrapartum stillbirth, the consultant's postnatal letter stated 'all the findings would probably suggest there was a little bit of growth restriction at the end, and that labour on top of a compromised baby caused the ultimate demise'. However, the letter failed to mention that the CTG was grossly abnormal for nearly 90 minutes before the stillbirth, that there was thick meconium, and that earlier birth by caesarean section would probably have resulted in a live birth. (2002)*

9.52 *In **2005** after a stillbirth there was appropriate discussion of the family's concerns, but no discussion about the growth restriction noted at post-mortem (not detected in the antenatal period) as a cause of the stillbirth, as well as an infection after probable pre-labour rupture of membranes. (2005)*

9.53 *In **2006** a family whose baby died at 3 days of age with severe HIE[189] and bleeding into an arachnoid cyst, noted that at post-mortem they were given the impression that 'haemorrhage into the cyst had caused the HIE' rather than hypoxia during labour. The multi-professional review team concluded there was clear evidence of a pathological CTG prior to birth and that the resulting features of HIE would be consistent with an intrapartum hypoxic insult which was likely to be due to cord compression worsened by injudicious use of oxytocin. (2006)*

9.54 *In* **2008** *a woman who experienced an abdominal wound dehiscence 5 days after caesarean section was told that 'the suture had snapped, and this was an equipment failure, not a medical issue'. (2008)*

9.55 *In **2013** after an intrauterine death that occurred in hospital during induction of labour, the family and GP were told that the cause of death was that the labour ward was too busy for her to be transferred for artificial rupture of the membranes (ARM). The Trust RCA did not consider that failure to monitor the fetal heart for 15 hours, (which contravened Trust policy), was the true cause. (2013)*

9.56 *In **2014** following IUD of 28 week twins, the consultant told the family that the scan a week before fetal demise showed that 'Doppler assessments of flow in the cord and brain were normal'. However, there was no evidence in the medical records that they measured Doppler flow in the brain when performing this scan. (2014)*

9.57 *In **2015** after a traumatic operative vaginal birth of the second twin, using 3 sequential instruments, a consultant discussed issues around the birth with the mother, on the postnatal ward, and explained that the baby was 'short of oxygen' during the birth, but did not mention the skull fractures that the baby had sustained. (2015)*

9.58 *Similarly in **2018** a family were told that there was no evidence of pre-eclampsia before a mother was admitted with an abruption and intrauterine death. However the review team noted that in the 2 weeks prior to the abruption the mother was being managed as an outpatient with proteinuria (measured by urinary PCR) and blood pressure that was increased from that recorded at booking. This does indicate that this mother did have known pre-eclampsia, which was a risk factor for abruption. Abruption cannot be predicted, or prevented, but if this woman had been managed as an inpatient, then urgent delivery as soon as the abruption was recognised might have achieved a different outcome. (2018)*

9.59 In a number of cases families felt that the Trust was reluctant to undertake investigations, or to change practice.

9.60 *After experiencing a neonatal death in **2005** a family told the review team: 'We just wanted to understand and maybe work with the hospital to try to change practice to avoid any parents having to go through the same painful ordeal. However, this certainly wasn't an option. It was like the door had been slammed in my face'. (2005)*

9.61 *In **2012** a family were told that there was a Trust investigation after the mother had to return to theatre because of intra-abdominal bleeding after an elective caesarean section, and that nothing different could have been done. However, the Trust has not given the review team any evidence of an internal investigation. The review team is critical of the care this woman received after her elective surgery. (2012)*

9.62 *In **2014** a meeting with the family to discuss the findings of the Trust investigation did not occur until more than 2 years after the birth, and the baby's neonatal admission, from an MLU with severe sepsis. After this meeting the Medical Director did send the family a letter outlining the results of the investigation, but also indicated that the letter had been composed from the Head of Midwifery's notes and transcription (it was obviously 'cut and pasted'). The letter concludes that there were still questions to be answered and confirmation was still required as to whether actions from the investigation had been undertaken.*

189 See glossary

This was 2 years after the case occurred. The review concluded that this letter was unprofessional and reinforced the apathy shown towards the case. The review team considers there appeared to have been little involvement with or support shown to the family. (2014)

Compassion and kindness

9.63 Many families reported to the review team a lack of compassion and kindness shown to them by Trust staff.

9.64 *In **2002** a woman with pre-eclampsia discharged herself 36 hours after delivering 25 week stillborn twins as she felt her care 'was appalling'. (2002)*

9.65 *In **2008** a woman reported her distress about the care she received on the postnatal ward after undergoing a postnatal laparotomy for a retropubic haematoma. She felt that on the ward 'There was no communication at all. I was shouted at, ordered about and forgotten…I was made to feel like an inadequate mother and made to feel like I was making up how poorly I was and I like I shouldn't have rung the bell or asked for help'. (2008)*

9.66 *In **2011** two families commented that 'midwives didn't care', 'showed no kindness [and] support' and 'there was no caring involved'. One mother told the review that she felt unsupported after suffering a cardiac arrest and was not offered any psychological support. She told the review that she was made to feel 'I was in the way and they wanted rid of me, they were in no way subtle about it once they decided that I had spent enough time in the unit'. (2011)*

9.67 *Another woman in **2015** told the review that she felt she had received poor care that also lacked empathy. (2015)*

9.68 The review team heard from families who felt unsupported and uncared for when their babies were unwell:

*In **2010** a baby was readmitted with significant jaundice. The family felt that their baby was 'starving to death' and complained about lack of feeding support. A review of the medical records indicated that inconsistent advice had been given to the parents. (2010)*

9.69 *In **2012** a mother felt ridiculed for having followed another staff member's advice on how to put on her daughter's nappy. (2012)*

9.70 *In **2014** a mother reported , whose baby was on the neonatal unit, that she was 'told off' for 'worrying about her pain too much'. The woman reported to the review team that she was told by staff 'what we tend to find is that those women who have babies next to them have more important things to think about. People like you who do not, are only concerned with themselves'. (2014)*

9.71 *In **2015** two families described the postnatal care as being 'truly awful' and that they 'felt like a burden' and 'not listened to'. One of these families also described a midwife calling the mother 'a princess' for asking for formulafeed for her baby. (2015)*

9.72 *In **2016** a mother reported being left alone in the birth room, with the call bell out of reach, just 40 minutes after giving birth. (2016)*

9.73 Concerning attitude issues towards families were also reported by some staff. One contributor to the staff voices process, reported to the review team that *'some staff [on the wards] ignored buzzers unless it was "their buzzers".'* This meant that some women asking for help could not access any support if their own midwife was busy, off the ward, or on a break. This contributed to some families feeling that *'midwives didn't care'.* The same contributor also commented that postnatal ward staff were probably quite unhappy and described *'not much understanding between labour ward and the postnatal ward'.* The same member of staff also stated: *'I wouldn't have wanted to go there as a patient'.*

9.74 Staff members told the review team that asking for help was seen negatively but were unwilling to be quoted directly as having said this, despite assurances of anonymity. This was not an attitude likely to foster a good working environment for staff, nor likely to lead to good care for families. Another member

of staff, stated that the Trust was *'a dreadful place to work…practice wasn't evidence based …guidelines woefully out of date…I tried to raise concerns unsuccessfully'.*

9.75 Whilst the review team noted that the Trust had a perineal follow-up clinic for women who had experienced 3rd and 4th degree tears, or other perineal problems, they also noted issues with some staff communication in this clinic.

9.76 *In **2009** a woman was referred to this clinic because of persistent perineal symptoms, despite no known history of significant perineal trauma at birth. In the clinic the consultant who saw her dismissed her symptoms, and said that no further investigation was required, without even examining the woman. This woman was subsequently seen in another hospital where a rectovaginal fistula was diagnosed, which must have occurred because of significant trauma at birth, probably a missed 3rd or 4th degree tear. (2009)*

9.77 *In **2014** when a woman was reviewed in this clinic after a 3rd degree tear the doctor wrote in the notes: 'Well, but fat and very anxious. Can try for a vaginal birth – risk of re-occurrence low'. (2014)*

Receiving postnatal care in the correct location

9.78 Care in the postnatal period for mother and babies must take place in an appropriate setting, according to clinical need.

9.79 *In **2012** there was inappropriate transfer to midwifery-led care in the postnatal period which led to poor management. The transfer of care, to a distant MLU, occurred 3 days after birth despite a complex caesarean section, massive obstetric haemorrhage, anaemia, postpartum pyrexia, persistent tachycardia and persistent pain. The mother was eventually transferred back, very unwell, to the consultant-led unit (inappropriately by car) on day 8 with severe sepsis, with both a pelvic abscess and a lung empyema[190]. (2012)*

9.80 *In **2017** a woman with known pre-eclampsia was transferred to a distant MLU for ongoing postnatal care on day 3, despite her blood pressure remaining elevated. (2017)*

9.81 *In **2017** a mother and baby who had been transferred to a standalone midwifery-led unit (MLU) for postnatal care after birth was advised by a midwife: 'Don't tell them the baby is 'grunty' or they will send you back to the consultant unit'. A family member subsequently highlighted their concerns and the mother and baby were transferred back to the consultant-led unit (2017)*

9.82 *In **2018** a mother and baby were discharged home 4 hours after vaginal birth but the baby's temperature was 36.1°C with no evidence of repeat measurement, the review team felt this was inappropriate. (2018)*

9.83 Follow-up appointments by community midwives after postnatal discharge from hospital should aim to both support the mother, and to detect and appropriately refer any maternal, or baby problems identified. In some cases this did not occur.

9.84 *In **2011** when a woman reported 'very little bowel control' on day 10, the midwife advised her to report this to her GP, rather than referring her to the obstetric team for review and management, or continuing to* review the situation herself. (2011)

9.85 In other cases women who had experienced pregnancy loss were advised to see their GP to get a prescription for therapeutic lactation suppression. It is normal practice to offer women lactation suppression after perinatal loss. The review noted evidence that lactation suppression was discussed with parents, but from the records of a **2016** early neonatal death it appears that Cabergoline was not stocked on the labour ward. This suggests that the management for families experiencing loss was not holistic.

190 See glossary

Staffing

9.86 Poor staffing levels, both midwifery and obstetric, will affect both the quality of patient postnatal care, and staff morale. It would appear that staffing levels and staff morale were an issue for some time at the Trust.

9.87 When contributing to the Staff Voices initiative in late 2021 one contributor graphically described the stress staff felt because of poor staffing levels, with postnatal ward midwives regularly being *'pulled to labour ward'* and described the way this affected care as: *'you … try and just do the work as quickly as possible, and there wouldn't be any quality of care'.* The same contributor also described that this prioritisation of the labour ward, leaving the postnatal ward understaffed *'really increased our stress levels because obviously, it's upsetting when you can't give the care that you want to give…especially on a postnatal ward where it led to healthcare assistants or the women's services assistants doing most of the clinical care with midwives just running in with some painkillers or IV antibiotics, or doing a quick check'.*

9.88 The response from the staff member, when asked about escalation of concerns regarding staffing levels on the postnatal ward, was *'you know, you can escalate, but you know if there's nowhere to pull, there's nowhere to pull. You're just left and you just have to get on with it'.* The contributor also reported pressure for early discharge *'they [postnatal women] can't even stay in for breastfeeding support'.*

9.89 Many staff contributors also reported significant staffing issues. They described: [a] '*shortage of midwives… needing to pull in staff (from wards and community)…robbing Peter to pay Paul,'* and *'[being] concerned about safety and staffing'.*

Bereavement

9.90 It is sadly inevitable that many of the families included in this review have experienced the loss of a baby, which can have a huge impact on their long-term wellbeing. As noted by SANDS (2021) *'Good care cannot remove the pain and devastation that bereaved parents experience, but poor or insensitive care makes things worse, both immediately and in the months and years that follow'.*

9.91 Compassionate bereavement care must begin when a family are told that their baby has died (or before death if the baby is known to have an abnormality incompatible with survival), it is therefore vital that all staff communicate compassionately with families at this very difficult time. Below are some cases from across the timespan of the review identified by the review team where families felt this did not happen:

9.92 *In **2002** a family complained about the way that a midwife sonographer informed them that one of the twins had died when the mother presented with ruptured membranes at 37 weeks gestation. (2002)*

9.93 *Similarly in **2009** a family complained about the manner of the doctor who diagnosed the absence of fetal heart activity, which they felt was insensitive. (2009)*

9.94 *In **2018** the review team noted that a family wished to continue a pregnancy with known abnormalities incompatible with survival and they were seen by the bereavement midwife and consultant neonatologist together during the pregnancy to plan care at the time of birth. After these meetings a letter outlining the plans for care was sent to the family. However, this information was inadequately conveyed to the labour ward staff, who were unaware of the agreed plans. This led to the inappropriate repeated discussion of the issues when the mother was in labour, and after the baby was born. It was also noted that some of the agreed plans were not followed, such as the family spending as much time with the baby as possible before discharge from the hospital. It is clear from the documentation that at the time of birth there was little, or no, discussion with the family with regards to meeting their individual requirements, nor to fulfil their required cultural and religious practices despite these having been agreed at the pre-birth meetings. (2018)*

9.95 In most maternity units it is routine practice to suggest that women go home after being given oral mifepristone following the diagnosis of an intrauterine death, to return after 36-48hrs for further management to induce labour. It is however very important that staff ensure that parents are given the option of staying in the hospital if they prefer, or that they are clearly informed that they can return to the hospital at any time if they wish.

9.96 *A mother described how she felt in **2010** 'When I left the hospital on the day I found out that my baby had died [at a scan]. I was told that they wouldn't expect me to return for 48 hours, from when the tablet was taken'. This family reported that they felt unsupported. (2010)*

9.97 *Similarly a mother raised concerns regarding staff attitudes after the very early neonatal death of a very premature baby in **2014**, who was born at 21+ week's gestation. She explained that she had to 'wait for the corridors to be empty before carrying her son back to the birth suite'. In her notes there was minimal documentation regarding postnatal bereavement care. (2014)*

9.98 Women who experience perinatal loss need to be cared for in a clinically appropriate area, so that both their physical and emotional needs can be addressed.

9.99 *In **2012** a family reported that their care after an intrapartum stillbirth was upsetting. Firstly the family were 'left in the room for I don't know how long…then put me in a wheelchair, gave baby to me (to hold), put us in a room and left us there'. This family also reported 'what was worse they put us in the maternity ward so we could hear babies crying'. Families have clearly explained to the review team how both compassion and an appropriate place of care can help make the unbearable more bearable. (2012)*

Consent to post-mortem examination

9.100 Post-mortem is the most useful investigation in supporting the determination of cause of death and its value is frequently underestimated by health professionals[191]. Deciding on whether to have a post-mortem investigation conducted can be one of the most difficult decisions bereaved parents face in the period immediately after their baby dies. It is essential that this is dealt with in a sensitive way by a professional trained to take post-mortem consent. The review team noted cases where discussion with families about having a post-mortem examination was insensitive or unhelpful. Below are two examples:

9.101 *A family in **2009** told the review team that: 'The doctor who went through the consent process for the post-mortem examination was observed by the midwife who documented "Noted that he went through documents very quickly and with little empathy. Family distressed by this and told me they were not happy with this when he left. Apologies given".' (2009)*

9.102 *Also in **2009**, a family reported that following the stillbirth of their daughter 'there wasn't time or space to make the important and difficult decision about consenting to, or declining, a post-mortem examination'. In this case the post-mortem consent was discussed only 6 hours after an unexpected stillbirth, and the family felt that the consultant obstetrician counselled them against having a post-mortem, and this was their 'largest concern about the care' the family received. (2009)*

Ongoing care after bereavement

9.103 Not surprisingly parents are very fragile at this difficult time, something all maternity staff should be aware of. Some families reported experiencing a lack of sensitivity to the review team. A family told the review team that in **2009** they found a consultant's attitude to be *'rude and completely dismissive of [their] concerns'.* (2009)

9.104 A family in **2011** felt deeply about *'the lack of compassion and empathy exhibited by the midwife'*. Also from **2011** the review team noted poor bereavement care and support and that there was evidence of a breach of confidentiality as there had been disclosure of the death of the baby to the woman's father without her consent. This had caused a strain in their relationship ever since. (2011)

9.105 It is reasonable to expect that maternity staff are careful to obtain accurate information when caring for bereaved families, or those with sick babies on the neonatal unit.

9.106 *A mother complained about the postnatal care she received in **2009** following a bereavement saying that the staff appeared unaware of the issues and she had to keep explaining distressing details at every shift change. (2009)*

191 https://www.sands.org.uk/professionals/sands-post-mortem-consent-package

9.107 *In another instance in **2014** a bereaved family reported seeing a different community midwife at each postnatal visit. (2014)*

Specialist bereavement care

9.108 Families who have experienced baby loss must have ongoing support, either from their own community midwife, or from a bereavement midwife. The review team noted a lack of support for bereaved families in many cases, over a long period of time.

9.109 *From a case in **2003** the review team noted that one woman said she was happy with the antenatal and intrapartum care she received but when she needed support following her term stillbirth this was 'sadly lacking'. In this case there was no information in the medical records about bereavement care apart from a checklist and mention of counselling in the bereavement follow-up letter. It is unclear whether this was ever arranged. (2003)*

9.110 *Following the loss of her baby in **2010** the clinical records indicated that the mother was discharged from maternity care on day 8 and advised to 'call if further support needed'. (2010)*

9.111 *In **2011** the review team noted an apparent lack of bereavement support after a stillbirth. The only evidence of involvement from the Trust was a single telephone call some four weeks after the birth. The notes from this call, provided by the Trust, indicate that the mother was advised to contact other healthcare professionals for support if she wished. (2011)*

9.112 *In **2012** one family reported that the bereavement care they received was 'appalling' and another family felt that the bereavement support was 'very tick box' and that they found the maternity bereavement service 'of no help'. (2012)*

9.113 *In **2016** the review team heard from parents of a lack of care and compassion in bereavement care following the neonatal death of their baby shortly after birth. (2016)*

9.114 Another important aspect of care at this difficult time is ensuring that parents receive all the information they require, or request, and that all appropriate services are informed of the bereavement.

9.115 *A family reported that in **2010** when they requested that the community midwife follow up the missing photographs of their stillborn baby that this did not occur. As the photographs had still not been sent to her months later the woman had to phone the ward herself to obtain them. (2010)*

9.116 *A family reported that in **2011** there was a delay in them being told that their baby had been returned following the post-mortem, which led to a significant delay in arranging the funeral. (2011)*

9.117 *In **2016** a health visitor was unaware of the neonatal death and provided congratulations and Bounty literature continued to be sent to the family, which they found distressing. (2016)*

Good bereavement care

9.118 In some cases, there was evidence of kind and compassionate support given to families after bereavement. The following are examples of that kind and compassionate care.

9.119 *In **2006** the community midwife was praised by the family for her care and compassion and they specifically asked for her in subsequent pregnancies. (2006)*

9.120 *In one case in **2011** the obstetric registrar offered condolences and gave a detailed discussion about post-mortem and the parents opted for a limited one with the knowledge that there was a limit to the information they would receive. (2011)*

9.121 *There was evidence in some cases that the maternity staff tried to help families with stillbirth registration. In **2014** a couple with English as a second language were escorted to the registry office to register their stillborn twins. It was also arranged for an interpreter to be present when the couple came to see their consultant for a follow-up appointment. (2014)*

9.122 *In **2012** the family reported that through bereavement support it was ensured that the family's concerns and questions were addressed in the Trust investigation.*

9.123 *In **2017** the parents reported effective information sharing, good levels of care including continuity of care after bereavement. (2017)*

Good postnatal care

9.124 Whilst the review has identified poor postnatal care it should be acknowledged that in the cases the maternity review team considered we also found examples of women receiving good, safe and supportive postnatal care.

9.125 *In **2011** there was evidence of effective team work with appropriate referral and involvement of social services, GP and health visitors. (2011)*

9.126 *In **2014** the review team also noted that 'the immediate midwifery care provided during the postnatal period was of good standard and aligned with local and national guidelines'. (2014)*

9.127 *In **2014** evidence was noted of extra postnatal community visits to provide more emotional support to a new mother. (2014)*

Good record keeping and good care planning

9.128 Good record keeping is fundamental to safe and high quality maternity care, and remains so in the postnatal period. Whilst the review has criticised poor record keeping, examples demonstrating appropriate and good quality postnatal record keeping were identified in **2010** and **2013**. The review team also identified sensitive documentation in the care of a family in **2008** and in another case involving a family in 2016 documentation was described as having a *'detailed midwifery record'* by the review team.

9.129 The review team also identified examples where problems likely to lead to a difficult outcome were identified during the pregnancy with evidence of good care planning in 2008. In cases from **2011** and **2015** the review team also noted evidence of family involvement in the planning of care.

9.130 Some cases of good clinical care were also noted. In **2011** timely multidisciplinary management was noted when a woman was readmitted with a severe wound infection after a caesarean section. The infection was promptly recognised as the severe life threatening condition of necrotising fasciitis, which was managed well.

9.131 In **2013** when a woman informed her community midwife that she felt 'unwell' at a routine visit, the community midwife recognised the severity of her condition and arranged prompt referral directly to the labour ward. When this woman arrived on the labour ward the midwives ensured that she was seen promptly by the obstetric registrar, who rapidly diagnosed sepsis and appropriately administered intravenous fluids and antibiotics within 30 minutes of her arrival in the maternity unit. She then went on to have good multidisciplinary management, including a short spell in ITU, and made an excellent, and fairly rapid, recovery. (2013)

LOCAL ACTIONS FOR LEARNING: POSTNATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

9.132 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

9.133 The Trust must ensure complete and accurate information is given to families after poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

Chapter 10

Maternal deaths

The impact on families when a mother dies

10.1 Families have explained to the review team that the impact of a maternal death and thus losing a mother, wife, daughter, sister, or grandchild is far reaching across a whole extended family and the effect of this remains with them forever. Here are some of the ways families who have spoken to the review team about maternal death have described this to us:

10.2 'It never goes away…you just kind of…and it's a natural thing, you just kind of withdraw within yourself a little bit. Usually, for me, that's like a month, six weeks, two months.' (**2002**)

10.3 'It's just sad, I ache for her every day, every day.' (**2007**)

10.4 'I think her Mum and Dad, they're still grieving now…Even now like, I mean you go round the house and there's always a candle lit, you know, they've got our wedding photos still up, you know, it's just a constant reminder when you go round to their house.' (Husband talking about his wife who died in **2011**)

10.5 '…she was having some problems and eventually she said to her step mum that she felt bad that her Mummy had died because she'd wanted to have a brother or sister.' This example is from a bereaved husband, talking about his first-born daughter whose mother died during a later pregnancy. His daughter believed that her wanting a sibling was the reason her mother had died in **2016**.

10.6 The review team noted that several families felt their questions surrounding the maternal death had not been addressed by the Trust. Bereavement support after the event was also described by families as inconsistent:

10.7 When asked as to whether an investigation into the death had been performed a husband whose wife had died in **2002** responded: *'There was no…it was just the…it was pulmonary oedema and obviously pre-eclampsia was like mentioned, or part of it. Yes, fluid on the lungs. No, they never gave an explanation for that, for why'.*

10.8 Another family member said to the review chair: *'It's what makes me angry, because I feel like the Trust got off lightly at the time with me, because I feel that they recognised, in that meeting, how desperately distraught I was and they just decided…like everything was done, you know…We can't find any reason for, but if you want to take a complaint elsewhere that's up to you…but as far as we're concerned there's no case to answer…is what they basically said. And I came out flabbergasted because I think I'd expected them to offer me a big apology, you know, and say oh yes, we've made loads of failings here, and all this, that and the other...And of course they didn't and when they didn't do it I just thought I can't do any more, like I haven't got the energy to do any more. So I think they got off lightly really, and it makes me feel bad that I didn't have the energy to do it, but it would have been too much for me to go through…because I want to go through this process [the Ockenden review] to get some answers for my own peace of mind as to what happened, because I laid a lot of blame on myself afterwards…'*

10.9 The family member further recalled: *'one doctor that wasn't so pleasant or helpful…when I rang him to ask some of the questions, his exact words to me were "if you keep digging into this you'll just find things you don't want to find". That's what he said to me, and then he put the phone down'.* (This feedback is from the partner of a mother who died in **2002**)

10.10 A partner of a woman who died in **2014** told the review chair: *'I was actually told that I would get to see [the investigations], they did an independent review on their midwives and then they did another one, I saw another lot…so the ones above them also went back on her case and went through all that, I was also told I would get them...[investigation reports] and we've never had them'.*

Number of maternal deaths reviewed

10.11 At the time of concluding this review, in total 19 maternal deaths were noted by the review team. Three of these occurred prior to the core review period (before 2000) and one death in **2015** occurred after the mother was transferred in labour to another trust. This woman's pregnancy care was reviewed by the team as the majority of the pregnancy care occurred at the Shrewsbury and Telford Trust's maternity services, but her death was not.

10.12 Of the 16 cases that occurred within the core review period, there were eight direct[192], and seven indirect maternal deaths[193], plus one accidental death resulting from a road accident, which was not investigated further by the review team.

10.13 One death which occurred at the Trust during pregnancy in **2019** was comprehensively investigated by the regional Healthcare Safety Investigation Branch[194] (HSIB) as per NHS policy. This case was not reviewed further by our team.

10.14 One mother who delivered at the Trust died in another hospital in **2019** and the family declined the HSIB review. It was not possible to obtain permission from the family regarding inclusion into our review. In cases such as this, there is ultimately learning for the whole maternity system and trusts involved must learn together through digital or remote means if necessary. The review team is not aware of any such joint learning in this case.

10.15 Clinical notes were unavailable for one woman who died in **2001**, despite recommendations that all maternity records should remain available for 25 years after the birth of the last child[195]. An external governance review was arranged after the family complained to the Trust and provided to the review team by the Trust. The review team was therefore able to review the quality of the Trust's internal investigation after the death, but not the clinical care.

Analysis of the maternal deaths

10.16 The remaining 12 maternal deaths were each reviewed by a multi-professional team of midwives, consultant obstetricians, a consultant obstetric physician and a consultant anaesthetist, with special interest in obstetric and cardiothoracic anaesthesia. Further experts (including experts in intensive care, cardiology, neurology and others) joined the team to give expert opinion or answer specific clinical questions where required.

10.17 As with all other reviews, for each maternal death review the team adopted a holistic and multi-professional approach, including access to all available governance documentation provided by the Trust and communication with the family of the deceased mother.

10.18 Although statistical analysis of the maternal deaths is limited due to the small numbers, the review team noted the relatively high number of direct maternal deaths at the Trust. This is in contrast to the overall national trend, where direct deaths have been declining since 2004[196]. This may be an indication that the care for pregnancy related conditions such as pre-eclampsia (PET), sepsis and major obstetric haemorrhage needs to be further improved locally.

10.19 The review team noted that all but one woman who died were of white ethnicity, a patient group which usually has a lower risk for mortality in pregnancy. Seven of the women who died were classified as obese at booking for maternity care (BMI> 30 kg/m2) and therefore were of higher risk for pregnancy related complications.

192 See glossary

193 See glossary

194 See glossary

195 Department of Health, Records Management: NHS Code of Practice: Parts 1 and 2: 2006, revised 2009 and 2016, include reference to HSC 1998/217: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients (Replacement for FHSL (94) (30))

196 MBRRACE-UK, Saving Lives, Improving Mother's Care (2020)

10.20 Two maternal deaths did not have a coroner's inquest. In three cases where there was a coroner's inquest the review team commented further on the cause of death as stated by the coroner:

*In **2002** a woman with pre-existing lung disease developed pre-eclampsia and had inappropriate fluid management with significant fluid overload, over many days. She later died from acute respiratory distress syndrome (ARDS). The pathologist at the inquest speculated that very high oxygen levels during ventilation on the intensive care unit led to the ARDS. The underlying respiratory condition and inappropriate fluid management were not identified at the inquest. The review team is of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.21 *In **2014** a woman with poorly managed sepsis and prolonged resuscitation efforts was found to have squamous epithelial cells in the pulmonary vessels at the post-mortem investigation and the cause of death was determined as amniotic fluid embolism (AFE). The review ream is of the opinion that fetal squamous cells in the systemic or pulmonary circulation of the deceased is not necessarily proof that she died of AFE and that sepsis was a significant contributing factor. The review team is also of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.22 *The post-mortem investigation in a woman who died of major obstetric haemorrhage in **2017** found evidence for an undiagnosed cardiac condition, which was classified as contributory to the death The review team is of the opinion that there is no evidence that the woman was affected by the cardiac condition in any way and that this did not contribute to her death.*

10.23 The clinical care and quality of the subsequent investigation were rated by agreement between the review team members as per below:

GRADING OF CARE	DEFINITION
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	Sub-optimal care in which different management might have made a difference to the outcome.
3 Major Concerns	Sub-optimal care in which different management would reasonably be expected to have made a difference to the outcome.

10.24 The quality of the incident investigation root cause analysis or RCA at the Trust was rated differently depending on the year the incident occurred, to reflect the national developments in incident reporting and investigation.

For cases up to and including 2010:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Evidence of recommendations for improvement.	Compassionate communication with family at time of incident.
Poor	Any of the above missing.	Very little or non-compassionate communication with family.
None	Incident not investigated.	No family involvement.

For cases from 2011:

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

Grading of care

10.25 The review team reviewed the maternal death cases individually prior to agreeing the grading at multidisciplinary team discussions. With hindsight, one will often judge a past decision by its outcome instead of based on the quality of the decision at the time it was made, given what was known at that time. The review team is conscious of the fact that there is a danger of judging past care decisions by the outcome, instead of based on the quality of the decision made at the time, which can lead to outcome bias when applying any grading of care. It is important to note that all cases were reviewed in accordance with best clinical practice and guidelines available at the time of the incident, to avoid outcome bias as much as possible.

10.26 The reviewers found none of the maternal death cases had received care in line with best practice at the time (grade 0). Three cases were found as requiring improvement in care, however, the eventual outcome would not have changed (grade 1). In six cases the care was rated as 2, meaning the reviewers found suboptimal care of the women and different management might have changed the eventual outcome. Three cases were graded as 3, where the eventual outcome could have reasonably been expected to be avoidable, had the care been different.

Grading and analysis of internal investigations

10.27 In line with the Terms of Reference of the review, all available governance documentation and family communication were reviewed in the context of best practice at the relevant time. A total of 11 incident investigations were considered. However, in some cases no comprehensive serious incident (SI) report was available (as would have been the expectation), but rather an abbreviated High Risk Case Review (HRCR), in the form of a spreadsheet. This appears to have been an internal Trust review process that has not been seen outside the Trust by review team members. It was not always clear to the review team whether, and if so how, these were shared with the families of the deceased women.

10.28 One maternal death in **2017** was investigated by an external provider. The review team agreed that the standard of the investigation was appropriate.

10.29 A maternal death that occurred in **2002** was not investigated by the Trust as the care was rated by them as appropriate, a finding with which the review team fundamentally disagree. The Trust maternity governance team noted *'This case was reported as a serious untoward incident and also a full report sent to CEMD (Confidential Enquiry into Maternal Death). It was also discussed at the mortality meeting, but it was felt*

that there were no lessons to be learned. This was a high risk pregnancy and Mrs X was aware of the potential effect this could have on her future. The staff were extremely saddened by her death'.

10.30 The review team acknowledges that the pregnancy in this case from **2002** was high risk, however there were multiple missed opportunities and a lack of understanding in regard to the mother's underlying condition and poor management of developing complications. The family in conversation with the chair of the review has explained how they felt the Trust 'blamed' the mother and her husband for her death, because had the mother not got pregnant she would not have died.

10.31 In another case in **2001** the family made three requests via the NHS complaints procedure for an external review into the death of the mother. It was finally arranged by the Trust's lay chairman and complaints convenor two years after the death in 2003 and identified significant issues in the care. In their letter to the family it is stated *'The lay chairman and I agree that there has been a long period of local resolution, including a meeting with the consultant in charge…and several letters from the chief executive. In fact, this is the third request for an independent review. The independent clinical advice supports your view that there are still significant issues which need to be addressed concerning the standard of care provided…'* From the available documentation the review team can conclude that the initial investigation into the death by the Trust was poor.

10.32 The review team rated all available Trust investigations into these maternal deaths as poor. We found repeatedly that significant omissions in care were not identified by the Trust investigators, leading to missed opportunities for learning that could affect the outcome for other women and babies in the future.

Findings

10.33 Many RCAs did not involve a multidisciplinary team, even if there were multiple professions involved in the care of the woman (for example there was usually an absence of specialities such as obstetric anaesthesia, intensive care, infectious diseases, cardiology and/or haematology). Frequently only a few internal maternity staff performed the investigations and even at mortality and morbidity review meetings a truly multidisciplinary discussion did not happen.

10.34 It appears that all these cases of maternal deaths were investigated purely internally, with no external expert opinion sought, except in the one case mentioned above.

10.35 If and when post-mortem results became available during the investigation that seemingly pointed to a direction of an 'inevitable outcome', the direction of the investigation changed in such a way that detailed scrutiny and holistic review of the entire care did not happen.

10.36 Issues in care that were identified were frequently treated as individual failings and actioned by 'internal reflection' of involved staff. The investigations did not follow the appropriate systems-based approach as outlined in the relevant NHS incident frameworks and significant learning opportunities for the Trust and the wider maternity teams were lost. These frameworks are discussed further in the report chapter focussing on clinical governance.

10.37 The review team noted that frequently the women themselves were blamed or held responsible for the adverse outcomes, without identifying underlying and obvious failings in care. A husband recalled how in **2011** his deceased wife was blamed when he was told: *'[it was] difficult for the midwives to listen to baby's heart beat due to her size'.* This was also recorded in the maternity records. Trust documentation pertaining to a maternal death in **2002** stated *'…she knew of the risks [related to pregnancy] and accepted these'.* In another case in 2002 the following was said *'...she must have been responsible for some of that because she clearly did not complain very much and tended to ignore many of her symptoms…'.*

10.38 In one case in 2014 there was a significant discordance between what was discussed with the relevant clinicians involved in the incident by email and the stated outcome of the internal incident investigation. The Trust investigation concluded *'no deviation in care and management identified relating to root cause'.* However, in emails that were sent by one of the lead investigators to individual staff involved in the care

of the mother, it is clear that significant omissions in care were identified: '*…none felt that discharge to the antenatal ward at that point was the correct action'.* This case highlights significant cultural problems in the Trust at the time. There appeared to be a lack of ability to come together and examine why this happened. There was no insight into the problem resulting in a poor investigation, which later informed the coroner's inquest. This affirms the overall findings of the review team that significant contributory factors and/or the root causes for poor outcomes were not identified, or to the extent they were identified, were not addressed with a robust action plan; demonstrating a lack of rigour and transparency in the RCA investigations.

10.39 There is also evidence from the available governance documentation and conversations with families that in some cases failings in care were not communicated in an open and transparent way, once the investigations were completed.

10.40 *In **2006** a woman with an underlying cardiac condition, developed significant tachycardia and low blood pressure after the delivery. In a meeting with the family after the investigation they were told that 'The ECG of a pregnant woman can be misleading to a junior doctor with general medical experience; as it can appear to suggest the heart is not coping; which is incorrect and a normal rhythm in pregnancy.' At no point was it discussed with the family as to whether this complication should have been escalated to a more senior doctor or cardiologist. There was also a missed opportunity to manage and treat the underlying causes of the tachycardia.*

10.41 *In **2014** another family who questioned the appropriateness of treatment for maternal sepsis were told in a debriefing meeting that 'she did not have signs of profound infection' which is not corroborated by the clinical notes. The internal discussion at the Trust regarding the serious incident found that the sepsis treatment had been not well coordinated, but this was not disclosed to the family.*

Learning from maternal deaths

Local Actions for Learning and Immediate and Essential Actions from report 1:

10.42 The review team re-emphasises the importance of the previous Local Actions for Learning for the Trust and Immediate and Essential Actions for the wider maternity system from their first report regarding the learning from the maternal deaths at the Trust. They can be found in Appendix 2 and form a vital part of the ongoing learning for the Trust and wider maternity system. In particular continued focus must be around timely escalation to an appropriately senior level and multidisciplinary team working. MDT training involving maternity teams working with ITU, anaesthetic and other colleagues in management of the deteriorating pregnant woman is needed. This will ensure the right team are always available with the skills to manage complexity.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

10.43 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

Chapter 11

Obstetric anaesthesia

11.1 Expert advice was sought from anaesthetist colleagues within the Maternity Review Team for a number of cases. Criteria for anaesthetic review for this report were the presence of severe pre-eclampsia or HELLP; eclampsia; postpartum haemorrhage of 3000ml or more; significant pre-existing maternal medical disease; and concerns regarding the management of obstetric anaesthesia. As a consequence, 68 cases were referred to anaesthetists within the Review Team. This is a small percentage of the overall number of cases reviewed in this report and an even smaller proportion of the overall number of maternities taking place at the Trust during the past two decades. Consequently, there is a limit as to how representative of anaesthetic provision at the Trust these cases can be considered to be. However, there were a number of recurring themes that are worthy of comment to facilitate further learning.

Anaesthetists and the multidisciplinary team

11.2 The role of the anaesthetist on duty for obstetric anaesthesia is much broader than being merely a technician for provision of pain relief and anaesthesia. They must also work as part of the multidisciplinary team in the management of women experiencing pregnancies or childbirth, complicated by certain obstetric issues or pre-existing medical disease. As described in the first report, the review team again found evidence that anaesthetic input on the labour ward was often task-focussed and lacking consideration of the wider clinical picture of the women in their care.

11.3 *In **2012**, ten days after emergency caesarean a woman was displaying florid signs of sepsis and a decision was made to reopen her wound. The specialty doctor anaesthetist gave appropriate intraoperative care at laparotomy which revealed pus in the caesarean wound and pus within the peritoneum[197]. However, there was no evidence of discussion regarding where the patient would be best managed postoperatively and no postoperative instructions were documented by the anaesthetist. She was discharged back to the labour ward overnight and stepped down to the postnatal ward the following day despite the patient's concerns about her breathing. A respiratory examination was not undertaken until the second postoperative day when the patient was experiencing chest pain and had a significant oxygen requirement. She was later found to have a loculated empyema[198] for which she was admitted to the high dependency unit and later transferred to another hospital for surgical management. There was no anaesthetic input into the subsequent high risk case review. (2012)*

11.4 *In **2019**, a woman developed severe intraoperative hypertension under spinal anaesthesia. Early the following morning the midwife noted unilateral arm and leg weakness and requested an assessment by the anaesthetist who suggested that this was a residual effect of the spinal anaesthetic, but did not document their review. Later in the day, after no improvement, a further review was requested and documented and the anaesthetist escalated their concerns to the consultant anaesthetist and medical team. A CT scan ten hours after initial concerns were raised revealed a subarachnoid haemorrhage[199] an internal Trust review of the case by a consultant anaesthetist found no problems with the anaesthetic care. (2019)*

11.5 As well as occasions where anaesthetists failed to involve themselves in the care of critically ill women, there were cases where the obstetric and midwifery teams failed to involve or inform the anaesthetist on duty about women with significant morbidity. Often the anaesthetist was only called to review a patient once a decision had been made to take them to theatre, sometimes for very urgent surgery, thus denying the anaesthetist the opportunity to make a considered assessment of the patient and to take steps to optimise the patient's condition prior to anaesthesia.

197 See glossary
198 See glossary
199 See glossary

11.6 *In **2004**, at 0520h, 50 minutes after a vaginal delivery, a woman had bled in excess of 1000ml. The midwife did not escalate this to the obstetric team until 0550h who, in turn, did not alert the anaesthetist until 0730h, just prior to transferring the patient to theatre for an examination under anaesthetic. Local guidelines regarding key personnel to be notified in the event of post-partum haemorrhage were therefore not followed. The woman raised concerns about her care when she subsequently attended an obstetric outpatient appointment. There is no evidence that her case was reviewed by the maternity governance team even though the consultant obstetrician stated in his letter from that appointment that it should be. The consultant mentioned that she would have a midwifery debrief appointment in order to address 'her various anxieties'. (2004)*

11.7 *In **2006**, ten days after an emergency caesarean section a woman was readmitted with collapse and blood loss in excess of a litre. Despite a decision within 20 minutes of admission by the consultant obstetrician that the patient would need an examination under anaesthesia, there is no evidence that the anaesthetist was notified for more than 4 hours (contrary to the Trust's postpartum haemorrhage guidance at the time). The anaesthetist assessed the patient 9 minutes before she was transferred to theatre. She was so unstable that she required a general anaesthetic, hysterectomy, and a blood transfusion of 11 units. An incident report was submitted but a consultant obstetrician decided that a high risk case review was not required. The consultant wrote to the obstetrician who performed the caesarean section stating that 'care throughout [the readmission with postpartum haemorrhage] seems to have been appropriate and decision making made at the appropriate level' but queried the possibility of injury to the uterus at caesarean section. (2006)*

11.8 *In **2008**, a multiparous woman was admitted with raised inflammatory markers[200] after premature rupture of membranes at 33 weeks of pregnancy. A scan the day after admission showed the baby was in a footling breech position. Despite a recognised high probability of the need for early delivery, the anaesthetist was not called to review the patient until a decision was made for a category 1 caesarean section when the patient had reached 7cm cervical dilatation 6 days later. There is no evidence of learning arising from this case. (2008)*

11.9 *In **2018**, despite repeated previous admissions with antepartum haemorrhage in a woman with known low anterior placenta accreta[201], the duty anaesthetist was not alerted to the presence of the woman in the hospital until the decision was made that she required a category 2 caesarean section, almost 36 hours after her admission with a further antepartum haemorrhage. Escalation by the duty anaesthetist to senior anaesthetic staff and involvement of additional theatre staff was then swift and her overall anaesthetic care good and safe. There is no governance documentation relating to this case. (2018)*

11.10 Failure of anaesthetic and obstetric resident on-call teams to escalate promptly to senior staff during times of high workload or when managing deteriorating or very ill women was noted in this review's first report and seen again in further cases reviewed for this current report. In response to a Local Action for Learning point from the first report, the Trust now has a specific guideline advising when the on-call consultant anaesthetist must be contacted by the resident anaesthetist. However, as with all guidelines advising on escalation to specific personnel (including the ones that were not followed in the vignettes below), this will only result in service improvement if its advice is adhered to, and if the consultant on-call is free to attend. Anaesthetic staffing at the Trust remains a concern which is discussed later in this chapter.

11.11 *In **2004**, the resident anaesthetist was called at 0530h to see a woman in labour following an intrauterine death thought to be due to placental abruption. He was unable to attend for an hour and a half due to workload, by which time the patient had bled 1400ml and was tachycardic[202].There is no evidence that this incident was reported or that any investigation or learning occurred.(2004)*

11.12 *In **2013**, a woman had labour induced due to pre-eclampsia. She had significant oedema, headache and visual disturbance. Her blood pressure was 166/115mmHg and she was struggling to cope with the impact*

200 See glossary
201 See glossary
202 See glossary

of an oxytocin infusion on her labour pains. 2h 25min elapsed between the duty anaesthetist being called and their attendance to site the epidural as they were busy in theatre. During this time the oxytocin infusion had to be switched off due to the woman's distress. Once the epidural was sited, the anaesthetist left the midwife to administer the initial doses, contrary to Trust guidance, as they were called for a category 1 caesarean section for another patient. There is no evidence that efforts were made to contact another resident anaesthetist or the consultant on-call to assist with the workload. An incident report was submitted about an unrelated aspect of her peripartum care, but no action plan or investigation was documented or made available to the review team. (2013)

Anaesthetic services, workforce and leadership

11.13 The first report raised concerns about anaesthetic staffing at the Trust, in particular at consultant level. The 2017 RCOG report[203] commented that anaesthetic consultant staffing was non-compliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland (OAA/AAGBI) Guidelines for Obstetric Anaesthesia Services[204] which recommended 12 consultant anaesthetist sessions per week to cover just the emergency work of the labour ward, with additional sessions required for management of clinics and elective caesarean list workload.

11.14 The Trust has a document reflecting its anaesthetic staffing and plans: Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants. Its first iteration was in 2010 and it has been amended over the years in response to service changes, audits, and a Clinical Negligence Scheme for Trusts (CNST) report, with a full review and update in 2015. At that point, the Trust self-evaluated that it required 14 sessions of anaesthetic consultant cover in order to comply with the OAA/AAGBI guidance but that it had a shortfall of three consultant sessions. Prospective cover for leave involved cover by another consultant or a specialty doctor.

11.15 By 2018 the self-evaluated number of sessions that required cover had risen to 16 but actual staffing remained static at coverage of 11 sessions only, a deficit of 5 sessions. Since the publication of the first report, the Trust has advised the review team that elective lists and clinics are almost always staffed by a consultant grade anaesthetist but that the labour ward only has dedicated consultant cover 50% of normal daytime hours. This falls short of current guidance from the Royal College of Anaesthetists (RCoA) as detailed in the Guidelines for the Provision of Anaesthetic Services (GPAS)[205].

11.16 The review team has been advised by the Trust that, out-of-hours, the anaesthetic consultant on-call at The Princess Royal Hospital, Telford, has responsibility for general theatres, intensive care, paediatrics, and the head and neck surgical service as well as obstetrics. This results in situations where, understandably, they are unable to be in more than one place at a time. The review team has been advised by staff that attempts to recruit new consultant anaesthetists in order to provide a separate rota to cover intensive care have so far been unsuccessful. The required training and skillset of the obstetric anaesthetists and also that required for the non-obstetric anaesthetists who cover the maternity service out-of-hours is not specified in RCoA's guidelines. The Trust's Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants document states that *'Staff are made aware of the availability and access to all guidelines, protocols and policies during their induction'* but does not give any more detail on any measures taken to assure staff training and updates. A list of consultants who provide input to the on-call service has been provided by the Trust and it is notable that a significant proportion are locums. There is a nominated lead obstetric anaesthetist who has an active role in leading and managing the service, and this is reflected in their job plan.

11.17 A team of specialty doctors provide the out-of-hours and much of the within hours resident cover to the maternity service. They are described by the lead obstetric anaesthetist as a 'senior stable workforce'.

203 The RCOG report -Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust July 2017

204 OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, June 2013, London

205 Guidelines for Provision of Anaesthesia Services (Chapter 9 Guidelines for Provision of Anaesthesia Services for an Obstetric Population 2020). RCoA. (https://rcoa.ac.uk/gpas/chapter-9)

Doctors in training spend daytime hours on obstetrics but have not contributed to out-of-hours provision since 2011. The Trust has provided no detail to describe the training and ongoing development of the specialty doctor group of anaesthetists upon which the service relies so very heavily. Access to learning and development opportunities can be limited for staff grade, associate specialist and specialty doctors (SAS) generally within the NHS, specifically in comparison to consultant colleagues or doctors in formal training programmes. This may be due to the role of SAS doctors in managing service pressures and their lower supporting professional activity (SPA) allowance compared to consultant staff.

11.18 A member of staff talking to the review team in the autumn of 2021 told us; *'We're just about functioning but we are having to use locums and every week you look at the system and it's just a mess of extra people doing different lists, slotting in. So we're getting by, you know, week to week. It's quite a challenge…you raise your concerns and everybody says yes, yes, this is a big concern but nothing really happens'.*

Management of common obstetric conditions

11.19 In a surprisingly large proportion of the cases reviewed for this report, common obstetric conditions were not recognised or not managed in line with established guidelines. There is evidence of women receiving excessive volumes of intravenous fluid prescribed by both anaesthetists and obstetricians. This took place in the presence of severe pre-eclampsia, contrary to local and national guidance regarding fluid restriction in such circumstances, and also after post-partum haemorrhage. In some cases, the women were displaying clear signs and symptoms of fluid overload over a protracted period before it was noted by medical staff.

11.20 *In **2004**, after discharge to recovery following examination under anaesthesia for post-partum haemorrhage, the patient continued with 100-150ml intravenous fluids per hour despite plentiful oral intake. Some 3.5 hours later she was noted to be desaturating and an hour after that she complained that her hands felt 'tight' and they were documented as oedematous. Her urine output overnight peaked at 320ml/h. An obstetric SHO prescribed a further two units of blood as there was a decrease in the woman's haemoglobin. The following morning, with oxygen saturations of 88% on air, she was finally diagnosed as being fluid overloaded. She passed 1600ml of urine in the hour after she was given intravenous furosemide[206] and shortly afterwards was able to stop oxygen therapy. (2004)*

11.21 *A woman who had symptoms and signs of severe pre-eclampsia in **2008** had her baby delivered by caesarean section after failed induction of labour. She was diagnosed with left ventricular failure[207] and pulmonary oedema[208] in the postoperative period when she had a positive fluid balance in excess of 2000mls. Fluid administration was consistently in excess of the nationally advised limit of 80ml/h with 1500ml being given in theatre alone. A handwritten note in the patient's hospital records stated that her case had been discussed at a governance meeting, but no documents reflecting this were supplied to the review team by the Trust. (2008)*

11.22 Obstetric haemorrhage is a common condition that all staff involved in the care of obstetric patients must be confident in recognising and managing. However, there were a number of instances where the obstetric and anaesthetic teams seemed slow to diagnose bleeding as the underlying cause of a woman's deterioration. For example:

11.23 *In the early hours of the morning after an elective caesarean section in **2012**, a woman became progressively tachycardic and hypotensive[209] feeling hot, clammy and dizzy, with a sense of ringing in her ears, vomiting, and loss of consciousness with a brief seizure. Despite a 30g/l drop in haemoglobin on blood gas sample analysis, raised lactate, and uterine tenderness, the staff grade anaesthetist who was called to see her (and the obstetric on-call team) did not recognise that the patient was bleeding as there was 'no excessive*

206 See glossary
207 See glossary
208 See glossary
209 See glossary

blood loss seen'. The medical registrar was called to comment on the seizure and suggested bleeding as an underlying cause. She was finally diagnosed as such once the obstetric consultant was contacted. An incident report was submitted, but there are no other documents available related to the case. (2012)

11.24 *Following a vaginal delivery in **2016** a woman suffered a postpartum haemorrhage which resulted in tachycardia, hypotension, and the administration of 3.5 litres of crystalloid[210] by the obstetric team. The haemoglobin pre-delivery was 123g/l and at its lowest was 60g/l. The obstetric registrar estimated blood loss as 1000ml and wanted to take the patient to theatre for an examination under anaesthetic. The consultant anaesthetist estimated blood loss as 2000-3000ml. The consultant obstetrician estimated blood loss as 1200ml and overruled the plan for examination under anaesthesia. After a unit of blood that day and three the following day, the haemoglobin improved to 89g/l. A blood loss of just 800ml was later documented on the woman's discharge summary. When the woman was readmitted a month later she had a large remnant of placenta removed under anaesthesia and required a further blood transfusion. There was no incident reporting concerning these events. (2016)*

11.25 Local Actions for Learning from our first report highlighted the need for development of evidence-based guidelines and multidisciplinary training for developing and maintaining staff skills in the diagnosis and management of obstetric conditions. The Trust's anaesthetists have worked to create a full range of obstetric anaesthesia guidelines in response to the first report, and now acknowledge the challenge in embedding them into clinical practice and monitoring adherence to them. It is reassuring to hear from staff interviews that obstetric skills and drills are now undertaken regularly on the labour ward and involve the multidisciplinary team, including the anaesthetists.

Postnatal follow-up

11.26 In the process of undertaking reviews of clinical records for the purposes of this report, it is apparent that many women who experienced complications did not have the opportunity to have a proper discussion with clinicians about their peripartum care. On occasion there has been poor practice and care on the part of the Trust that has not been adequately discussed, and on other occasions women have had a complicated and difficult childbirth. From the communications between women, their families and the review team it is clear that a sense of not being listened to, as well as a lack of understanding about peripartum events, has persisted for some women and families for many years, impacting negatively on their psychological state, even now.

11.27 With the power of retrospection, it is clear that many women would benefit from postnatal discussion with clinicians who can actually give individualised answers about their care. Such discussion can occur at the time of events taking place but must be reinforced after discharge, when women are more able to gather their thoughts and questions in advance of a meeting, be supported by the presence of a friend, relative or advocate if they so choose, and take notes of answers.

11.28 Outpatient postnatal follow-up by an anaesthetist must be offered for women for whom significant issues have occurred, especially where they may impact on anaesthesia management or anxiety during future childbirth. Such issues include inherent anaesthetic complications such as intraoperative pain, including where conversion to general anaesthesia became necessary, suboptimal epidural pain control with significant consequent distress, and postdural puncture headache. More serious complications such as awareness under general anaesthetic and neurological complications related to anaesthesia must also be followed-up in an outpatient setting. Clinicians must also recognise situations where women would benefit from a conversation and explanations regarding their anaesthetic care even when nothing has actually gone wrong. Provision of such appointments must be seen as part of a culture of openness and willingness to maximise improvement of patient care, rather than as an admission of failure on the part of the Trust.

210 See glossary

11.29 *A woman made contact with the Review Team regarding her 'horrendous' experience of pain during caesarean section under epidural top-up with intraoperative conversion to general anaesthesia in **1999**. Despite the passage of time, the experience still causes the woman distress to this day. On review of the medical records it is clear that the epidural never offered adequate pain relief in labour and there is no evidence that the top-up for surgery was checked for adequacy. Twenty minutes after arriving in theatre the patient was given a general anaesthetic with a note documenting 'switch to GA after initial incision for surgical reasons'. After a midwifery debrief, the patient's notes were passed to a consultant anaesthetist who wrote a note saying that 'bar reassurance, probably there is no specific reason to see her'. Although this case occurred before the main period of the review, it is included here as a reminder to all clinicians involved in maternity care how psychological injuries may persist for years afterwards. Efforts must be made to minimise such occurrences and to provide adequate help to manage the consequences of such events when they do occur.*

11.30 *Two days after an emergency caesarean in **2017**, a woman was admitted to HDU with acute lung injury. A confusing and conflicting range of underlying diagnoses were reflected in the notes and discussed with the patient by the obstetric, anaesthetic and respiratory teams. At discharge, the patient asked about the possibility of a debrief with an obstetrician. She later had a debrief with a midwife only, where no further insights on the woman's underlying medical diagnoses were discussed and she remained unclear as to what had caused her significant illness. Over a year later she was still requiring psychological support. In this case a multi-professional meeting with clinicians who had been involved in her care would have been more appropriate than a midwife-only debrief. (2017)*

Documentation

11.31 On performing reviews of medical records for this report, midwifery documentation has tended to offer the most consistent evidence for understanding the development and timing of events. Brief reviews by both obstetric and anaesthetic doctors are often not documented by the doctors themselves despite being of clinical significance, and anaesthetic documentation is commonly restricted to an anaesthetic chart only. Documentation on the anaesthetic charts was frequently patchy, lacking detail of block adequacy achieved before surgery, or medication administered.

11.32 *Despite attending a patient with massive antepartum haemorrhage, the duty anaesthetist in **2004** did not document their actions or plan. The patient was reviewed a number of times over the course of the subsequent day by a consultant anaesthetist who again did not document anything. Their reviews, actions and advice were documented by the midwife only. (2004)*

11.33 *Following a category 1 caesarean section for antepartum haemorrhage complicated by massive obstetric haemorrhage in **2015** the patient remained cardiovascularly compromised for a time period in recovery, as evidenced by low blood pressure and high heart rate on her observation chart. The healthcare worker who completed the observation chart also documented the presence of the consultant anaesthetist for the full 45 minutes of that instability, although the anaesthetist made no entry in the notes. (2015)*

Learning from adverse outcomes

11.34 An important part of the purpose of reporting adverse events is in order to inform staff about the possibility of risks, to learn from the adverse outcomes of the practice of others, as well as oneself, and to take steps, where possible, to minimise similar occurrences in future. Failure to learn from such occurrences and share reflections with colleagues, risks a failure of 'institutional memory' and may result in repeated and needless patient harm. Staff of all grades and specialties benefit from continual peer and self-review of their practice in the form of morbidity and mortality meetings. Just 39 incident reports concerning obstetric anaesthesia were submitted in the Trust during the time period 2008-2021. The Trust must consider whether such a low reporting rate indicates staff acceptance of poor practice and complications, or a lack of faith that reporting can effect change.

11.35 *A spinal anaesthetic was sited for a forceps delivery in **2010**. Documentation on the anaesthetic chart stated 'no pain on insertion/injection'. The woman developed foot and leg pain the following day but the anaesthetist declined to review the patient as they 'thought it unlikely to be related to spinal anaesthesia'. An MRI requested by the orthopaedic team showed oedema[211] of a low-lying and tethered conus[212]. Documentation of subsequent discussion between the anaesthetist and the woman reflects that she had actually experienced 'electric shock' pains on initial spinal insertion but the anaesthetist wrote that they had withdrawn the spinal needle when this had occurred. There was no explanation as to why there was a discrepancy between the documentation on the anaesthetic chart and the subsequent conversation. The patient needed ongoing management for neuropathic pain and foot drop after discharge. The chief executive's response to a complaint letter included the statement: 'Training is not an issue as [the anaesthetist's] main activity is undertaking epidural and spinal anaesthetics in the maternity department'. (2010)*

11.36 *In **2012**, a woman experienced non-postural headache and focal neurological symptoms after an epidural for labour by a staff grade anaesthetist (which took a number of attempts to insert, worked sub-optimally, and was sited more than five hours after it was requested due to labour ward workload). It was only on her fourth readmission with symptoms that brain imaging was undertaken and bilateral subdural haemorrhage diagnosed. In the Trust's response to her complaint letter, it stated that the anaesthetist had said that the subdural haemorrhage could not have related to an accidental dural puncture as none was noted at the time of epidural insertion, thus failing to acknowledge that unrecognised dural puncture may take place. Possible causes suggested in the letter were high blood pressure in labour, the stress of her baby being admitted to the neonatal unit, and a pre-existing neurological susceptibility. (2012)*

11.37 *In **2018**, a root cause analysis into the management of a woman with what was considered to be an atypical presentation of pre-eclampsia (drowsiness, reduced level of consciousness in conjunction with elevated blood pressure, headache, vomiting and epigastric pain) looked at statements from three midwives and an obstetric middle grade. It did not involve the consultant anaesthetist or consultant obstetrician involved in the patient's care at the time culminating in her emergency caesarean section and seizure. Nor did it address the failure of the obstetric and midwifery teams to check on blood results taken in triage the night before, when the woman was assessed and discharged home, which would have shown her to be severely hypercalcaemic[213]. Nor did it investigate how an incorrect (elevated) value of INR[214] was verbally reported to the team caring for her, resulting in unnecessary administration of blood products, a decision not to perform a planned lumbar puncture, and a decision not to manage a fibroid at the time of caesarean section. (2018)*

11.38 Anaesthetists should be included in and engage fully with the multidisciplinary team, both clinically, and in maternity governance activity. The Trust's Women's and Children's Root Cause Analysis planning proforma in use in 2018 has a list of job roles with the option of indicating who should be present. None of the 17 job roles listed is that of consultant anaesthetist.

11.39 Involvement of the anaesthetic team in governance activity requires a change in culture and attitude but also requires time and planning. Departmental leads and the executive team must address the resource requirements necessary for anaesthetists to take an active role in obstetric governance and ensure time away from clinical commitments is allowed for this purpose in anaesthetic staff job plans. This will necessarily have cost and recruitment implications. Conflicts of demands on the time of consultant anaesthetists must be addressed at executive level and not left solely to individual anaesthetists to resolve.

11.40 The terms of reference for the Trust's maternity governance meetings from January 2018 state that an anaesthetist is required to attend every three months – minutes of attendance suggest that even this low benchmark is not being achieved. It is important that, even in times of high clinical workload, anaesthetic presence at governance meetings must be maintained to ensure the safety and the integrity of the service in the longer term. This is certainly challenging if, as Trust staff advised the review team, there are still considerable issues with consultant anaesthetic staffing.

211 See glossary
212 See glossary
213 See glossary
214 See glossary

Local Actions for Learning

11.41 The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

11.42 The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

11.43 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

11.44 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

11.45 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by GPAS in 2020.

11.46 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.

11.47 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

Chapter 12

Neonatal care

Introduction

12.1 In this chapter we focus primarily on the clinical care provided by the neonatal team to babies delivered at the Trust. The majority of the care reviewed took place on the neonatal unit (NNU), but the neonatal team were involved in resuscitation of babies on the labour ward as well as managing some babies on the postnatal wards.

12.2 It is important to emphasise that in line with the terms of reference the cases reviewed only represent less than two per cent of the total births at the Trust and a small minority of neonatal admissions over the review period. Cases were ascertained due to either parental concerns about the quality of maternity care or due to poor outcomes - specifically neonatal death or brain injury. In addition, some cases came to light in the Open Book exercise arranged by the Trust which considered HIE and neonatal death as factors for referral to the review.

12.3 As well as identifying areas for improvement and learning, the review team also noted many examples of good neonatal practice and often excellent communication. The number of complaints by families about the care they received in the neonatal unit was quite low.

Organisation of neonatal services in the UK (2000-2019)

12.4 In 2001 the British Association of Perinatal Medicine (BAPM) updated its 1996 standards for hospitals providing neonatal intensive care. There was a recommendation that hospitals work together in networks and care of the smallest and sickest infants be centralised into larger centres, neonatal intensive care units (or NICU), known as level 3 units. This led to the development of managed neonatal networks and was incorporated into the Maternity Services National Service Framework in 2004. It was also recognised that clinical skills needed to be maintained in the local neonatal units (LNU), known as level 2 units, to provide short term intensive care (usually up to 48 hrs) for more mature babies in close liaison with their designated level 3 NICU.

12.5 In 2009 a Department of Health taskforce of neonatal professionals and parent representatives published a Toolkit for High Quality Neonatal Services[215] with service specifications to standardise special care, high dependency care and intensive care. In 2010 the National Institute for Health and Care Excellence (NICE)[216] published quality standards for neonatal specialist care. In most trusts compliance with these standards is reviewed through clinical governance processes.

12.6 NHS England commissions all levels of neonatal critical care. The commissioning of care is usually agreed with the neonatal network but ultimately is a formal agreement between the commissioners and the provider unit trusts.

Neonatal transport

12.7 Babies should ideally be delivered in the most appropriate setting for their predicted care needs. In utero (before delivery) transfer is preferable to postnatal transfer and has been shown to improve outcomes. However babies do sometimes need to be transferred after birth for escalation of care, or to access

215 Department of Health. Toolkit for High-Quality Neonatal Services (2009) https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

216 National Institute for Health and Care Excellence. Neonatal specialist care Quality Standard (QS4) (2010)

specialist care (e.g. for neonatal surgery). Over the period of this review, neonatal transport services, which were traditionally provided and staffed by the larger NICUs, were centralised in all networks so that a dedicated transport team is responsible for moving babies between units, and since 2015 most services have had a centralised telephone triage system. In the West Midlands, a centralised team has provided transport services 24/7 since 2008. Teleconferenced triage has become available in very recent years.

Organisation of neonatal services at the Trust (2000-2019)

12.8 Following the establishment of neonatal networks in England in 2004, the Trust's neonatal services initially formed part of the Staffordshire, Shropshire and Black Country Neonatal Network (SSBCNN) becoming an operational delivery network in 2013 (SSBCODN). The NNU and the obstetric services at the Trust are located within the Shropshire Women and Children's Centre, based at the Princess Royal Hospital (PRH) in Telford, having moved there from the Royal Shrewsbury Hospital (RSH) in late 2014.

12.9 Prior to 2006 the neonatal service at the Trust provided intensive care. Since 2006, when unit categories were first defined, it has been designated as a Local Neonatal Unit (LNU) of level 2. This means that it is commissioned to provide special care and high dependency care for newborn babies, as well as intensive care for periods of up to about 48 hours. Babies requiring longer-term intensive care and singletons born at less than 27 weeks gestation, if not transferred in utero, should be discussed with and transferred to a level 3 unit (NICU).

12.10 The neonatal unit at the PRH in Telford has 22 cots and is busy compared to other LNUs with above average numbers of preterm babies admitted. In 2018-19 it provided 7,425 care episodes, which was in the top quartile of critical care activity for neonatal units providing critical care in England.

12.11 The review team heard that the neonatal service at the Trust disputed its revised designation and did not work in line with the new scope of its responsibilities. There is debate why this was. Some at the Trust felt that due to the unit's size, expertise and geographical location (including receiving babies from Wales) it should have been designated as a level 3 unit. Others at the Trust have stated that there were insufficient cots and expertise elsewhere throughout the region, although this is disputed by the neonatal network[217]. The West Midlands Neonatal Operational Delivery Network confirmed in correspondence with the Chair of this review that *'capacity in both University Hospital North Midlands (which is the care pathway for SaTH and Royal Wolverhampton Hospital NHS Trust) has rarely been so that they would not take a baby that required NICU care'.* Despite this, the review team found evidence of non-compliance by the Trust with its 2006 level 2 designation until at least 2015.

12.12 The review team noted that for a period of nine years after the designation to a level 2 unit, transfer of babies from the Trust that required intensive care did not consistently occur in line with the national and network guidelines. According to the neonatal network capacity issues were not causative. The review team is of the clear opinion that NICU care relies on a properly resourced multidisciplinary team and that the designation as a level 2 unit after 2006 should have been respected and adhered to.

12.13 Following the contested designation as a level 2 unit in 2006, the review team has been advised that network leadership and the commissioners met with the Trust on several occasions, especially after the publication of a network care pathway document in 2011 to try to ensure that neonatal care within the Trust followed the guidance.

12.14 The Royal College of Paediatrics and Child Health (RCPCH)[218] carried out an invited review in 2013. They noted that *'given the availability of experienced and dedicated neonatologists, at the time of the visit the unit cared for a number of babies under 27 weeks and provided an enhanced range of intensive care services'.* They noted that this intensive care activity was not supported by the neonatal network and that the unit would in future work as a standard level 2 local neonatal unit. The Trust continued to deliver some aspects of intensive care outside the agreed care pathway until the unit moved to the Telford site in 2014.

217 Letter to Donna Ockenden from West Midlands Neonatal ODN dated 3rd September 2021

218 Report provided to the review team by the Trust

Cases considered by the review team also demonstrated that this progressive change in neonatal care took many years to be embedded into clinical practice:

12.15 *In **2011** a baby was delivered at 26 weeks gestation after threatened preterm delivery from 23 weeks with no record of consideration of in utero transfer Senior staff were closely involved in care at the Trust with a good relationship with the family and evidence of compassionate care was seen after the poor outcome. (2011)*

12.16 In the next revision of the network care pathway in 2015, it was made more explicit that advanced therapies should not be delivered at the Trust, unless in exceptional circumstances and after discussion with a neonatologist at the Royal Stoke Hospital (now University Hospitals of North Midlands) NICU. Sometime after the move to the new unit in Telford the neonatal unit started operating at the designated level 2.

Perinatal and neonatal mortality

12.17 The perinatal mortality rate (PMR) and the neonatal mortality rate (NMR) are measures which are used as benchmarks of the quality of obstetric and neonatal care, although other factors such as socioeconomic circumstances and maternal age also have an important influence on these measures.

12.18 The MBRRACE-UK perinatal surveillance annual reports have been available since 2013, and they have provided PMR and NMR data, 'adjusted and stabilised' with regard to key contributory factors, for individual trusts from 2014[219]. The neonatal mortality rate (NMR) for the Trust was above the average for similar providers (similar numbers of births LNUs) for the years 2014–2016, but in 2017 it dropped to below the average. In 2018 and 2019 it was 'red' (more than 5 per cent above the group average). It should be noted that in all these years the NMR and PMR were comparable to many similar units and were not statistical outliers. Mortality rates for preterm babies born between 2015 -2018 were also high for babies born within the SSBCODN network and for two of its neighbouring networks.

12.19 In 2009 the neonatal service at the Trust described itself in the National Neonatal Audit Programme (NNAP) report as a NICU, despite having been designated as a level 2 NNU in 2006. This review has also been provided with documentation of a presentation to the CCG in 2018 where a Trust representative outlined that one of the reasons that the Trust felt its neonatal unit had higher perinatal mortality than its peers was because it was being compared with level 2 units (LNUs) when it had in fact been operating as a level 3 unit (and therefore accepting and continuing to care for more complex cases) until 2016. In this presentation the Trust representative made the case that therefore the figures were not representative. They stated the reason for operating at level 3 was due to capacity issues elsewhere in the network. There has been no evidence seen by the review team that capacity in other units was an issue and this has been confirmed by the neonatal network. The review team note that the data is difficult to interpret as the Trust had consistently not worked at the level it had been allocated and that it should not have taken in excess of eight years for the Trust to have worked at the level it had been designated.

National Neonatal Audit Programme

12.20 The National Neonatal Audit Programme (NNAP) has measured the quality of care delivered by neonatal units since 2006. NNAP reports available online (2014-2019) indicate that, for the limited number of quality indicators, the NNU at the Trust was performing at above the average for LNUs in the UK. In particular, the Trust NNU achieved one of the best scores compared with other LNUs for communication (the proportion of parents who meet with a senior member of the neonatal staff within the first 24 hours of admission). Temperature control of babies was also above average and eye-screening was excellent for this period.

12.21 The length of stay on the NNU at the Trust for late preterm babies and more mature babies was reported to be longer than in other NNUs - this may reflect a need to improve transitional care facilities at the Trust. In 2018 and 2019 the proportion of neonatal nurses working in the NNU at PRH who had a specific

219 MBRRACE Perinatal mortality surveillance reports 2013-2016 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance
MBRRACE Perinatal mortality surveillance report 2017 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

qualification in the care of sick newborn infants was lower than the average for LNUs in the UK and appears to be falling.

Review of neonatal clinical care at the Trust

12.22 During our reviews we identified a number of cases where individual errors were made or there was poor practice. However, these were very much the exception and we have found no evidence of systemic poor neonatal practice or lack of care or compassion in the neonatal service. The review found evidence that identified failings in care were addressed by the Trust with the development of appropriate guidelines, but the review team does not know if the development of these guidelines then led to improvements in care. However, some incidents occurred with sufficient frequency, or were sufficiently important, that we feel there is scope for wider learning on a national level.

12.23 It appears from the majority of the medical records reviewed that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. There were frequent examples of the consultants being called to assist with resuscitations of newborn babies on the labour ward and in many cases their interventions led to an improvement in the short-term outcome.

12.24 Review of the medical records shows that the Trust was an early adopter of the Advanced Neonatal Nurse Practitioner (ANNP) model and that ANNPs played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. We noted their practice to be appropriate and that the ANNPs formed an important part of the neonatal staffing model. The quality of their entries in the medical records was generally noted to be of a very high standard. During the reviews we did not identify any systematic concerns about nursing care.

Transfers, referrals and escalation of care

12.25 Neonatal care is most effective when delivered in close partnership with other services as discussed above. When reviewing individual cases we found evidence of effective joint working:

12.26 *In **2005**, after an uncomplicated term delivery a baby became progressively seriously ill with breathing and neurological problems. On the first day of illness the problem had been recognised as a very severe metabolic disorder and advice on care was obtained from regional and national specialist services. Despite transport to the national centre being arranged sadly it was not possible for the baby to survive. Successful genetic diagnosis allowed counselling about future risk to be provided to the family. (2005)*

12.27 *In **2010** antenatal scans had suggested the possibility that a baby might have problems and a plan was in place for assessment and care at birth After delivery it became clear that the baby could not manage to breathe strongly enough on their own and needed support from a ventilator. Specialist reviews were arranged in Shrewsbury and the required investigations quickly carried out with close involvement of regional and national services. A definitive diagnosis of a neuromuscular disorder was very quickly established and palliative care agreed with the family. We found good evidence of highly effective and compassionate care with input from multiple specialists. (2010)*

12.28 We found evidence of appropriate communication with tertiary specialists when babies required escalation for specialist care, including surgical or cardiac care and good liaison with Alder Hey and Birmingham specialists regarding MRI scans and post-mortem reports. However, in some other cases we found planned deliveries being arranged at the Trust which had not had the involvement of specialist services as would have been expected.

12.29 *In **2008**, a baby was diagnosed with significant spina bifida[220] (lumbar myelomeningocoele) with severe hydrocephalus in the antenatal period. There was no evidence of tertiary fetal medicine or neurosurgical*

220 See glossary

discussion regarding appropriate tertiary referral. The baby delivered at the Trust. There were challenges delivering respiratory support in head box oxygen[221] and baby needed support with a ventilator when the transport team arrived at 30 hours of age, before they could be moved to Birmingham Children's Hospital, (BCH). Despite continuing intensive care in the regional unit the baby developed worsening respiratory distress at BCH as well as a coagulopathy[222] and remained too ill for surgery and died. (2008)

12.30 During the period when the neonatal service continued to operate as a NICU, despite its designation as a neonatal unit, some babies were delivered with major congenital anomalies requiring high level intensive care.

12.31 *In **2008**, there was an antenatal diagnosis of diaphragmatic hernia[223]. The parents were seen by a neonatologist and plans for delivery in Shrewsbury were discussed. An antenatal appointment was offered at Alder Hey. Parents declined this as they felt they had too many appointments to attend. The surgical service were aware of the plan to deliver locally and to transfer the baby after stabilisation. No major difficulties were encountered with the baby's initial care at Shrewsbury and baby was transferred but at the tertiary unit the baby progressively deteriorated and did not survive. (2008)*

12.32 In the same year another baby with the same major anomaly was delivered in Shrewsbury:

*The baby was diagnosed in the antenatal period in **2008** with a diaphragmatic hernia. The neonatologist wrote a letter to the parents and another to the paediatric surgeons in the local surgical centre at Birmingham Children's Hospital (BCH). This states 'baby has diaphragmatic hernia, booked to deliver at RSH and as a unit that is able to perform all levels of intensive care we feel that we are in a position to offer neonatal resuscitation and stabilisation pre-surgery at Shrewsbury. One of the neonatologists will personally be on call for the lady's delivery'. (2008)*

12.33 *The regional surgical service were aware of the planned delivery with no evidence seen by the review team that that they suggested any alternative plan. The baby died after three hours after challenges in delivering aspects of intensive care. Whilst the outcome might not have been different it was not clear that the parents had been offered the opportunity to discuss options with the specialist surgeons in Birmingham prior to delivery.*

12.34 Babies found to have diaphragmatic hernia during antenatal scans are now transferred for delivery in Birmingham Women's Hospital or Liverpool Women's Hospital. In our review of the medical records it was not always apparent that early consultation with a tertiary centre, to consider planning of transfer of care where appropriate, had taken place. It is possible that such consultations did take place but were not documented in the medical records to which we had access.

12.35 *In **2011** a woman presented at 25 weeks, with a twin pregnancy complicated by twin to twin transfusion syndrome[224]. There was antenatal discussion with Birmingham but the babies were born at RSH. The first twin needed prolonged resuscitation at birth. Later in the first week he required exceptionally extensive intensive care after a large brain bleed. There was no recorded discussion with a NICU and missed opportunities to transfer out in the first 2 days before baby became critically unstable. Sadly, the baby died. The other twin died at 5 months of age in a specialist centre, with airway problems. (2011)*

Management of babies with Hypoxic-Ischaemic Encephalopathy

12.36 Hypoxic-Ischaemic Encephalopathy (HIE) is due to impaired delivery of oxygen to the brain. Until around 2010 treatment was largely supportive, although clinical trials of brain or body hypothermia were undertaken in the early 2000s and published in 2005-2009 and cooling therapy was initially offered in a limited number

221 See glossary
222 See glossary
223 See glossary
224 See glossary

of centres participating in these trials. By 2009 it was established that therapeutic hypothermia significantly reduced the incidence of death or disability from HIE and the BAPM issued a position statement on its use. At this time therapeutic hypothermia (cooling) was normally delivered in NICUs although some larger LNUs in the UK still undertook this therapy on a transitional arrangement if agreed by the network.

12.37 To be most effective, cooling should be commenced (either passively or actively) by 6 hours of age. It is important that cooling therapy follows evidence-based pathways wherever possible. We found some examples of cooling outside this pathway.

12.38 *In **2010,** a baby born after cord prolapse with an umbilical cord pH 6.8 was cooled quickly and effectively, required full intensive care including inotropes to support blood pressure and mechanical ventilation to support breathing. The baby was not discussed with or transferred to a NICU. (2010)*

12.39 The review found that the clinical management of HIE in many cases was of a good quality but found that the cooling therapy delivered at the Trust was outside the agreed network pathway for this provider which stated: *'Newly born infants who require cooling for treatment of perinatal asphyxia will have active cooling initiated at RSH prior to being transferred with continued active cooling to UHNS or New Cross Hospital the Network Lead Centres or an appropriate neonatal intensive care unit'.*

12.40 *In **2011** a baby was cooled because of HIE. The seizures were very difficult to control despite anticonvulsants and so there was a documented discussion with a NICU outside the network but with a strong research reputation for cooling, who suggested it could be extended by 24 hours. The cooling in fact continued for a total of 6 days. Whilst there was no evidence of direct harm from this, it was unusual practice and outside the advised practice. The child continued to have epilepsy through early childhood. (2011)*

12.41 We did however find evidence of good practice in that the Trust diligently reported babies receiving therapeutic hypothermia for HIE to the 'cooling registry' which gathered data after the TOBY[225] study on hypothermia was published.

Resuscitation and stabilisation at birth

12.42 The review found a number of cases where the Newborn Life Support algorithm was not followed in the correct order. In particular, where cardiac compressions were started before lung inflation had been achieved. It is vital that an airway is established and effective lung inflation achieved before moving on to cardiac compressions as they otherwise will not be effective.

12.43 Intubation of small babies is a difficult skill, and one that is increasingly hard to gain competence in as intubation opportunities have become less frequent with greater use of non-invasive ventilation. We found in general that babies were intubated on the labour ward appropriately. The Trust appeared to be relatively late adopters of CO_2 detectors (which can help confirm the endotracheal tube is correctly placed). In some cases babies had multiple extubations and intubations in the first minutes of life, either due to uncertainty about their position or due to accidental extubation.

12.44 *In **2007**, an extremely preterm baby weighing just over 500g was in poor condition at birth, and had five intubation attempts including the use of a bougie. When successfully inserted, the ET tube was inserted too far. (2007)*

12.45 *In **2008** a baby at 23 weeks born in the Trust had two accidental extubations within the first hours of life, so required three intubations in four hours. The baby deteriorated on day 10 for which they were given a third dose of surfactant (unusually late). Deterioration was found to be secondary to intestinal perforation and they were then transferred to a surgical NICU. (2008)*

225 TOBY study group. Whole body hypothermia for the treatment of perinatal asphyxial encephalopathy: A randomised controlled trial (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409316/

Communication during neonatal resuscitation

12.46 In the cases considered by this review we sometimes found that a structured approach to communication to a senior doctor in a crisis situation did not always happen. Our view is that there should be a shift in expectations such that, when it is known that senior help cannot attend immediately, a formal two-way telephone dialogue, based on the SBAR (Situation, Background, Assessment, and Recommendation) structure, should take place at the time of calling for the senior help. This two way conversation directly with the resuscitation team should involve a review of the interventions which have been tried and advice from the senior help concerning the actions to be taken pending their arrival. This situation is not unique to this Trust.

Management of hypoglycaemia (low sugar levels)

12.47 The review identified a number of cases where there was prolonged hypoglycaemia without effective or timely intervention. In some instances this was due to the need to transfer from the midwife-led unit (MLU) to the neonatal unit.

12.48 *In **2018**, a term baby was born at the MLU in Princess Royal Hospital, Telford, at 03:44 with a very slow heart rate. After the neonatal team arrived and baby was intubated the heart rate improved. On arrival at the NNU at 04:55 the baby was hypotensive, hypothermic (planned) and had an apparently unrecordable blood glucose at 05:26 and 05:43. There is no evidence of it having been measured prior to this. An emergency blood transfusion was given for low haemoglobin, but the glucose was not addressed (even having been measured) until a bolus and infusion of dextrose were given at 07:05. This is 3 hours and 20 minutes after a major resuscitation (known to deplete glucose stores) and 1.5 hours after the glucose was first noted to be unrecordable. This may have contributed to the failure of the heart to respond to inotropes, fluids and other resuscitation measures. The first dose of antibiotics was not administered until 3 hours after admission to NNU and 2 hours after it was prescribed, despite IV access being in place. This is an unacceptable delay. Sadly, the baby died. (2018)*

12.49 *In **2007**, a growth restricted term baby had very low cord pH at birth (but the baby quickly recovered with Apgar[226] scores of 8 and 10), and required only facial oxygen. A paediatrician appropriately requested to keep baby warm and establish feeds. On review at 30 minutes, they noted profound hypoglycaemia. The paediatrician instructed "commence feeds as soon as mum ready and if concerned to inform NNU". A doctor was called to review the baby when it was noted to be dusky aged 1 hour. The requested senior review said baby did not need admission. No further glucose levels documented until admitted at 13 hours, when they were normal. This baby was later diagnosed with HIE. (2007)*

Management of sepsis

12.50 In general the management of babies with suspected sepsis was in line with national recommendations and common practice. However, in the majority of cases reviewed where infection or suspected infection were part of the clinical picture, it did not seem that the use of infection markers such as C-reactive protein[227] (CRP) for 'tracking' of the progress of the infection was standard practice. This was an active decision on the part of the neonatal consultants. We have not been able to identify a situation where the absence of these measurements was likely to have had a significant influence on the clinical outcome. However, infection markers can be useful in both the identification of infection and in guiding treatment and are widely used in neonatal practice. In more recent years the Trust has adopted the use of CRP.

226 See glossary

227 See glossary

Communication with families and documentation

12.51 Case reviews almost invariably showed evidence of good communication with the parents, especially by the ANNPs and consultants. There was evidence of compassionate care for the babies and their families, especially at the end of life or when considering reorientation of care towards comfort-orientated care.

12.52 *In **2002** a baby was born at full term and unexpectedly found to have severe respiratory problems from birth. The baby was diagnosed on the neonatal unit at Shrewsbury with severe pulmonary hypoplasia, (under-development of the lungs) and sadly this was untreatable and the baby died on the first day of life. There was extensive consultant involvement in the baby's short life, including the involvement of a second consultant in reviewing an unexpectedly serious case, a consultant doing the summary letter and, most importantly, sometime after the sad death, when all results were back, the consultant visited the family at home to go through the results of the baby's post-mortem examination and other specialised tests. The review observed this as an example of exceptionally good practice. (2002)*

12.53 We also found evidence that some parents had confidence in the quality of the consultant-led neonatal follow up:

*In **2001**, a baby was delivered by forceps after an eight hour 2nd stage of labour and developed HIE. The baby was discharged home well on day 9. The parents moved to Leicestershire but declined transfer of care to a local consultant and chose to come back to Shrewsbury for each neonatal follow-up visit to maintain continuity of care. (2001)*

12.54 We found some examples where neonatologists requested that obstetricians at the Trust review a baby's care when they perceived there were unexpectedly poor outcomes.

12.55 *In **2009**, a baby was born at 42 weeks, 50 hours after rupture of membranes with the cord tightly round its neck and thick meconium, and with a low cord pH of 6.5. Fortuitously the baby had a normal MRI brain scan and was said to be developing normally at 2 years of age. After seeing the family at an outpatient appointment the neonatologist wrote first to the risk manager in August suggesting the case was reviewed. The neonatologist also wrote to the obstetrician requesting a parental meeting and wrote again in November chasing this up as the family had still not heard anything. The long term outcome of this case is not known. (2009)*

12.56 In another case the neonatologist had concerns about the care of a baby after transfer between other NICUs:

12.57 *In **2008**, a baby was born at 23+1 weeks in RSH after in utero transfer and received 11 days intensive care before being transferred to a surgical NICU due to intestinal perforation. Having received surgery the baby was repatriated to a third neonatal unit and apparently arrived in a 'shocked' condition, hypotensive and hypothermic and died 1 week later. The neonatal consultant at RSH wrote to the neonatologist at the receiving hospital suggesting they raise this with the referring surgical centre as this was 'unacceptable'. This represents evidence of concern for governance and ensuring quality of care. These examples were infrequent, but evidence a desire to ensure good quality of care for patients and their families. (2008)*

Combined medical and nursing notes

12.58 The clinical records that were reviewed had separate medical and nursing entries. This has the potential for important information not being accessed by key members of staff involved in the care of individual babies. The standard of medical and ANNP note-keeping was generally good and the admission clerking in particular was generally very comprehensive. However, there was no obvious systematic approach for daily ward round reviews, which meant that continuity of potentially important information was sometimes lacking.

12.59 Although by no means universal, prior to the introduction of electronic clinical records many NNUs had moved to having combined medical and nursing notes. The Trust now uses joint neonatal and medical notes and are moving to an electronic patient record.

Middle grade or Trust Tier 2 neonatal staffing

12.60 For some of the cases reviewed it was clear that, out of hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care to both units. It is for this reason that it is a service specification for level 3 NICUs that there is separate middle-grade cover for neonatal and paediatric units and why level 2 LNUs should not undertake prolonged intensive care.

12.61 The review found evidence that in some cases this led to a delay in middle-grade attendance at deliveries and in reviewing sick babies on the neonatal unit. As already discussed the Trust were early adopters of the ANNP model and this undoubtedly provided some mitigation but it was not clear whether the neonatal unit was adequately covered at middle-grade level at all times.

Consultant neonatologist staffing

12.62 It is clear from the majority of case notes reviewed that involvement of the consultant neonatologists in clinical decision making, in the provision of neonatal care and in communication with parents and other family members was of a very high quality. The case notes usually record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They were usually involved in the long-term clinic follow-up of their individual patients, providing continuity of care. Information sharing was aided by the neonatal discharge summaries often being written by a consultant. Having met with staff it is apparent to the review team that this high level of direct consultant input may have been at some personal cost and may have been offered in part due to a desire to continue as a NICU after designation as a LNU in 2006.

12.63 For some of the cases reviewed the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This can also compromise the availability of skilled care. Given the size of the maternity and neonatal service at the Trust, if it was aiming to provide ongoing neonatal intensive care at the time, it would be essential to have designated neonatal consultants on call 24/7. This was highlighted by the RCPCH invited review in 2013:

12.64 *'The neonatal rota is not compliant with BAPM staffing arrangements given the level of intensity of services provided at the RSH site. There is an enthusiastic staff team keen to develop their skills and care for babies locally, and a consultant group that provides prospective cover out-of-hours, coming in to support juniors and general paediatric consultants even when not on call. This is not sustainable and must be addressed when the service moves. The current enhanced status is not supported by the network following a CCG-commissioned review of maternity services and will in future operate as a standard level 2.'*

12.65 It is the review team's understanding that separation of the neonatal and paediatric consultant on call rotas has now been achieved, and we found evidence that the neonatal service has, since the move to Telford and publication of the updated care pathway by the neonatal network in 2015, largely been operating appropriately as a level 2 Local Neonatal Unit.

LOCAL ACTIONS FOR LEARNING: NEONATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

12.66 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

12.67 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

12.68 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

12.69 The number of neonatal nurses at the Trust who are 'qualified-in-specialty' must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

OCKENDEN REPORT - FINAL

Section 4

Our call for essential action following completion of this review

Chapter 13

What happened in maternity services across England after our first report

13.1 Our first report Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was based on a review of 250 family cases and was published on 10 December 2020. The report outlined seven Immediate and Essential Actions, (IEAs) for maternity systems across England and 27 Local Actions for Learning, (LAfL) for the Trust.

13.2 Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs.

13.3 All trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

Additional funding for maternity services

13.4 Our first report highlighted that the amount of improvement required must be backed by real investment in maternity services.

13.5 In March 2021[228] the Government made available £95.6million of investment for maternity services across England for:

- 1,200 additional midwifery roles
- 100 whole-time equivalent consultant obstetricians
- Backfill to allow for multidisciplinary team training
- An additional midwife in every unit to support newly qualified midwives as they begin their careers.

13.6 Alongside this, in July 2021 the Government announced £2.45m[229] to be invested into maternity services. These funds were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress.

13.7 For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding (SDF)[230]. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies and their families.

228 NHS England and NHS Improvement Board Meeting November 2021. Agenda Item 6: Maternity and Neonatal Services Update https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-6-251121-maternity-and-neonatal-update.pdf

229 Gov.uk press release. Government pledges £2.45million to improve childbirth care (2021) https://www.gov.uk/government/news/government-pledges-245-million-to-improve-childbirth-care

230 NHS England. Guidance on finance and contracting arrangements for H1 2021/22 (2021) https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-h1-21-22-guidance-on-finance-and-contracts-arrangements.pdf

13.8 With a shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for midwives, increasing the number to 800 in England. To support retention of midwives, NHSE&I has also funded a pastoral care midwife[231] role in every maternity unit during 2021/22.

13.9 With midwifery and obstetric staffing numbers continuing to cause significant concern and attrition from the midwifery profession, midwives and doctors remaining on the frontline are working tirelessly to support mothers and their babies in achieving a safe outcome.

Our call to action

Funding

13.10 Whilst the funding announcements we have seen have already made significant strides in the right direction in improving maternity services for all, much more still needs to be done. The Health and Social Care Committee report[232] on maternity safety in England, published in June 2021, stated that NHS maternity units in England needed an investment of £200-£350m to prevent women and babies dying or sustaining avoidable harm. This view was supported by the NHS Confederation[233] and we state this level of investment must be forthcoming.

Continuity of carer (CoC)

13.11 We recognise the original aim of CoC which seeks to ensure a mother receives safe and personalised care from the same midwifery team with a named midwife who coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are met through all stages of maternity care. The CoC model was introduced with little recognition of its potential impact on an already pressured maternity system across England.

13.12 Recent guidance[234] has aimed to address the concerns expressed that CoC will lead to unsafe and inconsistent staffing and provides guidance for local planning and implementation of CoC. At a time of unprecedented stress on NHS resources we continue to hear concerns relating to attempts to support this model, which can lead to inequities in care provision. The CoC model must be reviewed and suspended until all Trusts 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 CoC models of care place on maternity services already under significant strain. The reinstatement of CoC should be withheld until robust evidence is available to support its reintroduction

13.13 As a multi-professional clinical review team comprising midwives, obstetricians, neonatologists and other specialist colleagues who work within (and closely with) maternity services in trusts across England, we strive to ensure that all women receive high-quality, safe care throughout their pregnancy pathway which is tailored to their individual needs. We all recognise the challenges faced by maternity services across England as they work to ensure that the maternity care provided leads to the best possible outcomes for mothers and their babies.

13.14 In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time. This is a Trust that was also failed by the wider maternity system which did not act, and this must not happen again.

231 Ibid n1

232 Ibid n2

233 NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021) https://committees.parliament.uk/publications/6290/documents/69337/default/

234 NHS England/ I (2021) *Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22* Available: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

13.15 We urge maternity services across England to continue their work in implementing the IEAs from our first report. We have seen so much excellent practice and a real desire to improve. Now, the NHS across England and the Shrewsbury and Telford Hospital NHS Trust must make ambitious plans to ensure timely implementation of the additional Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEA) from our final report.

13.16 As difficult decisions loom about NHS funding post the COVID-pandemic, maternity services in England **must not slip down the priority list.** The scale of this review is unprecedented in NHS history and after listening to so many families, we have been given an unrivalled opportunity to change and improve maternity service provision for all parents and their families now and in the future. Together the changes we have outlined, and the demand for better funding will ensure safer outcomes for more women and families, reducing the risk of unnecessary loss of life, injury and resultant heartbreak.

Chapter 14

Local Actions for Learning (LAfL) - the Trust

Clinical governance

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.1 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

14.2 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

14.3 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

14.4 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

14.5 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

14.6 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

14.7 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

14.8 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

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

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.10 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

14.11 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

14.12 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.13 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

14.14 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.15 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

14.16 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

14.17 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.18 There must be midwifery and obstetric co-leads for audits.

14.19 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

14.20 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

14.21 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

14.21 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.22 There must be midwifery and obstetric co-leads for developing guidelines.

14.23 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.24 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

14.25 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[235] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

14.26 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

235 NHS England. *Maternity self-assessment tool* (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

Antenatal care

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.27 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.28 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

14.29 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019)[236].

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.30 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

14.31 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.32 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

236 Ibid n11

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.33 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD ROUNDS AND CLINICALREVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.34 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017[237]). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

14.35 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021[238].

14.36 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR[239] to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.37 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

14.38 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

237 NHS England. *Seven day services clinical standards* (2017) https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

238 National Institute for Health and Care Excellence. Inducing labour NICE Guideline 207 (2021) https://www.nice.org.uk/guidance/ng207

239 See glossary

14.39 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts[240] and Saving Babies Lives[241]. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Intrapartum care

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.40 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

14.41 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

14.42 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

14.43 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

14.44 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.45 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

14.46 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

14.46 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.

240 Ibid n32

241 Ibid n11

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.47 Midwifery-led units must complete yearly operational risk assessments.

14.48 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

14.49 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.50 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

14.51 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

14.52 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

14.53 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.

14.54 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice[242].

14.55 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

LOCAL ACTIONS FOR LEARNING: NEONATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.56 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

14.57 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

14.58 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

14.59 The number of neonatal nurses at the Trust who are "qualified-in-specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

LOCAL ACTIONS FOR LEARNING: POSTNATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.60 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

242 RCoA Raising the Standards: RCoA Quality Improvement Compendium. Chapter 7 Obstetric Practice. 4th Edition September 2020

14.61 The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

LOCAL ACTIONS FOR LEARNING: STAFF VOICES

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.62 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER THIS REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.63 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

14.64 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Chapter 15

Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

15.1 We include these **Immediate and Essential Actions, (IEAs)** to improve safety in maternity services across England. These IEAs complement and expand upon the **Immediate and Essential Actions** issued in our first report. We note that NHS England and Improvement (NHSE&I) has supported the implementation of these actions in trusts across England since our first report was published.

15.2 These further **Immediate and Essential Actions** 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.

15.3 This review is supporting and endorsing the latest Health and Social Care Committee Report "The Safety of Maternity Services in England"[243]. We agree with the select committee that the budget for maternity services be increased by £200-350million per annum 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.

15.4 We further agree that the Department of Health and Social care (DHSC) must work with the Royal College of Obstetricians and Gynaecologists, (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) and 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.

15.5 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.

15.6 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.

15.7 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).

15.8 We endorse the recommendation that training targets should be enforced by NHSE&I's Maternity Transformation Programme, the Royal College of Midwives (RCM), the RCOG and the CQC through a regular collaborative inspection programme.

15.9 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.

243 Health and Social Care Committee. *The Safety of Maternity Services in England* (2021) https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

15.10 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 NHS England and NHS Improvement to Trusts[244] 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.

15.11 This review also supports the NHS Maternity Digital 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.

15.12 The Parliamentary Health and Social Care Committee Report recommendations on staffing, training and learning from patient safety incidents echoes 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 Immediate and Essential Actions will make a significant contribution to the delivery of safe maternity care.

15.13 Importantly: We state that DHSC and NHSE&I 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.

244 Letter dated 15th February 2022- Ref PAR 1393

1: WORKFORCE PLANNING AND SUSTAINABILITY

Essential action – financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England 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 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 CNST and CQC requirements. • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.
Essential action – 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 (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement 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.

1. WORKFORCE PLANNING AND SUSTAINABILITY (CONTINUED)	
	• All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator 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 which 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 HDU 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 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

Essential action

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, and patient safety champion and 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 coordinator 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 (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 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.

2: SAFE STAFFING (CONTINUED)	
	• All trusts must develop strategies to maintain bi-directional 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 managements of locums. 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	
Essential action 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

Essential action

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, 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 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, 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

Essential action

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 which involve a change in practice must be audited to ensure a change in practice has occurred.
- Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.
- All trusts must ensure that complaints which meet SI threshold must be investigated as such.
- All maternity services must involve service users (ideally via their MVP) 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

Essential action

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/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

- NHS England and Improvement 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/investigation must have an independent chair, must be aligned with local and regional staff and 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

Essential action

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 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

Essential action

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 have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.
- NICE Diabetes and Pregnancy Guidance 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 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

9: PRETERM BIRTH

Essential action

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 2 (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

Essential action

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 which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made
- Midwifery-led units must complete yearly operational risk assessments.
- Midwifery-led units must 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 accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information 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

Essential action

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 datasets 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, and 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 Good Medical Practice by the GMC
- Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets 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 whilst 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

Essential action

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

Essential action

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 outcome.
- Compassionate, individualised, 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.

14: NEONATAL CARE

Essential action

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

This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and 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 Local Maternity Neonatal Systems (LMS/LMNS) quarterly.
- 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, ANNP 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 which 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.

14: NEONATAL CARE (CONTINUED)

	• 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 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course 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 ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

15: SUPPORTING FAMILIES

Essential action 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.

Appendices

Appendix 1: Hearing the voices of staff

Staff voices engagement strategy

1.1 In engaging with and listening to current and former staff at the Trust, we intended to highlight where they saw and see scope for improvement, but also to report on good practice in maternity services over the years. Staff were offered the opportunity to share any information with us that they felt would support them in having their views and voices heard. The culture within the Trust and specifically maternity services and whether it has changed over time is an important factor in order to understand the potential cause of any systemic problems.

1.2 Prior to conducting the staff survey for this review we reviewed the results from annual NHS staff surveys at the Trust over the previous 10 years. Staff across NHS organisations are encouraged to complete this survey each year and data are used to improve staff experiences locally and throughout the NHS, ultimately benefitting patient care. We also reviewed the Trust results from the Maternity and Neonatal Health Safety Collaborative (MatNeo) Culture Survey in 2018, which was part of the national Maternity and Neonatal Improvement Programme.

1.3 The NHS annual staff survey has undergone several iterations over the years and the Trust has restructured its service centres/ clinical divisions on a number of occasions. It therefore proved difficult to attribute the available data specifically to staff who worked directly within maternity services. The MatNeo Survey[245], although identifying themes particular to the service, had limits in covering historical aspects of the culture at the Trust.

1.4 The review team worked directly with the Trust to ensure that past and present staff were offered the opportunity to contribute to this review. Reassurances were given with regards to anonymity and confidentiality and that responses would not be shared with the Trust. We developed a staff voices engagement strategy - known as 'Staff Voices', using a bespoke questionnaire survey followed by conversations with staff. The chair of the review also conveyed messaging regarding the Staff Voices strategy through local radio stations and via social media with the aim to reach out to as many former and current staff as possible.

1.5 Despite the assurances around confidentiality and not sharing findings with the Trust there is evidence from multiple conversations and contacts from staff themselves that they remained reluctant to participate. There appeared to be two main concerns from the staff who contacted the review who were uncertain about whether to participate or not - firstly they described being dissuaded from participating by their managers at the Trust. Secondly they expressed concerns about the ongoing police investigation at the Trust, Operation Lincoln, and whether the review team intended to pass information from staff to the police as a matter of routine. Whilst this was not the intention of the review team, the police have requested that we retain any relevant material and we may be required to disclose information to the police in due course.

1.6 In total only 109 staff came forward and participated in the review, some completed the survey only, some both completed the survey and spoke to us and some only spoke to us, declining to fill in the survey. We are sorry that so few staff members felt able to participate. In the last few weeks immediately prior to publication, 11 of the 109 staff who had come forward either fully or partially withdrew their cooperation or did not respond to multiple requests to use their content. This means that overall we have been able to use the staff voices of only 98 current or former staff at the Trust.

245 Provided to the review team by the Trust

The launch of Staff Voices

1.7 The staff voices survey was conducted from 12 May until 30 June 2021, with follow up conversations with staff occurring until January 2022.

1.8 Some staff employed by the Trust contacted the review team directly using the designated staff voices email address and asking for the link to the survey rather than accessing the link provided through the Trust. Many of these messages sought reassurance that the Trust would not know they had completed the survey. Some staff messaged the review chair directly, seeking assurance of confidentiality.

'...[I am] working for the trust and would like to take part in this survey but only if 100% confidential'. (Staff member, email to the review team)

'[working]...within SaTH [the Trust] as long as my name won't be mentioned and whatever I say is kept confidential I'm willing to take part in the survey'. (Staff member, email to the review team)

'Some staff were told be careful about how they answered this survey and were told to remember any comments made could be considered as part of the police investigation. This is the kind of passive aggressive approach of threat that NHS organisations use to deter staff from speaking up. It is so historically ingrained in the culture and possibly will have put staff off participating in the survey'. (Staff member, email to the review team)

1.9 These concerns were further confirmed during conversations held with current staff. One member of staff said: :

'…….and I know a lot of my colleagues didn't want to get involved because they were frightened, they were intimidated by the process'.

1.10 Another member of staff told the review team:

'I said, "Have you written out your questionnaire yet?" "No, we have been told not to"……...but people won't because they have to put their name against the allegations and that sort of thing, and these people they've, as I have said before, they've got their friends and they just will not speak up, they daren't, they daren't speak up, you know.'

'So I know multiple people that have not approached you to speak because of fear, because of how it was put in that briefing [from the Trust to staff] …….. there were people that had every intention of completing their survey and then after that, no way. I was like but this is your chance to speak. How can you make any changes? How can you do anything about it when we're given this opportunity but they're still working there? I think they were perhaps fearful of their jobs, I don't know'.

Another member of staff describing how fearful they felt about speaking up in the maternity service in early 2022 told the review:

'We used freedom to speak up and because of the reporting process they have to follow those concerns ended up going back to those we had concerns about...'

1.11 Overall, when taking into consideration the number of staff who are currently employed within the service and the number of former staff employed throughout the twenty years of the review's timeframe, we are disappointed that just 84 staff completed the survey. By comparison, in 2018, 192 (58%) staff who were working within the maternity and neonatal services at the Trust completed the MatNeo culture survey. Therefore we appreciate that our findings and conclusions are of limited value. However, having put considerable effort into hearing the voices of staff and having been told by the staff who participated how important it was to them to be heard, we believe this content is important despite the low number of participants.

Staff Conversations

1.12 Staff were asked within the questionnaire survey whether they agreed to a confidential face-to-face video interview with members of the review team and 76% of those completing the survey responded with 'yes'. Some staff contacted the review team via email requesting to speak with us, but did not want to complete the questionnaire survey.

1.13 The review team was also keen to speak with staff who held leadership positions within the Trust, maternity services and Clinical Commissioning Groups (CCG) to gain insight into the culture and changes over the years. The Trust and CCG contacted those staff who were of potential interest to the review to advise them of the request and to gain their consent for sharing their contact details. Other Trust and CCG staff were also able to contact us directly if they wished.

1.14 All interviews were conducted via a videoconferencing platform. Participants were advised they would receive a copy of the transcript of the conversation which they could annotate as they wished and that they could send additional information to the review team.

Staff Voices Results

1.15 In total, we received 84 staff survey questionnaires and conducted 60 staff interviews. Each staff member was allocated a confidential staff number. Of the survey respondents, 49% had been employed by the Trust for less than 10 years, 39% for between 10 and 20 years and 12% for more than 20 years. The majority of staff who engaged with the review were still employed by the Trust. The majority of staff were either employed or had been employed in clinical roles.

	Question	Yes	Sometimes	No	Total	Percentage 'Yes'
Professional and / or clinical concerns	Have you ever raised any professional or clinical concerns?	48	-	36	84	57.1%
	Have you ever been concerned about patient safety?	52	-	32	84	61.9%
Bullying	Have you personally witnessed or experienced bullying in the workplace at SaTH?	55	-	29	84	65.5%
Mandatory training	Do / did you have managerial support to attend mandatory training days?	55	20	9	84	65.5%
Teamwork	Did / do you think your multidisciplinary team works well together?	37	36	11	84	44.0%
Staffing Levels	Have you ever escalated concerns about staffing levels during your shift?	51	-	22	84	60.7%
Improvements	Did / do you feel there were / are any barriers to attempts to make improvements to the maternity service?	42	21	21	84	50.0%
Family and Friends Test	Would you recommend SaTH to family and friends for maternity care?	38	27	19	84	45.2%

Category	Question	Never	Rarely	Sometimes	Often	Always	Total
Culture	Whilst at SaTH did / do you enjoy coming to work?	2	16	34	27	5	84
	How often did / do you take part in multidisciplinary traning) (e.g. obstetricians, midwives, neonatologists, support staff training together)	15	16	30	12	11	84

1.16 Many staff who spoke to us appeared very committed to the Trust, spoke of pride in the service and demonstrated loyalty and support towards their colleagues. Staff members told us: *'…So I wanted to make clear that was what I'd seen. These people I've worked with have been trying really hard'*…Another member of staff said: *'I do actually enjoy it and the team that I work with are a fantastic team…'*

1.17 From the questionnaires and interviews we identified key themes that had an impact on staff working in the Trust over the years and can give (albeit limited due to the small numbers) some insight into the culture throughout the years.

Merger of two trusts to form one trust

1.18 Staff described the difficulties they felt they experienced caused by the merging of the two sites to form one Trust and subsequently the move of consultant maternity services to Telford in 2014. One staff member said:

'…I think it's really tough for the management board. I think there was a disconnect in previous Trust boards, I think it was really hard. We did have quite an aggressive management structure when it was all about reconfiguration. It clearly felt like a new Chief Exec had come, Department of Health driving through, reconfiguration and relocating to Telford. We felt pretty coerced into agreeing to relocate to Telford, which clearly is wrong, and now, there's talk about it was the wrong decision, the services are in the wrong place, but the majority of us thought that in the first place'.

1.19 Another staff member said:

'As far as I could tell, you know, the Trust had been stuck, basically, for about twenty years, unable to make any progress, the two local authorities, the two populations at daggers drawn, you know, resisting every single change. …..trying to find a way through that log jam and come out the other side of it with a set of proposals that would make services less unsustainable.'

1.20 Another staff member told the review:

'…..we hadn't merged yet, …. and one of the great things that made me take the job in Telford was because the management team were based in Telford, because it was just one hospital, and they were incredibly responsive. You would bump into the Chief Exec on the corridor, the Medical Director, you could raise a concern or make a suggestion,…. oh, I wonder if this could actually improve patient care or this would be a good thing for safety, and it was really easy to get things …..changed because there was that responsiveness. With the merger…..the management structure was almost entirely based at RSH. They don't come over, they're not based at Telford, so you get none of the corridor conversations, which shouldn't really be the way we communicate but actually is often the way communication happens, so we don't have that access.'

Trust leadership

1.21 In our first report we discussed the high turnover of Chief Executives (CEOs), executives, non executives and other leadership roles at the Trust. Such a high turnover will inevitably impact on the performance of an organisation. One staff member told the review team:

'…..I think that's part of the problem…. they haven't got a consistent leadership…..and it was a mess, you know, you can't describe it any other way, there'd been no leadership whatsoever'.

1.22 Another staff member said:

'One of the historical factors for the Trust is that there have been several management restructures, many different chief execs, and a real churn at the Trust board level as well…… I went through three management restructures, reappointed each time to a slightly different role…… Each of those management restructures sometimes took up to about eighteen months from the first letter of people being put at risk to people being

in place…… each time you lose good people, because there's only so many management restructures……. So, no sooner had you made a working relationship with an executive, than the next one was on their way. And also, with each of those structures came, obviously, slightly new ways of doing things, new policies, new training, some of the previous ways were not required, and there was a new focus'.

1.23 Another staff member said:

'….I guess that takes time, developing that trust in leadership does take time, and certainly one of the things that SaTH has not benefited from is longevity of leadership.'

1.24 Three other staff members told the review:

'So, there's been little in the way of corporate memory and additionally, the new incumbents would have to establish their relationships with the existing management structure'.

'We'd just had another Chief Executive who wanted to do yet another reorganisation and we were all supposed to apply for our posts and do maths tests and English and chemistry and I just thought, "I can't…..".

'…it's really bizarre, we've had … we're on our third Medical Director since I've been in this role and we're on our third Director of Nursing. The current establishment, it seems to have much more traction and we seem to see much more evidence of things happening. The previous people that were in post, similarly, were saying all of the right things but it just wasn't translating it, the action wasn't happening. It was like there was a disconnect. The executives knew of the problem, they didn't understand the core cause of the problem'.

Culture

1.25 A priority when reaching out to staff at the Trust was to understand the culture within the maternity service and possibly the wider Trust. Through the survey, staff were asked 'Have you personally witnessed or experienced bullying in the workplace at the Trust? 65% of respondents replied with 'yes'. Of those 65%, 38% felt able to report it and of these, 33% felt it was adequately dealt with.

1.26 One staff member told the review team:

'Culture is a big thing because I feel there's a reluctance to change there.'

1.27 Another staff member told us:

'I feel that there are historical organisational/cultural issues that are very complex in how this situation has developed. I really believe that there are wider system errors that have let down women and their families but also staff. There are some really good people who care immensely about what they do but operating in a system that is in crisis management continually, can have significant impact on the ability to maintain passion and compassion.'

1.28 A further contributor stated: *'…. the fear of speaking out is all-pervasive in SaTH and it's a very difficult thing to get rid of if that has been the culture for not just ten years, but twenty years, thirty years, it's inbred within the culture at SaTH that if you speak out, something is going to happen to you……you'll be bullied or you'll be moved or you'll be … you know, something will happen, something will be … make it difficult for you.'*

1.29 One staff member described their own experience: *'X .was so strident that you tended not to argue with her, she was a bully, 100%'.*

1.30 Another contributor said: *'*

….when I joined. We just had the conversation about the need to change the culture, in terms of safety culture, that was very clear, and the organisation went with that process, including Listening into Action, which was another initiative that was brought in…… which is important, because I think staff hadn't felt previously that they'd got a voice to be heard. So, I think that Listening into Action was very important at that stage in terms of changing that culture within the organisation'.

1.31 Three different staff members told the review team:

'….previously, these groups have been split up in clinical areas but they go elsewhere and still behave in the same way. They are…big voices, they're dominating, they're intimidating…'

And: *'There are cliques there and, you know……. they are a little gang, and, yes, they will make your life hell…… I am speaking to colleagues now and they won't speak out… you couldn't speak to senior management, if you tried you got shot down'.*

And: *'And the safety huddles that we used to go to, I mean some of them were…. would speak to some of the managers like absolute … it was just you'd stand back and think, "This is bullying".'*

1.32 Other staff members described a 'clique' on the labour ward at the Trust with a culture of undermining and bullying. Some staff members described that this had negatively and seriously affected their mental health. Other staff members described that the behaviour experienced on the labour ward was so bad that they had difficulty finishing their shifts and cried secretly whilst in work. These staff declined for their direct quotes to be used, because they were fearful of being identified.

1.33 Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.

1.34 One staff member said: *'….it's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work, not sure how people are going to be with you, not being invited out onto nights out. Simple things like that, not being included in coffee mornings, and things like that….. it's very difficult to speak out, I've been there myself and I ended up going off ill with it'.*

1.35 A current staff member in maternity services at the Trust spoke to the review team in early 2022 but described themselves as fearful to do so. The staff member said *'I really had to think very carefully about approaching the staff voices….when we were told not to speak out, but I will do it and take the consequences because it is the right thing to do…I am clear that there is no support for those that speak up...'.*

1.36 Periodic rotation through the clinical areas within a maternity service is a system evident in most maternity services. Its aim is to ensure that staff remain competent to deliver care in the main clinical environments and gain wider experience, and it also enhances professional development. It is also believed to improve communication as there is an understanding and awareness of what happens in other clinical areas. Some staff commented on the process within maternity services at the Trust, with some saying that poor behaviours still remain at the Trust.

'…they would have almost three or four months of these rumours going around, "There's going to be a change list; there's going to be a change list", and then finally, when the change list came out, there was a lot of anxiety from quite a few midwives.'

'The communication of the change list over the years has been very poor and has caused a massive amount of stress for all of us because you just find out that you're on the change list and off you go.'

'There was a lot of cliques there, a lot of managers were cliquey, there was the change list that was used as a… you had the impression that if you were a pain you would get moved, you know and nobody wanted that and, you know, it still goes on today….. I think that the managers, I think they are aware of the clique and I think they have tried to separate them but they're so deeply ingrained into the system… the management's almost scared to get rid of them because they almost form the core of the delivery suite expertise.'

'…they just didn't want students at all, they were not happy to have students…'

Governance

1.37 We routinely questioned staff regarding the governance systems across the wider Trust. Two staff contributors said:

'……one of my concerns at the time was really that…, I don't think the Trust had a robust governance framework, to be honest.' '….and we ended up having to just work within our department, because when we asked within the Trust there just wasn't that resource... the Trust wasn't as advanced as that, they just didn't understand what we needed, so we ended up doing that'.

'certainly my experience is it's not about the people on the floor doing the work, it's the whole system behind it that isn't always as helpful as it could be and that affects those people that are trying their best …'

1.38 Another contributor told the review: *'……yes, it did feel as though we weren't perhaps hearing all that we should have been hearing…….. We struggled consistently to get information from SaTH in those meetings from 2009 -2012. Reviews of serious incidents seemed to take a long, long, long time to happen and there was an impression of evasiveness around how the learning from those reviews was shared. Reading the last Ockenden Report it was clear to me that whatever learning was taken from the incidents that are described wasn't actually shared and taken forward, so the same things were happening over and over and over again, and in the context of an organisation who may describe themselves as a learning organisation I never felt that it really was'.*

1.39 A number of other staff members told the review team of their experiences:

'It was a system wide failure to be able to escalate these priority pieces of work and to push it through, there didn't seem to be the guidance, there didn't seem to be the governance, there didn't seem to be the process of challenge…'

1.40 Another staff contributor said:

'This has just started recently, by recently I would say in the past four or five years, but before then we didn't have this system, you see. We didn't have clinical governance, it was just on the go, word of mouth, that if there was an issue you would get it discussed between you and the consultant, for example, or whoever was involved, but we didn't have this learning procedure or learning process as is currently being done.'

1.41 Another staff member said

'….things started to become visible when the CQC went in and we were given [an] inadequate rating……. but prior to that, it would be that things were kind of filtered down really by word. To be honest, there was a lack of process, a real lack of processes.'

Staff voices on statutory supervision of midwifery

1.42 Commenting on the ineffective nature of the process of statutory supervision of midwifery at the Trust one contributor said: *'My recommendation was that there was a supervisory investigation. At the time it was dismissed because it was such a tight, tight group of supervisors, it was impenetrable and if you're in, you're in, and X was in. So, they were not keen to conduct that….. If they decided that this particular practitioner did not need a supervisory investigation then it was up to them. So, if your face fits, then you were okay.'*

1.43 Other contributors told the review team that the same people were involved in supervision investigations as in internal maternity governance investigations and that statutory supervision was only a process of internally 'marking their own homework'.

Improvements in maternity governance from the perspective of staff

1.44 Some staff reported that in more recent years, the governance processes within maternity services at the Trust have improved.

'It has improved, there is no doubt that it has improved in comparison to the past, whether this is enough I don't know now. Obviously time will tell, but definitely there is now clinical governance, there are high-risk case discussions, meetings, and these issues that we've never had in the first ten, twelve years of my work here in this hospital.'

'…..there were lots and lots of changes that were really, really for the better, and the MDT really came together. I think also there was organisational developments as well, because the anaesthetist started doing some scenario-based training that we would all be invited to.'

'….there is a much better process now of incidences being shared. Certainly in the last five years, maybe even less than that……. Some line managers are very good at sharing all memos and other managers not so'.

1.45 Other staff cautioned that the improvements seen within maternity services at the Trust remain very fragile and that the Trust needs further observation, scrutiny and support as of spring 2022. A staff member said: *'Ladies are being cancelled, rebooked and cancelled due to staffing issues and I have considered leaving as I worry about the impact this is having…'. The staff member added: 'I have been really worried…it is important people are aware of the situation...'.*

Oversight of safety and performance within maternity services

1.46 A number of contributors reported to us that, for a long time, executives and board members viewed the maternity service as performing well and as a result did not apply a high level of scrutiny to the service. Equally external scrutiny did not raise sufficient concerns at board level. The following remarks illustrate this:

'….whilst they were confident and very strong individuals, very clear about their ability to manage their teams and manage the business, I didn't have any reason to question that they would come to me if they had concerns'.

Another contributor added: *'…at no stage did me, and this is my fault, but at no stage did I pick up that there was such a deep-seated problem in that service…'*

1.47 Other staff members told the review team:

'…….we got best performing and we got CNST Level 3, you know, so these are independent organisations coming in, looking at it. Therefore……. you should have some confidence in what these bodies are telling you…'

'……when scrutinised by quality and safety, when scrutinised by the Trust Board to give a reasonable account of their abilities to maintain their service. We did develop "deep dive" reviews at various stages and there was a sense that compared with some other areas of difficulty within the Trust, Maternity was not on the radar at that stage. That, of course, was triangulated with other perspectives, so views from the CQC, and you'll be aware that in the early phases, the CQC reports were positive ones. They were rated as good.'

'….it was published and it obviously came to our Board meeting, we discussed it in the Board. I think, I mean the overall message from that report was that…. they said safe and good quality services in a learning organisation.'

'It was presented to us, I think, by SaTH as being more positive than it actually was. It was a kind of oh well, the RCOG think we're okay.'

'They were one of the ones I trusted and, given all the external results we were getting that actually confirmed how good the service was they ran'.

'…..we were working within a Trust that had considerable financial challenges, some challenged services, and that was the focus of the Trust, really. So, maternity and women's and children's was referred to as the flagship of the organisation, and trying to get additional resources into the care group was really difficult.'

'….we'd achieved CNST level three gold standards, and that was … I don't know, not a badge of honour, but there was a lot of interest within the Trust that we should be awarded that….gave evidence with others at a parliamentary review into maternity care, and we were asked to go as one of those services that was considered to be providing good care, and we gave our evidence there. So, I think from that time, 2004 onwards there was this perception that we had a really good service, and we were regularly reviewed and visited.'

'As a maternity service, we were considered to be very good, which is why it's been a bit of a shock, all this happening. We were considered to be very good….'

Staffing

1.48 It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response. The following six vignettes highlight some of the concerns expressed about staffing:

'…it was really clear just how difficult it was to sustain a safe level of cover…'

'I don't remember them actually saying that they needed more funding for midwifery staff, but certainly they raised staffing as an issue repeatedly.'

'I asked for a Birthrate Plus review…… which - surprise, surprise - really showed everything that we'd felt…… deficit 30 whole time [posts]…. Were your co-coordinators supernumerary? Not always, usually because of the staffing levels.'

'…the midwives, they were obviously short-staffed….. The shift leader was constantly having a patient…. When you're working on the labour ward, you sometimes couldn't get hold of the shift leader because she was in looking after a woman….. Was not supernumerary and it was really difficult.'

'….but a lot of the shifts there were like by the grace of God that one could have been me… it was scary…. it was a system issue, as in this lady needs to go and we can't get her, she can't go, there aren't enough midwives, you know. They were the issues.'

'I feel like there isn't enough of everyone to kind of go round to make sure that everybody's getting the care that they need.'

In 2018, 46% of respondents to the MatNeo survey reported concerns about poor levels of staffing.

Patient Safety

1.49 Within the staff voices survey, 62% of respondents reported they had been concerned about patient safety, with many feeling their concerns were not adequately addressed.

'T*he patient safety issues I would say they were probably more when I worked on the wards, and that was mainly again just staffing. I spent a lot of time on the antenatal ward, and the amount of times, you know, you needed to get a lady to labour ward and "no staff, no staff, I can't take her, I can't take her" or "Yes, you can bring her, but you will have to come with her", you know, leaving just one other member of staff, you know, that, that, they were the main things really, was trying to get ladies to labour ward in a timely manner. I think they would be the biggest, biggest issues I had seen really.'*

'..Nobody went out at any time wanting to harm anybody, it's just we didn't have the training and we didn't have the staff and that's how it was, unfortunately, and we didn't know any different.'

'We're not giving them the right tools here, we're not supporting them, and we're not giving them the right staffing levels.'

Caesarean section

1.50 Staff commented on the low caesarean section rate at the Trust, which was discussed in our first report. There was disagreement from the staff who contributed to the review as to whether there was a reluctance to offer caesarean section when requested. One staff member said:

'There was always a perception that we were reluctant to offer maternal request caesarean section, which wasn't true but we had a policy to arrange appointments with senior clinicians in order to fully understand the request and provide advice.'

1.51 However, a number of other staff interviewed had differing recollections on the same topic, with examples from four staff shared below:

'….and they would definitely try to avoid a caesarean section…… they were always trying to, how can you put it, try for a normal birth all the time…… it was a couple of times, I pulled the emergency bell because I had a bradycardia going on. They came in and I was actually told off for pulling the emergency bell. I thought to myself, "What's going on here?" I absolutely did not understand it. It's like, you know, they would just let things run purely because they didn't want the doctors to come in, and sometimes you could see some of the shift leaders not wanting to call the registrar in or any of the doctors in …..'

'They were always very proud of their low caesarean rates…….I personally found all the failed/attempted instrumental deliveries very difficult to deal with. I had never seen so many injuries/HIE/resuscitations from this. Nothing to be proud of.'

'I was worried with this escalation thing especially with the patients who are going with the emergency caesarean section….. when we are worried about, for example, a CTG, and they will try and try and try at the end until the baby is really poorly…..because they told me they want to keep the caesarean section really low.'

'I couldn't believe that that was still, the culture was the same – it was almost we have to do everything to get a vaginal delivery and we've got to keep the section rate low, we've got to keep the epidural rate low…….. In 2014 it was the same guys that I'd seen in early 90s', very much the same culture.'

Midwifery led units

1.52 A number of staff discussed the safety of working in the Midwifery Led Units (MLUs) and the challenges they faced. Examples from three staff are shared below:

'….that to run five midwifery-led units out of our establishment, I questioned whether our model was fit for modern-day purpose…….. but Shropshire, you know, its accolade was, "We've got five midwifery-led units". … one of the consultants described it as, you know, the MLU as being the sacred cow, and that's how it felt, that it was okay to have five midwifery-led units if we were staffing the whole organisation in the way that it needed to be done, but we weren't, and it just felt as if you'd got two completely opposite ends of the care that was being given.'

'So, I was put in this really difficult situation of knowing what to do with this woman who's booked at the consultant unit and they could have transferred her earlier. I mean, by the time I went into the room, right, I mean this woman was delivering anyway, but it was… you could say it's a near-miss really, that it was a near miss.'

'The one thing I was really struggling with was whenever the consultant unit was short-staffed, they would take MLU staff, but they wouldn't close the MLUs at that time. So some MLUs were left with one midwife available and no on-call midwife and hope that a woman didn't come in in labour because there wouldn't be a second MLU midwife to back her up and that troubled me no end. It was not a safe situation and it was a disaster waiting to happen.'

Escalating concerns

1.53 Within the survey, when asked whether they had ever raised any professional or clinical concerns, 57% responded with 'yes'. Of these, 52% said there was a clear pathway to follow to escalate professional or clinical concerns. Examples from staff are shared below:

'The culture at SaTH is that if you have done something wrong, keep it in-house and we punish you for that, you know, whether that's you're investigated or whether that's you're moved on a change list or we make your life very difficult or you end up handing your notice in because you have been almost hounded in a way to the point where you have left because of your mental health, you become more and more reluctant to speak out and that's the danger, isn't it?'

'….has actually told us off for putting in Datix, or raising critical incidents about concerns we have, because this is, [they] would describe it as whistleblowing and it's wrong….. to have significant individuals in the organisation telling you that isn't what you should do is very harmful.'

'….So I went along and was basically, yes, told that everything was, I shouldn't be raising concerns and, you know, that I didn't understand the system and that everything was fine and, you know, again just not to raise concerns. I was in tears because I was basically a rotten person and I shouldn't be upsetting the apple cart and, you know, it was irresponsible to go raising these concerns. Afterwards I was completely shocked, I actually couldn't face going in for a few days.'

'It is difficult to know where to take concerns when you have escalated through relatively senior channels and there is no improvement. A clear pathway or process would, I believe, support staff in expressing these frustrations - everyone is under immense pressure and everything is a priority however there needs to be a means of acknowledging concerns and identifying how to implement an improvement strategy irrespective of if this needs to be over a long period of time.'

'So I think we've been proportionate when we've raised concerns but most of the time people say yes, we understand, that's a valid concern, but there's no practical solution to it.'

Multidisciplinary team (MDT) working and training

1.54 Some staff were keen to share with the review team that they had positive working relationships across the multidisciplinary teams, that the Trust was a good place to work and they were focussed on giving high standards of care. When asked within the survey whether they felt the MDT works well together 87% responded with 'yes' or 'sometimes'. 37% of respondents replied that they 'rarely' or 'never' took part in MDT training, 36% said 'sometimes' and 27% 'often' and 'always'.

1.55 Some staff described fractious relationships amongst the teams that may have presented as barriers to effective communication.

'……but there were fallings out between the Band 7s and the consultants, I remember there being arguments, maybe clashes in personality….. some of the Band 7s…., maybe weren't as much good communicators.'

'…was so arrogant and rude, you'd be afraid to ring [X} with any concerns. [X] was intimidating….. was very derogatory about midwives,… the midwives found [X] very rude and arrogant and intimidating and would prefer not to deal with [X]...'

'We would find that the doctors would walk in and just come and look at what was going on because there wouldn't be that communication from the coordinator to the doctors. You just felt like there was very much an "us and them".'

'I think bullying was rife on the maternity unit and this is part of it, that these consultants, there were one or two or even three that would intimidate the midwives and junior doctors, and make sure that they are not approachable'.

'…this collaboration of training together, it really wasn't happening'.

Improvements

1.56 Within the survey, staff were asked whether they felt there were any barriers to attempts to make improvements to the maternity service. 50% of respondents replied 'yes' and a further 25% replied 'sometimes'.

'So we're going to put that into our protocols and policies and before it was just "mañana", we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.

'I think we have always wanted to improve the services because things never, you know, they must obviously change in order to improve, you just can't carry on the same way as you are. So, as far as I was concerned, yes, there was a thirst for improvement, for learning, you know, and how we can actually change things as well'.

'I wholeheartedly believe, and I know my colleagues believe senior management ….. have been a barrier for change'.

1.57 Other staff, however, reported that continuous improvements within maternity had been made over the years and the unit had engaged with national initiatives such as customised growth charts, the maternity early warning score and 'Saving Babies Lives'. A staff member told the review team:

'Since my appointment to consultant I have been involved in, instigated and led a number of improvement projects within the maternity department. All of the projects became multidisciplinary from an early stage.'

Impact of the review on staff

1.58 Staff reported being deeply affected by the ongoing review. Some staff explained that they would decline to meet with the review team for this very reason. One of the criticisms levied at the review team was there were misconceptions regarding the culture at the Trust.

'I feel that the culture in the unit now is different, I think there's a lot of people who have struggled, and personally my health's not been good as a result of this. ..there's been a lot of people who have really struggled from a mental health point of view, physical health point of view, because of this….. there's a resolve in the unit that we will improve and get better but there's also a sadness in the unit that we've ended up where we've ended up, and I think it is quite hard for the staff who've been there a long time.'

1.59 Other members of staff told the review team:

'…there's a number of colleagues who will never recover from this…'

'From the media perspective, it feels like people like me or my colleagues are portrayed as some sort of perpetrators, villains, but actually, I do feel we should all be on the same side here, but it doesn't feel like it.'

Response to the Independent Maternity Review

1.60 Staff who spoke to the review team were generally positive about the changes they had witnessed following the publication of our first report and the maternity services improvement programme:

'I think that the lessons from this inquiry are going to be transferable to the whole NHS'. The same staff member continued: *'….so the really great thing to come out of the external review has actually been the funding to expand … and I'm really grateful for that, really, really grateful'.*

1.61 Another staff member told the review team:

'No, I really hope that things change. I hope it changes for the…..good….. It's not all bad, and for the families, first and foremost really, because it's heart-breaking to see some things on Facebook where [The] Shropshire Star have put something up and if you read the comments from public members it's horrible to see people questioning whether they're going to be safe or not, when I know that there are so many staff there, I would quite happily let them look after me and have done.'

1.62 Further staff comments included their distress at not being listened to when they had tried to raise concerns at an earlier time *'… we were all just shell-shocked. Whenever a report comes in, you read it and there are bits you identify with and I couldn't even talk. I broke down ……I remember breaking down and they were proper angry sobs, it's not just, "I'm upset because families have gone through this, clinicians have gone through this", I am angry and I am hurt and I'm angry because nobody has listened and I don't believe the change has happened quick enough and I tried to explain that.'*

'I do feel very sorry about what's happened and I've reflected a lot on what I could have done differently…'

There were a number of positive comments about the first report from a range of staff including:

'I was impressed by the report identifying the need for nationwide improvements, learning from this experience. I think there's a story there that has been identified and it will be lovely to see that being implemented more effectively, more widely.'

'I mean maybe actually we didn't know necessarily the right questions to ask, so knowing some of the right questions to ask would have been helpful. For instance, I had no idea that they didn't have an adequate anaesthetic service, so that, if you haven't got adequate anaesthetic cover for your sections, obviously you're not going to do one if you can get away with it, or think you can get away with it, and that was something I had never thought of asking. So maybe it's about actually having a national sense of exactly what we should be checking on, as commissioners, so that we're not falsely reassured.'

'….it was shocking and very upsetting to see that those things hadn't come to light during the time that I thought that we were doing as good a job as we could at understanding what was going on in the services that we commissioned.'

Conclusions

1.63 This engagement strategy reached out to staff through liaising directly with the Trust and through social media platforms and local media reporting. We are extremely grateful to the staff who have been willing to share their experiences as we appreciate how difficult it has been to make that decision. Some expressed feelings of guilt at speaking with us and many were tearful as they recalled individual experiences and what they had observed in dealing with other colleagues and within their service over many years.

1.64 The members of staff who engaged with us really matter and their voices must be heard. They speak about the culture and raising concerns but not being heard. They speak about trying to do things to the best of their ability without the necessary frameworks in place that would enable them to learn from any errors made. What they say is supported by what we have seen throughout this review- that maternity services within the Trust had poor governance systems for a long time, which allowed it as an individual service to develop its own systems in isolation without effective internal and external surveillance.

1.65 We cannot underestimate the toll on staff of being under constant intense scrutiny. We met staff who were deeply affected by what had happened in their service. However, many of the staff who engaged with us stated that they were adamant to learn and do all they could to ensure their maternity services were safe for the families in Shropshire.

LOCAL ACTIONS FOR LEARNING: HEARING THE VOICES OF STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

1.66 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey and the recent feedback from current staff.

Appendix 2: Immediate and Essential Actions from our first report

Immediate and Essential Actions to improve care and safety in maternity services as outlined in our first report

1: ENHANCED SAFETY	
Essential Action Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	• Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them. • An LMS cannot function as one maternity service only. • The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY

Essential Action

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead.
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.
- The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.
- This must also include regional integration of maternal mental health services..

5: RISK ASSESSMENT THROUGHOUT PREGNANCY

Essential Action

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING

Essential Action

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
  - Improving the practice of monitoring fetal wellbeing
  - Consolidating existing knowledge of monitoring fetal wellbeing
  - Keeping abreast of developments in the field
  - Raising the profile of fetal wellbeing monitoring
  - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
  - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT

Essential Action

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.
- Women's choices following a shared and informed decision making process must be respected.

Appendix 3: Glossary of terms

Definitions and medical and midwifery terms used throughout our report

Abruption	Is the early separation of a placenta (afterbirth) from the lining of the uterus before completion of the second stage of labour. It is one of the causes of bleeding during the second half of pregnancy.
Abscess	Collection of pus
Absent End-Diastolic Flow	Is a useful feature which indicates underlying fetal vascular stress if detected in mid or late pregnancy
Acidaemia	A condition of raised blood acidity
Acute respiratory distress syndrome (ARDS)	A life-threatening lung injury that allows fluid to leak into the lungs. Breathing becomes difficult and oxygen cannot get into the body
Advanced neonatal nurse practitioners (ANNP)	Introduced to undertake the Tier 1 duties on the neonatal rota, jointly shared with ST1 - 3s. The post holders practice at a senior practitioner level to provide autonomous clinical care
Anomalous Left Coronary Artery to Pulmonary Artery (ALCAPA)	A very rare form of congenital heart disease
Amniocentesis	A medical procedure to obtain a small amount of amniotic fluid that is used to further investigate suspected fetal chromosomal abnormalities
Amnio-infusion	Refers to the instillation of fluid into the amniotic cavity
Amniotic Fluid Embolism	A rare condition where the amniotic fluid – which surrounds and protects a baby inside the womb – can leak into the mother's blood vessels during labour, causing a blockage. This can lead to breathing problems, a drop in blood pressure and loss of consciousness. A small number of women survive amniotic fluid embolism with risks of long-term complications including neurological problems because of a lack of oxygen to the brain, however most women do not survive
Amniotomy	Artificial rupture of the membranes (ARM)
Anaemic	Lack of enough red blood cells to carry adequate oxygen to the body's tissues
Antepartum	The period of pregnancy that includes the 24th week of pregnancy until birth

Antihypertensive medication	Drugs used to control high blood pressure
Apgar score	This is an accepted method of assessing how a newborn baby has adapted to extrauterine life, immediately following birth
Augmentation of labour	Is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour either by intravenous oxytocin infusion and/ or artificial rupture of membranes. It can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and facilitate cervical dilatation and vaginal birth
Auscultation	A method of periodically listening to the fetal heart with a stethoscope
Arachnoid cyst	Benign cyst in the brain
BCH	Birmingham Children's Hospital
Birthing centre	A birth centre staffed by midwives, they may be "stand alone", (some distance from a consultant-led unit) or alongside, often in the same building/ on the same floor as a consultant-led unit.
Birthrate Plus® (BRP)	Is a method for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. From the data collated, the methodology calculates the number of midwives required to meet the defined standards and models of care whilst informing local workforce requirements, holiday and travel allowances etc
BLISS	A charity for babies born premature or sick
Born Before Arrival (BBA)	Refers to a birth which takes place before arrival to a maternity unit, or a homebirth before the arrival of a midwife
Bougie	A small wire over which a breathing tube can be passed in difficult airways
British Association of Perinatal Medicine (BAPM)	Is a professional association and registered charity. They aim to improve standards of perinatal care by supporting all those involved in perinatal care to optimise their skills and knowledge, deliver and share high quality safe and innovative practice, undertake research, and promote the needs of babies and their families
Cabergoline	A drug used to suppress lactation (milk production).
Caesarean hysterectomy	Hysterectomy (surgical removal of the womb) at the time of, or soon after, delivery by caesarean section

CAF	Common Assessment Framework is a tool designed to help practitioners working with children, young people and families to assess children and young people's additional needs and strengths for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them
Cardiopulmonary	Relating to the heart and lungs
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Category 1 caesarean section	Is when there is immediate threat to the life of the woman or fetus and delivery is recommended within 30 minutes
Category 2 caesarean section	Is when there is maternal or fetal compromise which is not immediately life-threatening and delivery is recommended within 75 minutes.
Catheter	Tube (usually to drain the bladder)
CBT	Cognitive Behavioural Therapy
CDH	Congenital diaphragmatic hernia, a serious congenital anomaly where some of the bowel lies within the chest and causes breathing difficulties
CEMACH	Confidential Enquiry into Maternal and Child Health
Cerebral Palsy	Is caused by a problem within the brain that develops before, during or soon after birth. Cerebral Palsy affects movement and coordination
Clinical Commissioning Groups (CCG)	Were established as part of the Health and Social Care Act in 2012, and consist of groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Clinical Negligence Scheme for Trusts (CNST)	An insurance scheme administered by NHS Resolution (NHSR) in which individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims. Trusts which achieve standards set by the scheme receive a reduction in premiums
Chorioamnionitis	A serious condition in pregnant women in which the membranes that surround the fetus and the amniotic fluid are infected by bacteria. It can also cause serious complications in the newborn baby. This includes infection (such as pneumonia or meningitis), brain damage, or death

Coagulopathy	Coagulopathy is often broadly defined as any derangement of haemostasis resulting in either excessive bleeding or clotting, although most typically it is defined as impaired clot formation
Colloid fluid	Non-crystal fluid used as a temporary substitute for blood
Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)	Was created to improve the understanding of the causes of death in late fetal life (from 20 weeks post-conception) to infancy (one year after birth). CESDI created a standardised grading system to categorise mortality reviews and identify cases of suboptimal care
Consultant-led Unit (CU)	Refers to a maternity unit which has the support of obstetricians and midwives to facilitate high-risk care during the antenatal, intrapartum or postnatal period. Consultant-led units also require the support of the wider multi-disciplinary team including (but not limited to) anaesthetists, theatres and a neonatal team
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anaesthetists. They have a neonatal unit staffed by neonatologists and nurses
Continuous Positive Airway Pressure (CPAP)	It is a type of non-invasive ventilation (NIV) or breathing support
Cooling	Therapeutic hypothermia is an effective way to treat newborn babies who have experienced a lack of oxygen and/or blood flow to the brain and other organs before or during labour and delivery. Reducing a baby's body temperature to 33.5oC to protect the brain
Cord prolapse	Happens when the umbilical cord slips down in front of the baby after the waters have broken. The cord can then come through the open cervix (entrance of the womb)
Counselling	Professional guidance and discussion to support complex choices with families that ensures sharing of evidenced-based information to enable informed decision and personalised care
CPR	Cardio pulmonary resuscitation (chest compressions and breaths)
Critical care unit	Intensive care or high dependency care unit
CRP	C-reactive protein. A marker of infection or inflammation
Crystalloid	A solution of water and salts for intravenous administration
Culture	Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations

Diaphragmatic Hernia	Diaphragmatic hernia is a birth defect where there is a hole in the diaphragm
DATIX	An incident reporting form
Dichorionic, diamniotic (DCDA) twins	Each has their own separate placenta with its own separate inner membrane (amnion) and outer membrane (chorion)
Direct Maternal Deaths	Are defined as those related to obstetric complications during pregnancy, labour or puerperium (six weeks) or resulting from any treatment received.
Deflexed occipito-posterior position	Poor position of the fetal head
Diuretics	Drugs used to increase urine production
Doppler assessment	Assessment of the blood flow in various fetal blood vessels, commonly the umbilical vessels or the middle cerebral artery (MCA)
Dual instruments	There are two main instruments used in operative deliveries – the ventouse and the forceps. In general, the first instrument used is the most likely to succeed. Dual instrumentation describes both types of instruments being used to perform an operative vaginal delivery
Duty of candour	Legislation to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Each Baby Counts	A national quality improvement programme set by Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. This improvement programme is now closed
Eclamptic fit	A fit occurring as a consequence of severe pre-eclampsia
E. Coli	A bacterium that can cause infection
EMDR	Eye Movement Desensitisation and Reprocessing
Empyema	Pus in a body cavity
Endometritis	Infection within the uterus (womb)
Escalate	To become more important or serious, or to make something or someone do this.
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death

External Cephalic Version (ECV)	Is a process by which a breech baby can sometimes be turned from buttocks or foot first to head first. It is a manual procedure that is recommended by national guidelines for breech presentation of a pregnancy with a single baby, in order to enable vaginal delivery
Extradural haematoma	A sub-periosteal haematoma located on the inside of the skull, between the inner table of the skull and parietal layer of the dura mater (which is the periosteum)
Extubation	Removal of an artificial breathing tube from a baby's airway
EUA	Examination under anaesthetic
Faecal incontinence	Lack of bowel control
Fetal blood sampling (FBS)	Is a procedure to take a small amount of blood from an unborn baby (fetus) during pregnancy. FBS should be advised in the presence of a pathological fetal heart rate (FHR) trace unless there is clear evidence of acute compromise (i.e. immediate delivery is thought necessary)
Fetal bradycardia	Fetal heart rate of less than 120 beats per minute
Fetomaternal haemorrhage	The entry of fetal blood into the maternal circulation before or during delivery
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Footling breech	Is when one or both of the baby's feet are born first
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
Fresh eyes assessment	Refers to a "buddy system" of CTG review to improve interpretation and documentation
Funisitis	Inflammation of the connective tissue of the umbilical cord that occurs with chorioamnionitis
Furosemide	A drug that promotes removal of fluid from the body by production of urine, a diuretic
GAP	The Growth Assessment Protocol: a national programme to improve patient safety in maternity care
Gastroschisis	A defect of the abdominal wall where intestines are found outside of the baby's body, exiting through a hole alongside the umbilicus (belly button)
General Medical Council (GMC)	A statutory body with the purpose to protect, promote and maintain the health and safety of the public by working to protect patient safety and support medical education and practice across the UK. The GMC works with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems

Governance	The way that organisations are managed at the highest level, and the systems for doing this. Clinical governance can be defined as a framework through which the National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care. NHS staff need to ensure that the appropriate systems and processes are in place to monitor clinical practice and safeguard high quality of care
GROW Chart	Customised antenatal charts for plotting fundal height and estimated fetal weight
Growth retardation	Growth significantly less than expected
Grunting/grunty	An abnormal noise made by a newborn baby with breathing issues
Guedel airway	A device placed in the mouth to keep the airway open
Haematoma	Blood clot (not in a blood vessel)
Haematologist	A doctor specialising in disorders of the blood
Haematuria	Blood in the urine
Haemodynamic	Relating to the flow of blood
Haemoperitoneum	Blood in the abdominal cavity
Hb	Haemoglobin level i.e. assessment of anaemia
HDU	High Dependency Unit
Healthcare Commission (HCC)	The Commission for Healthcare Audit and Inspection, also known as the Healthcare Commission was created in 2004. It was responsible for assessing standards of care provided by the NHS. Its responsibilities were taken over by the Care Quality Commission in 2009
Headbox oxygen	An oxygen hood or head box is used for babies who can breathe on their own but still need extra oxygen. A hood is a plastic dome or box with warm, moist oxygen inside. The hood is placed over the baby's head
HELLP	Haemolysis (of red blood cells): Elevated Liver (enzymes): Low Platelets. HELLP is a syndrome that occurs with serious pre-eclampsia, and indicates severely deteriorating organ function
High frequency oscillatory ventilation (HFOV)	An advanced form of respiratory support
Hypoxic ischemic encephalopathy (HIE)	Refers to the damage caused in a baby's brain when the baby does not receive enough oxygen and / or blood flow around the time of birth, or during pregnancy. Graded into HIE grades 1-3 depending on severity
High Risk Case Review (HRCR)	An internal process used in Shrewsbury and Telford Hospitals NHS Trust over the period of this review created to investigate incidents which were said to not meet the threshold for being a Serious Incident

The Healthcare Safety Investigation Branch (HSIB)	They investigate incidents that meet the Each Baby Counts criteria and their defined criteria for maternal deaths *www.hsib.org.uk/maternity/what-we-investigate/*
Higher Specialist Trainee (HST)	Middle grade, or Tier 2 doctor, registrar
'Hub and Spoke' Model	Refers to a specific type of service model design consisting of a main base supported by additional bases or branches. In maternity services, the hub is the consultant-led unit and the spokes are midwiferyled units or community bases
Human factors	Refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety
Humerus	The long bone in the arm
Hydronephrosis	Swelling of the system that collects urine from the kidney, usually because of obstruction lower down the renal tract
Hypercalcaemic	High calcium levels in the blood
Hyperinsulinism	Excessive secretion of insulin, leading to low blood sugar
Hypertension	High blood pressure
Hypotension	Low blood pressure
Hypotensive	Abnormally low blood pressure
Hypothermic cooling	Involves cooling the baby down to a temperature below homeostasis to allow the brain to recover from a hypoxic-ischemic injury
Hypovolaemia	Low blood volume, usually secondary to blood loss
Hypoxia/Hypoxic	Is a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia)
Indirect Maternal Deaths	Are those associated with a disorder, the effect of which is exacerbated by pregnancy
Indices of Deprivation	Are datasets used to classify levels of deprivation within small areas. Deprivation rates are measured by the assessment of various factors including income, employment rates, education, housing and crime
Inflammatory markers	Substances that can be measured in blood tests that, when elevated, indicate that there is inflammation occurring within the body
Infused	Given intravenous fluid (not blood)
Inotropes	Intravenous medication to treat very low blood pressure

International Normalised Ratio (INR)	A blood test/ calculation which assesses the time taken for blood to clot
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Instrumental delivery	An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cup are used to help deliver the baby
Intrapartum	During labour
Intrauterine death (IUD)	Also called stillbirth: An unborn baby dies inside the womb before birth. This is described as 'late' when it happens in a woman who is 24 weeks pregnant or more, and is estimated to occur in 1% of all pregnancies
Intraventricular Haemorrhage (IVH)	Bleeding inside or around the ventricles within the brain
ITU	Intensive therapy (care) unit
Intubation	Placing a breathing tube in a baby's airway to assist ventilation
Intraventricular haemorrhage (IVH)	Bleeding into the fluid cavities within the brain, usually in preterm babies
Ketonuria	Occurs when high levels of ketone bodies which occur when cells are broken down for energy are present in the urine
KIDS-NTS	Children's and Neonatal Transport team for the West Midlands
Labour ward coordinator	Senior midwives who coordinate the clinical workload and activity on the labour ward
Laparotomy	Surgical opening of the abdomen
Laryngeal mask	A device placed in the airway instead of intubation
Liquor	The water surrounding the baby in the womb
Left ventricular failure	When the left side of the heart is unable to pump blood to the body effectively such that it is insufficient for the body's needs
Level 3 neonatal unit	Neonatal units are graded 1-3, 3 being equipped to care for the most pre-term and unwell infants requiring the highest levels of investigation and treatment
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit (formerly known as level 2 neonatal unit)
Local Authority	Refers to an organisation within local government which is responsible for public services and facilities.

Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Local Supervising Authority Midwifery Officer (LSAMO)	A senior officer who was responsible for upholding the standards of statutory midwifery supervision at a regional level. Statutory supervision was abolished in 2017
Local Supervisory Authority (LSA)	This organisation was responsible for the function of statutory supervision of midwives. The LSA was accountable to the Nursing and Midwifery Council (NMC) which set rules and standards for midwifery. This authority was disbanded when Supervision of Midwifery was abolished
Loculated empyema	Pockets of pus that have collected inside a body cavity
LSCS	Lower segment caesarean section
Lower specialist trainee (LST)	Tier 1 doctor or Senior House Officer
Macrosomic	A newborn baby that is much larger than expected
Magnesium infusion	Drip used to decrease the risk of an eclamptic fit
Malpositioned baby	Usually the fetal head engages in the occipito-anterior position (more often left occipito-anterior (LOA) rather than right) and then undergoes a short rotation to be directly occipito-anterior in the mid-cavity. Malpositions are abnormal positions of the vertex of the fetal head relative to the maternal pelvis
Maternal death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Dashboard	Is a tool which can be used within clinical governance to benchmark activity, and to monitor quality and performance indicators such as birth complications and mode of delivery
Maternity and Neonatal Collaboration	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
Maternity Transformation Programme	The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for women by ensuring that there is the capacity in the workforce nationally

Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
Mat Neo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. A national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
MDT	Multi-disciplinary Team
Meconium	Baby's bowel contents in the liquor (water) which sometimes suggests fetal distress (thick meconium is more likely to suggest this)
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a Modified Early Obstetric Warning System
Midwife-led units (MLU)	Are another name for birth centres that are run by midwives and have a home-like environment. They are most suitable for women without complications and can be next to a hospital maternity unit ('alongside') or situated in the community ('freestanding')
Midwifery Continuity of Carer (MCoC)	Midwifery continuity of care is a model of care, which aims to limit the number of different healthcare professionals a woman sees throughout her pregnancy. Its aim is that the pregnant woman will receive intrapartum care from a midwife she has met previously during her current pregnancy, thereby providing greater continuity
Mifepristone	A drug used to prepare the uterus (womb) for early contractions usually induced by another drug given approximately 36 hours later
Monochorionic twins	Twins sharing the same blood supply from the placenta. This can lead to unequal sharing of the blood supply which can lead to the death of one or both twins
Moulding	The bones of the fetal head can move closer together or overlap to help the head fit through the pelvis.
MRI scan	Magnetic Resonance Imaging –detailed scan, often of the brain
Multiparous	A woman who has given birth once or more

Multidisciplinary team	Is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended care. In maternity this tends to be midwives, obstetricians, anaesthetists and neonatologists
Myelomeningocele	A form of spina bifida where the spinal cord is exposed at birth. This is when a sac of fluid comes through an opening in the baby's back. Part of the spinal cord/ nerves can be in the sac and are damaged
Neonatal Data Analysis Unit (NDAU)	Analyses neonatal data nationally
National Reporting and Learning System (NRLS)	Is a central database of patient safety incident reports
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life • Early neonatal death - a live born baby who died before 7 completed days after birth • Late neonatal death - a live born baby who died after 7 completed days but before 28 completed days after birth
Neonatal Networks	A network of neonatal units working together to provide neonatal care to a geographical area. Also knows as 'managed clinical networks' or 'operational delivery networks'
NHS England and NHS Improvement (NHSE&I)	The body that leads the NHS in England
NHS Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA), now known as NHS Resolution (NHSR), manages negligence and other claims against the NHS in England on behalf of its member organisations. Its aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff
NHS Resolution	A body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care
National Institute for Health and Care Excellence (NICE)	Provides national guidance and advice to improve health and social care
NICHE	An independent consultancy service available to all healthcare providers (including mental health, acute, specialist, ambulance, primary and community), social care partners, commissioners, local authorities and regulatory organisations
NICU	Neonatal intensive care unit
NLS	Newborn Life Support Course (national training course)

NMR	Neonatal mortality rate (deaths within 28 days of life)
National Neonatal Audit Project (NNAP)	National audit of neonatal outcomes
NNU	Neonatal unit
Non-Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation
NQM	Newly qualified midwife of less than one year since becoming a professional registrant.
Nulliparous	Describes a mother who has not given birth before
Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oedema	Accumulation of fluid in bodily tissues
Office of National Statistics (ONS)	Is responsible for collating and publishing statistics relating to health, economy, population and society at local, regional and national levels
Open Book	The cases identified by the Open Book arose from the Shrewsbury and Telford Hospital NHS Trust (supported by NHSI) undergoing its own investigation of cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. These were then reported to the review team
Operative delivery	Refers to a delivery in which the operator uses forceps, a vacuum, or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing
Operative vaginal delivery	Vaginal birth assisted with forceps or ventouse
Organisational structure	The way in which a large company or organisation is organised, for example, the types of relationships that exist between managers and employees
Oscillator	A form of high frequency ventilatory support that keeps the lungs open with a constant positive end-expiratory pressure
Oxygen saturation	Concentration of oxygen carried in the blood
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Paediatric	Branch of medicine that is dealing with infants, children and adolescents
Parliamentary and Health Service Ombudsman (PHSO)	An organisation which works with individuals and groups in an organisation to explore and assist them in determining options to help resolve conflicts, problematic issues or concerns, and to bring systemic concerns to the attention of the organisation for resolution

PCT	Primary Care Trust
Perinatal	The period of time that includes the entirety of pregnancy up until and including the first complete year following birth
Perinatal death	A stillbirth or early neonatal death
Perineal tear	A tear occurring during childbirth. 1st and 2nd degree tears are common, and not serious. A 3rd degree tear involves the anal sphincters as well as skin, vagina and muscle. A 4th degree tear extends into the rectum
Perineal follow-up clinic	A clinic to follow-up women who have experienced 3rd and 4th degree tears
Perinatal loss	Loss of a baby during pregnancy or soon after birth. Includes stillbirths and neonatal deaths
Peritoneum	The membrane which lines part of the abdominal cavity and covers the organs that lie within it
Placental	Reference to the 'afterbirth'
Placental abruption	When the placenta separates from the uterine wall either before or during labour
Placenta accreta	Abnormally deep attachment of the placenta into the muscle of the uterus (womb)
Perinatal mortality rate (PMR)	Stillbirths and deaths within 7 days of life
Post-partum haemorrhage (PPH)	Significant bleed after giving birth
Post-partum	After the birth
Pre-eclampsia (PET)	A condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is delivered. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria). The condition can be very serious for mother and baby
Pre-labour preterm rupture of membranes (P-PROM)	Is the rupture of membranes prior to the onset of labour, in a patient who is at less than 37 weeks of gestation
PRH	Princess Royal Hospital- Telford- current location of neonatal service
Primary Care Trust (PCT)	Were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups (CCGs)
Primiparous or Primigravid	A woman who is pregnant for the first time

Professional Midwifery Advocates (PMAs)	Support midwives to ensure that women and babies receive good quality, safe care
Prophylactic	Intended to prevent something occurring by being given early – for example a medication
Prostaglandin	A synthetic hormone that is used in obstetrics to encourage uterine contractions and cervical ripening (Shortening and dilatation)
Proteinuria	Protein detected in a urine sample
Pulmonary	Relating to the lungs
Pulmonary oedema	An excess of watery fluid in the lungs
Pyelonephritis	Severe kidney infection
Pyrexia	High temperature
Qualified in Speciality (QIS)	Postgraduate specialist training for neonatal nurses
Royal College of Midwives (RCM)	A professional organisation and trade union committed to serving midwifery and its workforce
Royal College of Obstetricians & Gynaecologists (RCOG)	Professional body of obstetricians to improve healthcare for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's healthcare worldwide
RCPCH	Royal College of Paediatrics and Child Health
Respiratory Distress Syndrome (RDS)	Breathing difficulty, usually in preterm babies due to immature lungs
Retained products	Pieces of placenta and/or membrane left in the uterus (womb) after delivery of the placenta (afterbirth)
Retropubic haematoma	Blood clot formed behind the pubic bone
Rectovaginal fistula	An abnormal channel that has developed between the rectum and vagina usually as a consequence of childbirth
Rectus sheath haematoma	Blood clot caused by bleeding from the rectus abdominus muscle (i.e. abdominal wall muscle)
Risk Management Strategy	The systematic identification, assessment and evaluation of risk. Used properly in healthcare, it can not only be a process to report incidents, but also minimise the harm that clinical or resourcing errors can cause to patients and staff
Root Cause Analysis (RCA)	Is the process of examining what happened in order to establish, how and fundamentally why an adverse event occurred. It should result in preventative measures to minimise future risk of reoccurrence.
RSH	Royal Shrewsbury Hospital – former location of neonatal service
SANDS	Stillbirth and neonatal death support charity

SaTH	Shrewsbury and Telford Hospital or NHS Trust or the Trust
Situation, Background, Assessment and Recommendation (SBAR)	An easy to use, structured form of communication that enables information to be transferred accurately between individuals
SBR	Serum bilirubin – to determine the level of jaundice in a baby
Serious Incidents (SI)	Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in unexpected or avoidable death, serious harm or injury. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Previously known as Serious Untoward Incidents (SUI)
Sepsis	Severe infection
Septicaemia	Blood poisoning
Shock	Fall in blood perfusing organs, usually recognised because of a fall in blood pressure and a rise in heart rate. Shock has a number of possible causes, blood loss being the most common in maternity patients
Shoulder dystocia	Shoulder dystocia is when a baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body
Situational awareness	Can be defined simply as 'knowing what is going on around us', or – more technically – as 'the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future'
Spina Bifida	A condition that affects the spine and is usually apparent at birth. It is a type of neural tube defect (NTD)
Squamous epithelial cells in the pulmonary vessels	Cells from the baby found in the lung vessels of the mother
SSCBCN	Staffordshire, Shropshire and Black Country Neonatal Network
SSCBCODN	Staffordshire, Shropshire and Black Country Operational Delivery Network
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. An antenatal stillbirth occurs at or prior to the onset of labour. An intrapartum stillbirth occurs after the onset of labour

Subarachnoid haemorrhage	Bleeding in the space between the brain and the skull
Surfactant	A medicine given directly into the lungs of premature babies
Symphysis fundal height	A measurement from the Symphysis Pubis to the top of the fundus (womb) that monitors fetal growth
'T' incision	When the cut made on the uterus is both horizontal and vertical. The subsequent scar is weak, and therefore there is a greater risk of uterine rupture in a future pregnancy
Tachycardia	Fast heart rate
Talipes	A condition affecting one or both feet that is caused by a shortened Achilles tendon or as a result of fetal lie within the womb. Usually self-resolving with exercise or physiotherapy, but in some cases requires further intervention
Tethered Conus	Neurological condition where the end of the spinal cord is fixed by tissue attachments at the bottom of the spinal canal rather than moving freely
Therapeutic lactation suppression	Use of drugs to suppress milk production
Thermoregulate	Whereby the body maintains its core temperature
Third or fourth degree perineal tear	A perineal tear which involves damage to the fourchette, perineal skin, vaginal mucosa, muscles, and anal sphincter
Thrombosis	Blood clot in a blood vessel, usually in a vein
TOBY registry	A national register of babies that received cooling for HIE
Tocophobia	Is a pathological fear of pregnancy and can lead to avoidance of childbirth
Transfused	Given a blood transfusion
Transport team	A specialist service for safely transferring babies between care providers
Trial of instrumental birth	A term used when a difficult instrumental birth is anticipated, usually performed in an operating theatre with quick and easy recourse to caesarean section
Twin to twin transfusion syndrome (TTTS)	Is a rare condition that occurs during a twin pregnancy when blood moves from one twin (the 'donor twin') to the other (the 'recipient twin') while in the womb
UHNM	University Hospitals of North Midlands (Royal Stoke University Hospital)
Ureter	Tube down which urine passes from the kidney to the bladder
Ureteric obstruction	Blockage of the ureter

Urologist	A doctor specialising in disorders of the urinary tract
Uterine artery	Main artery (but not only artery) supplying blood to the uterus (womb)
Uterine rupture	When the uterine wall bursts, this usually occurs during labour, but can occur during pregnancy. Uterine rupture generally occurs when the uterus has a previous scar. Some types of scar, increase the risk of rupture in future pregnancies
Urinary PCR	Protein/creatinine ratio in the urine to measure the level of protein more accurately than a dipstick assessment
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal
WMNODN	West Midlands Neonatal Operational Delivery Network

Appendix 4: References

References used in the report

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

Department of Health and Social Care. The government's response to the Health and Social Care Committee report: safety of maternity services in England (2021)
https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-committee-report-safety-of-maternity-services-in-england

NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021)
https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf

Health and Social Care Committee. The safety of maternity services in England (2021) https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

Department of Health. Safer Maternity Care: The National Maternity Safety Strategy - Progress and Next Steps (2017)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

Statement by the Secretary of State for Health and Social Care Sajid Javid. Special Health Authority for Independent Maternity Investigations (2022)
https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560

Introduction

Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020)
https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

Chapter 1. Concerns that led to this review - a timeline

Healthcare Commission Letter to the Trust's Chief Executive Officer 18 April 2007
https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf

Graham, D. Independent Review of the case of Kate Seren Stanton-Davies at the Shrewsbury and Telford Hospital NHS Trust (2015)
https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf

Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group. Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust (2013)
https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

2014 Trust Board papers supplied to the review team

NHS Litigation Authority Clinical Negligence Scheme for Trusts. Maternity Clinical Risk Management Standards 2013-14. The Shrewsbury and Telford Hospital NHS Trust. Level 3. (2014)

NHS Health Education West Midlands. PMET Review Findings Report Summary (2014)

Care Quality Commission. Shrewsbury and Telford Hospital NHS Trust Quality Report (2015)
https://api.cqc.org.uk/public/v1/reports/0826982d-e4d9-48da-bc92-a78c8fc9b933?20210518113404

Ovington, C. Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017)
https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

Royal College of Obstetricians and Gynaecologists. Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust (2017)

NHS Improvement. 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 (2020)
https://www.england.nhs.uk/midlands/publications/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/

Royal College of Obstetricians and Gynaecologists Invited Reviews a guide (2015)
https://www.rcog.org.uk/globalassets/documents/about-us/invited-reviews/rcog-invited-reviews---a-guide-oct-2015.pdf

Royal College of Obstetricians and Gynaecologists. Statement regarding an Invited Review by Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust (2020)
https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/

Royal College of Obstetricians and Gynaecologists. Invited Review Service.
https://www.rcog.org.uk/en/about-us/invited-review-policy/

Care Quality Commission. 2018 inspection report on Shrewsbury and Telford Hospital NHS Trust
https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

Who's Who at the Trust – internal document received by the review team on 9 September 2020

Chapter 2. How we approached our review

Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020)
https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

A confidential enquiry into cases of neonatal encephalopathy
https://pubmed.ncbi.nlm.nih.gov/12390986/

Kirkup, B. The Report of the Morecambe Bay Investigation. (2015)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

NHS Resolution. NHS Resolution's Annual report and accounts 2019/20
https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/

Background information about the Trust

Ministry of Housing, Communities and Local Government 2019 Indices of Deprivation – Telford and Wrekin.
https://www.telford.gov.uk/download/downloads/id/15603/index_of_multiple_deprivation_2019_-_telford_and_wrekin.pdf

Knight, M., Bunch, T., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. Kurinczuk, JJ. (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. (2021) Oxford: National Perinatal Epidemiology Unit, University of Oxford.

NHS England and NHS Improvement. Equity and equality. Guidance for local maternity systems. (2021)
https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

Healthcare Quality Improvement Partnership. National Maternity and Perinatal Audit Clinical Report 2017
https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf

Shrewsbury and Telford Hospitals NHS Trust (2020). Deliveries by Ethnic category and age – 2000-2020.

MBRRACE-UK. Perinatal mortality surveillance report for births (2013-2018)
https://www.npeu.ox.ac.uk/mbrrace-uk

Jardine, JE., Fremeaux, A., Coe, M., Urganci, IG., Pasupathy, D. and Walker, K. Validation of ethnicity in administrative hospital data in women giving birth in England: cohort study (2021) British Medical Journal Open, 11(8). doi: https://doi.org/10.1136/bmjopen-2021-051977

World Health Organisation. Adolescent pregnancy. (2020)
https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

Royal College of Obstetricians and Gynaecologists. Induction of Labour at Term in Older Mothers. (2013)
https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_34.pdf

Office for National Statistics. Conceptions in England and Wales: 2018.
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-area-of-usual-residence

Office for National Statistics. Birth characteristics in England and Wales: 2019. (2020)
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019#age-of-parents

Chapter 4. Clinical governance

NHS England. Report a patient safety incident
https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/

NHS England. Serious Incident Framework, (2015)
https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

National Patient Safety Agency. National framework for reporting and learning from serious incidents requiring investigation. (2010)
https://www.afpp.org.uk/filegrab/NPSAconsultationdocument.pdf?ref=1064

Ovington, C. Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017)
https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

Parliamentary and Health Service Ombudsman (PHSO). An investigation report into how the NHS failed to properly investigate the death of a three-year old child (2016)
https://www.ombudsman.org.uk/publications/learning-mistakes-0

Parliamentary and Health Service Ombudsman (PHSO). A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015)
https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

House of Commons Public Administration and Constitutional Affairs Committee. Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. (2017)
https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf

Magro, M. Learning from five years of cerebral palsy litigation claims. (2017) NHS Resolution
https://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group, Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust (2013)
https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

Maternity and Neonatal Collaboration survey 2018, provided by the Trust

Healthcare Safety Investigation Branch. Annual Review 2020/21 (2021)
https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/HSIB_Annual_Review_Brochure_2020-21_FINAL.pdf

Shrewsbury and Telford Hospitals NHS Trust Board Report (2018) outlining the Royal College of Obstetricians and Gynaecologists review of maternity services.
https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf

Care Quality Commission report provided by the Trust to the review team, site visits were November 2019 and the report published in January 2020

NHS Constitution. NHS Complaints Guide (2021).
https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service

NHS Wales. Using the gift of complaints (2014)
http://www.wales.nhs.uk/usingthegiftofcomplaints

General Medical Council. The professional duty of candour
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour

Royal College of Obstetricians and Gynaecologists. Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31 (2013)
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

NHS Resolution, NHS Litigation Authority. NHS Litigation Authority Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards 2013-14, The Shrewsbury and Telford Hospital NHS Trust, Level 3, p23 (March 2014)

NHS Resolution. The maternity incentive scheme year 2 results. (2020)
https://resolution.nhs.uk/2020/02/13/the-maternity-incentive-scheme-year-two-results/#:~:text=The%20maternity%20incentive%20scheme%20was%20launched%20by%20NHS,but%20also%20a%20share%-20of%20any%20unallocated%20monies

Care Quality Commission, Shrewsbury and Telford Hospital NHS Trusts Inspection report (2018)
https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

NHS England. Maternity self-assessment tool (2021)
https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

Royal College of Obstetricians and Gynaecologists. Each Baby Counts: key messages from 2015 (2016)
https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/rcog-each-baby-counts-report.pdf

Parliamentary and Health Service Ombudsman. Learning from mistakes. (2016)
https://www.ombudsman.org.uk/publications/learning-mistakes-0

Parliamentary and Health Service Ombudsman. A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015)
https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

House of Commons Public Administration and Constitutional Affairs Committee. Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. (2017)
https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf

NHS England website. NHS Patient Safety Strategy 2019.
https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England. NHS Patient Safety Strategy 2019.
https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England. Introductory Patient Safety Incident Response Framework. (2020)
https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

NHS Employers. Consultant contract frequently asked questions (2009)
https://www.nhsemployers.org/sites/default/files/2021-06/consultant-contract-faqs_0.pdf

Chapter 5. Clinical leadership

Joseph, M, L. Huber D, L. Clinical leadership development and education for nurses: prospects and opportunities (2015)
https://pubmed.ncbi.nlm.nih.gov/29355179/

NHS England: National Maternity Review: Better Births: Improving Outcomes of maternity services in England (2016) p72:
https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Royal College of Midwives (RCM) Leadership - what's that got to do with me? Midwives Magazine Issue 2 2012 [online].
https://www.rcm.org.uk/news-views/rcm-opinion/leadership-what-s-that-got-to-do-with-me/ [Accessed 24th November 2021].

Royal College of Obstetricians and Gynaecologists (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.
https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf [Accessed 01 December 2021].

Royal College of Obstetricians and Gynaecologists (2021) Workplace Behaviour Toolkit.
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/workplace-behaviour/toolkit/ [Accessed 01 December 2021].

Department of Health. Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994–1996. (1998).RCOG, 2004, CEMACH, 2007,

Kirkup, B. (2015) The Report of the Morecambe Bay Investigation.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Knight et al, 2016 and NHS, 2019. Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019).
https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

2014 Trust Board papers supplied to the review team

Kings Fund. Safe Births: Everybody's business (2008)
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/safe-births-everybodys-business-onora-oneill-february-2008.pdf

The Kings Fund. Midwifery regulation in the United Kingdom (2015)
https://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom

NICHE 2016 Independent Review of West Midlands local Supervising authority (LSA) Supervisory Investigations Governance arrangements dated 31st August 2016, ref 2031-16, supplied by the Trust

Fatolitis, P. and Masalonis, A. 'Human Factors in Aviation and Healthcare: Best Practices, Safety Culture and the Way Ahead for Patient Safety', Journal of Ergonomics vol 11 issue 5. (2021)
https://www.longdom.org/open-access/human-factors-in-aviation-and-healthcare-best-practices-safety-culture-and-the-way-ahead-for-patient-safety.pdf [Accessed 01 December 2021].

Kirkup, B. (2015) The Report of the Morecambe Bay Investigation.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021]

Flin, R., O'Connor, P. and Crichton, M. Safety At The Sharp End. (2008) CRC Press; Florida.

Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and Dixon-Woods, M. How to be a very safe maternity unit: An ethnographic study. (2019)
https://www.thisinstitute.cam.ac.uk/research-articles/safe-maternity-unit-ethnographic-study/ (Accessed 01 December 2021).

National Institute for Health and Care Excellence. Safe midwifery staffing for maternity settings. (2015) https://www.nice.org.uk/guidance/ng4 [Accessed 01 December 2021]

Royal College of Obstetricians and Gynaecologists. Each Baby Counts. 2020 Final Progress Report. (2020)
https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/ebc-2020-final-progress-report.pdf [Accessed 01 December 2021].

Civility Saves Lives (2017) Civility Saves Lives.
https://www.civilitysaveslives.com/ [Accessed 01 December 2021].

Youngson, G. and Flin, R. Patient safety in surgery: non-technical aspects of safe surgical performance (2010). doi: 10.1186/1754-9493-4-4.

Mannion, R. and Davies, H. Understanding organisational culture for healthcare quality improvement, British Medical Journal (2018) doi: 10.1136/bmj.k4907:
https://www.bmj.com/content/363/bmj.k4907

Chapter 6. Our findings following review of family cases

Kirkup, B. The Report of the Morecambe Bay Investigation. (2015)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

E S Draper, et al. A confidential enquiry into cases of neonatal encephalopathy. Arch Dis Child Fetal Neonatal Ed 87 (2002), F176-F180

Chapter 7. Antenatal care

NHS England. Better Births (2016)
https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Centre for Maternal and Child Enquires. Perinatal Mortality 2008 (2010)
https://www.publichealth.hscni.net/sites/default/files/Perinatal%20Mortality%202008.pdf

National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010)
https://www.nice.org.uk/guidance/cg110

MBRRACE-UK. Perinatal Confidential Enquiry. Term, singleton, normally-formed, antepartum stillbirth (2015)
https://www.hqip.org.uk/wp-content/uploads/2018/02/perinatal-confidential-enquiry-term-singleton-normally-formed-antepartum-stillbirth-report-2015.pdf

NHS England. Saving Babies' Lives Care Bundle
https://www.england.nhs.uk/mat-transformation/saving-babies/

National Institute for Health and Care Excellence. Antenatal Care Clinical Guidance 6 (2003)
https://www.nice.org.uk/guidance/cg6 and Antenatal Care for uncomplicated pregnancies Clinical Guidance 62 (2008) https://www.nice.org.uk/guidance/cg62

Royal College of Obstetricians and Gynaecologists. Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31 (2013)
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

NHS England. Saving Babies' Lives Version 2: a care bundle for perinatal mortality (2019)
https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

Clifford, S., Giddings, S., Southam, M., Williams, M., Gardosi, J., The Growth Assessment Protocol: a national programme to improve patient safety in maternity care. (2013)
https://www.perinatal.org.uk/wwwroot/pdf/nz/GAP_article_MIDIRS_Dec_2013.pdf

Gestation Network. Growth Charts GROW
https://www.gestation.net/growthcharts.htm

National Institute for Health and Care Excellence. Twin and triplet pregnancy NICE Guideline NG137 (2019)
https://www.nice.org.uk/guidance/ng137

National Institute for Health and Care Excellence. Diabetes in pregnancy: management from preconception to the postnatal period NICE guideline NG3 (2020)
https://www.nice.org.uk/guidance/ng3

Confidential Enquiry into Maternal and Child Health. Diabetes in pregnancy: are we providing the best care? (2007)
https://www.publichealth.hscni.net/publications/diabetes-pregnancy-are-we-providing-best-care

National Institute for Health and Care Excellence. Hypertension in pregnancy: diagnosis and management NICE guideline NG133 (2019)
https://www.nice.org.uk/guidance/ng133

Confidential Enquiry into Maternal and Child Health. Saving Mothers' Lives 2003-2005 (2007)
https://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005

Tracy, K. et al. Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, A randomised controlled trial. (2013) Lancet. Vol 382, Issue 9906 p1,723-32

Royal College of Obstetricians and Gynaecologists. Roles and Responsibilities of a Consultant – Workforce Report (2021)
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

Royal College of Obstetricians and Gynaecologists. Improving patient handover: Good practice no. 12 (2010)
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-12/

NHS Improvement. Implementing huddles and handovers 0- a framework for practice in maternity units (2019)
https://www.pslhub.org/learn/patient-safety-in-health-and-care/transitions-of-care/handover/nhs-improvement-implementing-huddles-and-handovers-%E2%80%94-a-framework-for-practice-in-maternity-units-25-march-2019-r136/

Propess package leaflet
https://www.medicines.org.uk/emc/files/pil.135.pdf

National Institute for Health and Care Excellence. DINOPROSTONE
https://bnf.nice.org.uk/drug/dinoprostone.html

Royal College of Obstetricians and Gynaecologists. Each Baby Counts: 2019 progress report (2020) https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2019-progress-report/

Royal College of Obstetricians and Gynaecologists. Reduced fetal movements: Green top guideline 57 (2011)
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

NHS England. Seven day services clinical standards (2017)
https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

National Institute for Health and Care Excellence. Inducing labour Nice Guideline 207 (2021)
https://www.nice.org.uk/guidance/ng207

Chapter 8. Intrapartum care

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. Safer Childbirth Minimum Standards for the organization and delivery of care in labour (2007)
https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf

National Institute for Health and Care Excellence Safe midwifery staffing for maternity settings (2015) https://www.nice.org.uk/guidance/ng4

Ockenden, D. Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. (2020):
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Royal College of Obstetricians and Gynaecologists Safe Staffing (2021)
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing/

Royal College of Midwives. RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings (2016)
https://www.rcm.org.uk/media/2369/rcm-guidance-on-implementing-the-nice-safe-staffing-guideline-on-midwifery-staffing-in-maternity-settings.pdf

Nursing Midwifery Council. The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. (2015, updated 2018)
https://www.nmc.org.uk/standards/code/

Civility Saves Lives. Civility Saves Lives (2017)
https://www.civilitysaveslives.com

Royal College of Obstetricians and Gynaecologists Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales. (2021)
https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/safe-staffing/rcog-guidance-on-the-engagement-of-long-term-locums-in-maternity-care.pdf

National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies (2017)
https://www.nice.org.uk/guidance/cg190

https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/december-2016/montgomery.pdf

Care Quality Commission Inspection (2021)
https://www.cqc.org.uk/provider/RXW?referer=widget3

Rowe, R, Draper, ES, Kenyon, S, Bevan, C, Dickens, J, Forrester, M, Scanlan, R, Tuffnell, D, Kurinczuk, JJ. Intrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry. (2020) BJOG 127

Glenister C, Burns E, Rowe R. Local guidelines for admission to UK midwifery units compared with national guidance: A national survey using the UK Midwifery Study System (UKMidSS). (2020) PLoS One. Oct 20;15(10):e0239311. doi: 10.1371/journal.pone.0239311. PMID: 33079940; PMCID: PMC7575094.

Rowe RE. Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality. (2010) Quality and Safety in Health Care19 (2):90-4.

NHS England. The NHS Long Term Plan (2019)
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Ockenden, D. Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. (2020):
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Chapter 9. Postnatal care

Royal College of Obstetricians and Gynaecologists. Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021)
https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

Keogh B, Seven Days a Week, NHS England (2015)
https://www.england.nhs.uk/seven-day-hospital-services/the-clinical-case/

Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019).
https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

MBRACE-UK Perinatal Mortality Surveillance Report: UK Perinatal Deaths for Births from January to December 2015 (2017)
https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

Sands. Sands post-mortem consent package
https://www.sands.org.uk/professionals/sands-post-mortem-consent-package

Chapter 10. Maternal deaths

Department of Health, Records Management: NHS Code of Practice: Parts 1 and 2: 2006, revised 2009 and 2016, include reference to HSC 1998/217: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients (Replacement for FHSL (94) (30))

MBRRACE-UK, Saving Lives, Improving Mother's Care (2020)

Chapter 11. Obstetric anaesthesia

The RCOG/RCM Report Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust July 2017

OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, June 2013, London

Royal College of Anaesthetists Guidelines for Provision of Anaesthesia Services for an Obstetric Population 2020.
(https://rcoa.ac.uk/gpas/chapter-9)

RCoA Raising the Standards: RCoA Quality Improvement Compendium. Chapter 7 Obstetric Practice. 4th Edition September 2020

Chapter 12. Neonatal care

Department of Health. Toolkit for High-Quality Neonatal Services (2009)
https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

National Institute for Health and Care Excellence. Neonatal specialist care Quality Standard (QS4) (2010)

Letter to Donna Ockenden from West Midlands Neonatal ODN dated 3rd September 2021

Report provided to the review team by the Trust

MBRRACE. Perinatal mortality surveillance reports 2013-2016.
https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance

MBRRACE. Perinatal mortality surveillance report 2017.
https://www.npeu.ox.ac.uk/mbrrace-uk/reports

TOBY study group. Whole body hypothermia for the treatment of perinatal asphyxial encephalopathy: A randomised controlled trial (2008)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409316/

Chapter 13. What happened in maternity services after our first report

NHS England and NHS Improvement Board Meeting November 2021. Agenda Item 6: Maternity and Neonatal Services Update
https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-6-251121-maternity-and-neonatal-update.pdf

Gov.uk press release. Government pledges £2.45million to improve childbirth care (2021)
https://www.gov.uk/government/news/government-pledges-245-million-to-improve-childbirth-care

NHS England. Guidance on finance and contracting arrangements for H1 2021/22 (2021)
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-h1-21-22-guidance-on-finance-and-contracts-arrangements.pdf

NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021)
https://committees.parliament.uk/publications/6290/documents/69337/default/

NHS England/ I Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22 (2021)
https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

Hearing the voices of staff

Provided to the review team by the Trust

Appendix 5: Terms of reference (TOR)

Original terms of reference as of May 2018

An independent review of the quality of investigations and implementation of their recommendations relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospitals (the Trust).

The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry (subject to receiving consent from the families).

Background

This review follows a number of serious clinical incidents, beginning with a new born baby who sadly died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 a number of further investigations and reviews (internal and external) were also undertaken to confirm whether:

- Appropriate investigations were conducted and
- The assurance processes relating to investigations in the maternity service were adequate.

In response to these previous reviews a comprehensive maternity service improvement action plan was put in place by the Trust. The progress of the implementation of the recommendations from these previous reviews has been monitored on a continual basis by the Trust Board. The action plan was devised with input from the parents of the baby who died in 2009. The parents have received ongoing communication in regard to the progress and implementation of actions identified within the plan.

Scope and purpose of this latest independent review

The independent review will be undertaken by a multidisciplinary **REVIEW TEAM** of independent external reviewers who will submit their findings to an **INDEPENDENT REVIEW PANEL**.

The **REVIEW TEAM** will comprise:

- Two midwives
- Two obstetricians
- Two neonatologists

The multidisciplinary **REVIEW TEAM** will undertake to:

- Review only those cases for which consent is granted to access the records pertaining to the case;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
- Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
- Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
- Consider how the parents, patients and families of patients were engaged with during these investigations;
- Reserve the right to undertake a second-stage review of primary cases should the considerations

above justify such action following agreement with the Executive Medical Director NHS Improvement and

- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

The **INDEPENDENT REVIEW PANEL** will undertake to:

Receive and quality assure the **REVIEW TEAM's** findings in each case reviewed;

- Under the leadership of the chair, develop the report of the findings of the review and
- Actively engage and communicate with families relevant to the specified cases, where they have expressed a preference for such engagement, in particular around the review's findings and recommendations.

In addition the **INDEPENDENT REVIEW TEAM** will assess the extent to which the Trust had appropriate arrangements in place for the oversight and governance of the incidents and the reporting mechanisms to the Trust Board.

The review process will comprise:

- A review of all the investigations in the cohort including but not limited to root cause analysis (RCAs), preliminary fact finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Trust policy and National Guidance;
- A review of the relevant / associated improvement plan and pace of improvement against the timelines identified in the plan and
- Contact with parents or relatives to establish their understanding of their involvement in previous investigations.

The **REVIEW TEAM** and **REVIEW PANEL** will be provided with direction in relation to the conduct of the review to ensure that there is consistency in the approach to reviewing each case. The **REVIEW TEAM** and **REVIEW PANEL** will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process.

If the **REVIEW TEAM** or **REVIEW PANEL** identifies any material concerns that need further immediate investigation or review, the NHS Improvement Executive Medical Director must be notified immediately.

The **REVIEW PANEL** will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement.

The Review Panel

The **REVIEW PANEL** will be chaired by an independent chair, appointed by NHS Improvement and supported by a panel of experienced clinicians and stakeholders with expertise in maternity services or governance and assurance processes.

The **REVIEW PANEL** will comprise:

- An NHS Improvement-appointed independent chair
- An NHS Improvement-appointed Director of Midwifery from outside the region
- A Senior Quality Manger from NHS Improvement
- An external independent midwife
- An external consultant obstetrician
- An external consultant paediatrician/ neonatologist
- NHS England midwifery representative from outside the region.

Key Principles

The review will be expected to:

- Engage widely, openly and transparently with all relevant parties participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and children;
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management and
- Consider the implementation challenges of proposals including the workforce.

Timeframe

The final review report and proposals should ideally be available within one month of the review being completed.

Directions to the REVIEW TEAM and REVIEW PANEL in relation to the conduct of the review:

1. Did the Trust have in place at the time of each incident mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
2. Were incidents and investigations reported and conducted in line with the time relevant national and Trust policies?
3. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
4. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 6: Revised terms of Reference (TOR)

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.
2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.
3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

   a. appropriate investigations were conducted; and

   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.
6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.
7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.
8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:

a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;

b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;

c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;

d. Consider how the parents, patients and families of patients were engaged with during these investigations;

e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and

f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:

a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 7: Review team members

Ms Donna Ockenden – Director, Donna Ockenden Limited, Chair of the review.

Donna Ockenden was assisted and supported by the following team members (In alphabetical order from their first name):

Obstetricians

Mr Alexander Taylor – from June 2020

Dr Anthony Falconer – from November 2018 until September 2020

Dr Antoinette Johnson – from March 2021

Dr Austin Ugwumadu – from July 2020

Dr Bode Williams – from April 2021

Dr Bronwyn Middleton – from November 2020

Dr Clare Tower – from March 2021

Professor Dharmintra Pasupathy – from October 2019

Dr Elisabeth Peregrine – from February 2021

Dr Heather Brown – from November 2018 until June 2020

Dr Joanne Page – from November 2020

Dr Jonathan Frappell – from December 2019 until March 2021

Dr Louise M Page – from November 2018 until October 2020

Dr Karin Leslie – from August 2020 until March 2021

Dr Marwan Salloum – from August 2020

Dr Matthew Cauldwell – from January 2021

Dr Michael Magro – from March 2021

Dr Nikki Jackson – from October 2020

Dr Paula Galea – from September 2020

Dr Penny Law – from November 2018 until June 2021

Dr Rachel Marshall-Roberts – from September 2020 until November 2021

Mr Richard Howard – from November 2018

Dr Sandra Newbold – from January 2020

Dr Umber Agarwal – from April 2021

Midwives

Amanda Mansfield – from November 2018 until June 2020 and from March 2021

Amanda Davey – from May 2017

Angela Frankland – from May 2021

Angie West – from May 2017

Bronwen Grigg – from January 2021

Caroline Clarke – from May 2017

Carolyn Romer – from November 2018 until August 2021

Ceri Staples – from September 2020

Charlotte James – from July 2019 until January 2022

Helen Harling – from December 2020 until May 2021

Helen Smith – from March 2020

Jacqueline Oliver – from May 2019

Jane Patten – from May 2017

Jessica Scoble – from September 2019 until September 2020

John Bell – from July 2019

Julie Jones – from November 2018

Dr Kate Nash – from April 2020

Kerry Madgwick – from January 2021

Kerry Thompson – from June 2020

Konstantina Stavrakelli – from September 2020

Lauren Graham – from September 2020

Merida Sculthorpe – from November 2020

Natalie Adams – from September 2020

Nicola Rose-Stone – from November 2019 until November 2020

Teresa Manders – from October 2019

Tina Spiers – from October 2020

Neonatologists

Dr Alison Jobling – from April 2020 until October 2021

Dr Chris Day – from March 2021

Dr Charlotte Groves – from November 2018 until June 2020

Dr Eilean Crosbie – from March 2021

Dr Huw Jones – from November 2018 until March 2021

Dr Lawrence Miall – from March 2021

Dr Michelle Parr – from March 2021

Dr Michael Hall – from March 2019

Professor Minesh Khashu – from June 2021

Dr Ngozi Edi-Osagie – from March 2021

Dr Paul Crawshaw – from February 2019

Dr Ranganna Ranganath – from April 2021 until October 2021

Dr Ryan Watkins – from December 2018 until March 2021

Dr Sarah Davidson – from July 2021

Dr Sunita Seal – from April 2021

Dr Tosin Otunla – from February 2020

Dr Vimal Vasu – from February 2019 until September 2020

Paediatricians

Dr David Gibson – from August 2021

Professor Ian Maconochie – from November 2018 until June 2021

Dr Julian Sandell – from March 2019 until April 2021

Obstetric Physician

Dr Anita Banerjee – from November 2018

Anaesthetist

Dr Andrew Combeer – from February 2021

Dr Elizabeth Combeer – from February 2021

Dr Renate Wendler – from November 2018

Neurologist

Dr Sean J Slaght – from December 2019

Cardiologist

Dr Richard Jones – from May 2020

Intensivist

Dr Phil Young – from July 2020 until March 2021

Dr Frank Schroeder – from May 2021 until December 2021

Family Support and Psychology Provision for Families

Maternity Review Psychology Service, hosted by Midlands Partnership NHS Foundation Trust

Dr Katie Bohane – Lead for Psychology Service from January 2021

Dr Katie Woodward – Clinical Psychologist from April 2021

Eloise Lea – Clinical Psychologist from April 2021

Emma Campbell – Assistant Psychologist from October 2021

Dr Kirsty Langley – Clinical Psychologist from July 2021

Dr Rachel Lucas – Trust Recovery Lead and Director of Psychological Services from June 2020

Dr Ursula Bacon – Clinical Psychologist from September 2021

Dr Victoria Caines – Clinical Psychologist from November 2021

SANDS – Stillbirth and neonatal death charity

Dr Clea Harmer – Chief Executive of Sands from January 2021

Jen Coates – Director of Bereavement Support and Volunteering from June 2020

Maria Huant – Bereavement Support Services Manager from June 2020

Bereavement Training International

Paula Abramson - Bereavement Training International and lead for the Listening Ear Service from June 2020

CBUK – Child Bereavement UK

Ann Chalmers – CEO, Child Bereavement UK from June 2020

Karen Smith – PA to the Chief Executive & Executive Manager from June 2020

Sarah Harris – Director of Bereavement Support and Education from November 2021

Administrative support provided by:

Aimee Humphrey - Administration for the Maternity Review from May 2021

Barbara Watkinson – Administration for the Maternity Review from April 2019 until July 2020

Charlotte Lidster – Administration for the Maternity Review from January 2020 until December 2020

Michelle Wright – First Rate PA, Administration for the Maternity Review from April 2018

Monika Niziol – Administration Assistant to Donna Ockenden the Chair of the Maternity Review from July 2020

Rebecca Jones – Administration Assistant for the Maternity Review from October 2020 until December 2021

Sara Kempton-Hayes – Administration for the Maternity Review from February 2019 until July 2020

Zoe Bolt – Administration for the Maternity Review until September 2018

HR and Employment Law specialist:

Dianne Lambdin, Director Sussex HR Hub Ltd

Communications and media support provided by:

Kristianah Fasunloye – Astraea PR

Shaline Manhertz – Exceeding your potential

Kim Inam – Editing and proofreading

Kirsa Wilkenschildt - Graphic design

Pam Rene – Events support and logistics

Ben Cloud – Millstream Productions, film and video production

Louis Dady – Millstream Productions, film and video production

Legal advice was provided by Gowling WLG:

Nicholas Cunningham

Patrick Arben

Sarah Grey

Claire Van Ristell

Finance support

Jane Blaber – Liberty Bookkeeping

Carol Warmington – Specialist Payroll Services

Hilary Julian – Maximus Accountancy Services Limited

IT support

VENOM IT – IT services provider

Samuel Thompson – Samuel Thompson Corporate Ltd – Website design

E02725921
ISBN 978-1-5286-3229-4

Reading the signals

Maternity and neonatal services in East Kent – the Report of the Independent Investigation

October 2022

Dr Bill Kirkup CBE

HC 681

Return to an Address of the Honourable the House of Commons
dated 19 October 2022 for

Reading the signals

Maternity and neonatal services in East Kent – the Report of the Independent Investigation

Ordered by the House of Commons to be printed on 19 October 2022

Dr Bill Kirkup CBE

HC 681

This publication is available at www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us at england.iiekmsteam@nhs.net

ISBN: 978-1-5286-3675-9
E02788893 10/22

Printed on paper containing 40% recycled fibre content minimum.

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office.

Contents

List of figures and tables

Open letter to the Secretary of State for Health and Social Care and Deputy Prime Minister and to the Chief Executive of the NHS

The death of a baby is a devastating loss for any family. As one bereaved mother put it, *"When your baby dies, it's like someone has shut the curtains on life, and everything moves from colour to darkness."* How much more difficult must it be if the death need not have happened? If similar deaths had occurred previously but had been ignored? If the circumstances of your baby's death were not examined openly and honestly, leaving the inevitability of future recurrence hanging in the air?

The Panel investigating East Kent maternity services heard the harrowing accounts of far too many families to whom all of this had happened, and more. If it was hard for us to listen to, we could not imagine how much harder it was for those families to relive, although the effects on those who were giving us their accounts were often all too clear. The primary reason for this Report is to set out the truth of what happened, for their sake, and so that maternity services in East Kent can begin to meet the standards expected nationally, for the sake of those to come.

But this alone is not enough. It is too late to pretend that this is just another one-off, isolated failure, a freak event that *"will never happen again"*. Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

For that reason, this Report is somewhat different to the usual when it comes to recommendations. I have not sought to identify detailed changes of policy directed at specific areas of either practice or management. I do not think that making policy on the basis of extreme examples is necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. More significantly, this approach has been tried by almost every investigation in the five decades since the Inquiry into Ely Hospital, Cardiff, in 1967–69, and it does not work. At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places.

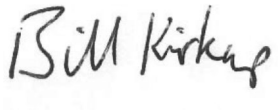
This Report identifies four areas for action. The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose, and at responding to challenge with honesty. None of these are easy or necessarily straightforward, because longstanding issues become deeply embedded and difficult to change. Nor do I pretend to have the answers to how best they should be tackled: they require a broader-based approach by a wide range of experienced experts. But unless these difficult

areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later. This Report must be a catalyst for tackling these embedded, deep-rooted problems.

Above all, we must become serious about measuring outcomes in maternity services. There are obvious difficulties, given that pregnancy and childbirth are physiological in most cases and poor outcomes less common, but this must not become an excuse. Meaningful, risk-sensitive outcome measures can be found, as they have been in other specialties. They can be used, not to generate meaningless league tables, but to identify results that are genuine outliers. Only in this way can we hope to detect the next unit that begins to veer off the rails before widespread harm has been caused, and before it has had to be identified by families who have suffered unnecessarily. There is work under way in the NHS but it needs further support and direction and the approach must be mandatory, not optional. I am ready to discuss and explain further how this can best be done.

But if we are to break the cycle of endlessly repeating supposedly one-off catastrophic failures, all four areas must be addressed. There are very difficult and uncomfortable issues here, but we cannot in all conscience pretend that "it will not happen again" unless we are serious about tackling them.

My thanks are due to everyone who assisted with this Investigation, including NHS and Trust staff, and it would not have been possible without an incomparable Panel, Advisers and Secretariat. Most of all, however, thanks are due to the families, some of whom made the Investigation happen in the first place and all of whom helped us understand the reality, often at great personal cost to themselves. We owe it to them to listen and learn, not only for East Kent but for NHS services elsewhere.



Dr Bill Kirkup CBE

October 2022

Chapter 1: Missed opportunities at East Kent – our Investigation findings

Introduction

1.1 The Panel has examined the maternity services in two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020, in accordance with our Terms of Reference. Responsibility for these services lay with East Kent Hospitals University NHS Foundation Trust (the Trust).

1.2 We have found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

1.3 The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively. We identify here eight clear separate opportunities when that could and should have happened.

1.4 It is therefore only right that in our Report we indicate where, in our judgement, accountability lies for missing the opportunities to bring about real improvement in the clinical outcomes and in the wider experience of families in East Kent.

1.5 The consequences of not grasping these opportunities are stark. Our assessment of the clinical outcomes, set out in Chapter 2, shows that:

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.
- The Panel has not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

1.6 We have no doubt that these numbers are minimum estimates of the frequency of harm over the period. We made no attempt to review other records or to contact families who did not volunteer themselves. It was our judgement that we had enough evidence based on the existing 202 cases to identify the problems and their causes, and we did not wish to delay publication of our findings.

1.7 Nor was the harm restricted to physical damage. Chapter 3 sets out the equally disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

1.8 This chapter sets out what we have found in East Kent maternity services, and how the Trust failed to read the signals and missed the opportunities to put things right. We know that this will make for painful reading for families affected but also for the Trust, for regulators and for the wider NHS. But unless this is stated and acknowledged, history in East Kent and nationally suggests that there is a real danger that our Investigation will become yet another missed opportunity, not only in East Kent but elsewhere.

1.9 As well as setting out what happened, we identify here the underlying failures that led to the harm we found, as well as some key themes that must be addressed in the response to the failures in East Kent. This chapter also explains the missed signals and where accountability lies. The evidence behind our findings is laid out in Chapters 2 to 5; in Chapter 6, we draw out the lessons with recommendations both for East Kent and for national application.

Our findings

1.10 There is a crucial truth about maternity and neonatal services which distinguishes them from other services provided at hospitals. It is in the nature of childbirth that most mothers are healthy, and, thankfully, their babies will be too. But so much hangs on what happens in the minority of cases where things start to go wrong, because problems can very rapidly escalate to a devastatingly bad outcome.

1.11 We listened carefully to the families who have participated in our Investigation, and we listened equally carefully to staff at the Trust and in other relevant organisations. As a result, we identified problems at every level within the services:

- What happened to women and babies under the care of the maternity units within the two hospitals
- The Trust's response, including at Trust Board level, and whether the Trust sought to learn lessons
- The Trust's engagement with regulators, including the Care Quality Commission (CQC), and the actions and responses of the regulators, commissioners and the NHS, regionally and nationally.

Running through each one of these layers has been a failure to recognise and acknowledge the scale and nature of the problem.

1.12 We have found that the Trust wrongly took comfort from the fact that the great majority of births in East Kent ended with no damage to either mother or baby.

1.13 This failure reflects badly, not only on practice within East Kent maternity services, but on how statistics are used to manage maternity services across the country as a whole. We believe that it should be possible for individual trusts to monitor and assess whether they have a problem; that it should be possible for the NHS regionally and nationally to identify trusts whose safety performance makes them outliers; and that it should be possible for the regulators to differentiate the services provided more quickly and reliably. We set this out in our first key area for action, to be addressed below and in Chapter 6.

1.14 More immediately, the Trust should acknowledge the full extent and nature of the problems which have endured over the period. It has not yet done this in full. We have found that its failure to do so explains why the action that has been taken has not been sustained and has not had the impact needed.

What happened to women and babies

1.15 Chapter 2 gives details of our assessment as to whether the cases within our Investigation involved suboptimal care. We used the approach of the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), now commonly referred to as CESDI scores.

1.16 In these cases, we have not found that a single clinical shortcoming explains the outcomes. Nor should the pattern of repeated poor outcomes be attributed to individual clinical error, although clearly a failure to learn in the aftermath of obvious safety incidents has contributed to this repetition.

1.17 Although there are shortcomings in the physical infrastructure at both hospitals, and there have been periods of staffing and resource shortages, we have not found that these played a causative role in what happened. While these factors require attention, and are rightly the subject of national consideration, they do not justify, explain or excuse the experience of the families using East Kent maternity services as revealed by our Investigation.

1.18 Similarly, the geography of East Kent, its coastal location, the demographics of its population and the distance between the two hospitals are factors, but they should not have been regarded as explaining or justifying the service provided. We have found evidence of these factors fuelling what is sometimes referred to as a "victim mentality". Those who should have provided leadership have been tempted to regard themselves as victims of geography, recruitment difficulties and a neglected estate.

1.19 Rather, we have found that the origins of the harm we have identified and set out in this Report lie in failures of teamworking, professionalism, compassion and listening.

Failures of teamworking

1.20 Teamworking is crucial to modern healthcare. Poor teamworking may result from a lack of respect for other staff and a lack of mutual trust, with insufficient credence given to the views of others. Failure to work effectively together leads directly to poor care and jeopardises patient safety. In maternity services, it leads to staff failing to escalate clinical concerns promptly or appropriately. As a result, necessary assessments and interventions are either done by the wrong people with the wrong skillsets or are not done at all. In both cases, the risks to safety are obvious.

1.21 We found gross failures of teamworking across the Trust's maternity services. There has been a series of problems between the midwives, obstetricians, paediatricians and other professionals involved in maternity and neonatal services in East Kent. Some staff have acted as if they were responsible for separate fiefdoms, cultivating a culture of tribalism. There have also been problems within obstetrics and within midwifery, with factionalism, lack of mutual trust, and disregard for other points of view.

1.22 We found clear instances where poor teamwork hindered the ability to recognise developing problems, and escalation and intervention were delayed. The dysfunctional working we have found between and within professional groups has been fundamental to the suboptimal care provided in both hospitals.

1.23 Poor teamworking was raised as a prominent feature by many of those we interviewed. Some obstetricians had *"challenging personalities … big egos … huge egos"*. Midwives showed *"cliquey behaviour"* and there was an in-group, *"the A-team"*. This behaviour was displayed *"in front of women"*. One clinician told us that *"many times we could have done better … the culture in obstetrics and the relationship with midwifery were poor"*. An external assessor with wide experience of the NHS said that the Trust had *"the worst culture I've ever seen"*. Another, from a different organisation, had *"not encountered such behaviour anywhere else"*.

1.24 We have found divisions among the midwives which at times included bullying to such an extent that the maternity services were not safe. We also found that some obstetric consultants expected junior staff and locum doctors to manage clinical problems themselves, discouraged escalation, and on occasion refused to attend out of hours. This, too, put patient safety at significant risk. We have found that midwives and obstetricians did not always share common goals, and that this damaged the safety of patient care. One mother, who asked a paediatrician why her baby had died, was told that *"if you want to look for blame, you should be looking at the obstetricians not me".*

Failures of professionalism

1.25 Professionalism means putting the needs of mothers and babies first, not the needs of staff. It means not being disrespectful and not disparaging other staff in front of women, who lose confidence in services as a result and may make poorly informed decisions about their care. It means not blaming women when something has gone wrong, and it means making decisions on who is best placed to care for an individual based on their clinical need, not on who belongs to which staff clique.

1.26 We found clear and repeated failures to uphold these principles. Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families. A family member heard a consultant describe the unit they were in as *"unsafe"* to a colleague in the corridor, which was hardly the way to raise any legitimate concerns they may have had.

1.27 Others sought to deflect responsibility when something had gone wrong. A staff member visited a mother the day after a significant problem with her baby had been missed at birth. The mother remembers that the staff member did not ask how her baby was, but said: *"[Y]ou do remember I was handing over, don't you?"* Another woman, whose baby had died, was told: *"It's God's will; God only takes the babies that he wants to take."*

1.28 In other cases, women themselves were blamed for their own misfortune. A woman admitted to hospital to stabilise her type 1 diabetes pointed out to antenatal ward staff that they were not adjusting her insulin correctly. She was told that *"we're midwives not nurses and we don't deal with diabetes … it's not our issue and you don't fit in our box"*.

1.29 We heard that midwives who were not part of the favoured in-group at WHH were sometimes assigned to the highest-risk mothers and challenged to achieve delivery with no intervention. This was a downright dangerous practice.

Failures of compassion

1.30 Technical competence alone is not sufficient for good care, if it is delivered without compassion and kindness. Uncompassionate care can be devastating for the wellbeing and mental health of the recipients. It can cost women the care that they need and it can affect their peace of mind, sometimes in extremely fraught situations that involve the loss, or potential loss, of their baby's or their own life or health.

1.31 We heard many examples of uncompassionate care that shocked us. A woman who asked for additional information on her condition during an antenatal check was dismissively told to look on Google. A mother who was anxious about her baby's clavicle, fractured during a difficult delivery, was told that *"collar bones break all the time because they are built to do that to get them out easier"*. Another, who asked why an additional attempt at forceps delivery was to be made, was brusquely told that it was *"in case of death"*. Women who pointed out that their spinal or epidural analgesia was not effective and they were in pain were ignored or disbelieved; one told us that *"they didn't listen … they carried on, obviously, to cut me open. I could feel it all."*

1.32 The effects of many further examples of lack of compassion are considered in detail in Chapter 3.

Failures to listen

1.33 Good care must involve listening and responding appropriately. Women know what they are experiencing at that moment in a way that a clinical attendant cannot. Failing to listen – or, worse, telling someone that they must be wrong – is disrespectful and dangerous. A wise physician, William Osler, encouraged clinicians over 100 years ago to *"listen to the patient,* [they are] *telling you the diagnosis"*. Ignoring or discounting what a patient says means discarding clinical information that may make the difference between a good outcome and a disaster.

1.34 We have found that there have been repeated failures to listen to the families involved, as exemplified in Illustrative Case A.

Illustrative Case A

A's second pregnancy progressed normally to term, when she reported a loss of clear fluid and suspected that her waters had broken spontaneously. No fluid could be seen on examination, and she was sent home with a view to inducing labour a week later. After four days, however, she telephoned the hospital to say that she was experiencing contractions and her baby's movements had reduced markedly over the previous day. As her contractions were deemed not yet frequent enough to indicate established labour, she was asked to wait at home despite her concern over her baby's movements. When she attended the following day with more frequent contractions, her baby's heartbeat could not be found, and she gave birth to a stillborn baby.

1.35 In some cases, we have found that this failure to listen contributed to the clinical outcome. In others, it was part of a pattern of dismissing what was being said, which contributed significantly to the poor experience of the families within our Investigation, as Chapter 3 sets out. Aspects of the families' experiences have been extremely damaging and have had a significant effect on the outcome for them.

Failures after safety incidents

1.36 We found that the same patterns of dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents, including those incidents that led to death or serious damage. Although some staff were caring and sympathetic, and this was recognised and welcomed by families, others were not. Sadly, but naturally, the poor responses are the ones that remain in families' memories. In a number of cases, the dysfunctional relationships between

the staff involved were all too visible to the families themselves. This was such a common feature that we have concluded that it was part of the culture at QEQM and WHH.

1.37 Time after time, we heard that staff not only failed to show compassion, they also denied responsibility for what had happened, or even that anything untoward had occurred. Similarly, we have found instances where the mother was blamed for what had happened.

1.38 Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families about what had happened. Safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning. The instinct was to minimise what had happened and to provide false reassurance, rather than to acknowledge errors openly and to learn from them. Where the nature of the safety incident made this impossible, a junior obstetrician or midwife was often found who could be blamed.

1.39 The following example (Illustrative Case B) illustrates a number of features we have found repeated many times, and the harm to wellbeing that can result from a failure to listen and to respond compassionately. It also shows that multiple failures may coexist in the same case.

Illustrative Case B

"We feel lucky that we have our daughter and grandson; other people weren't as lucky as us. But we are where we are by a whole string of luck rather than by good planning and good care." (B's mother)

B was pregnant for the first time and chose care in her local Midwifery-Led Unit (MLU). She had a good relationship with the midwife she saw. The midwife told B how lucky she was to be fit and healthy, and B trusted her advice, although she had scans which showed excessive growth of her baby that was not investigated or followed up. At 39 weeks pregnant, B developed two significant complications of pregnancy: pre-eclampsia and obstetric cholestasis (a liver condition). A doctor recommended induction of labour and noted the risk of a postpartum haemorrhage and the need for tests of her disordered liver function and blood clotting. The blood-clotting results were lost until after her baby was born.

Despite the risk factors, B was monitored only intermittently in labour, and she received varying advice from different professionals about the likelihood of requiring a caesarean section, which unsettled her. Progress was slow, and the next day her cervix stopped dilating at 7cm. B's baby was born by caesarean section, apparently uneventfully, although the need for extra stitching to control blood loss from the uterine incision was recorded.

Afterwards, B and her family were placed in a recovery room, where they remained alone for over two hours, undisturbed by staff who should have carried out postoperative checks. After this time, B's family were alarmed by blood emerging from under the blanket and realised to their great distress that she was bleeding very heavily. They raised the alarm, and staff implemented the hospital's protocol for massive postpartum haemorrhage.

B was taken to theatre while her mother and other family members were left with the new baby, waiting anxiously and tearfully for news in a four-bedded bay, separated from other mothers and babies only by curtains. After some time, their request to be moved to a side room was granted. In theatre, B was thought to be bleeding because of an atonic uterus – this is when the uterus has not contracted effectively after the birth –

and a device called a Bakri balloon was placed in the uterus and inflated to reduce the bleeding by compression. B was then transferred to the intensive care unit.

Meanwhile, the family remained with the baby, who now needed feeding. B's mother asked for assistance: *"I asked for milk, and this was the thing that was really quite upsetting at the time, the baby needing feeding, and I was told that 'we encourage breastfeeding here and if you want milk you have to go to ASDA, it's up the road'."* After she insisted, some milk was brought, but the irritation of staff was obvious, she said, and no advice was given on feeding under the circumstances. Some staff were subsequently helpful, but others made the family feel that they were being a nuisance.

During the night, family members saw the consultant obstetrician again, who explained that B was still bleeding and would need to return once again to theatre. The family recall the consultant saying, *"'you're really lucky because I've phoned a friend' and this rings a bell, because I thought, oh no, we're going 50/50 next and then we're going to ask the audience. I couldn't believe* [they were] *saying it."*

The "friend" was a consultant gynaecological oncologist who carried out an exploratory operation. They found that there was an extensive collection of blood in the broad ligament (alongside the uterus). The bleeding was from a tear in the cervix extending into the upper vagina, which must have occurred at the time of either the caesarean section or the insertion of the Bakri balloon. The consultant tied off blood vessels in the pelvis, including the internal iliac artery, a major artery, and evacuated the blood. This stopped the bleeding, but B required extensive blood transfusion.

B's subsequent recovery was steady, but her mother remembers being severely reprimanded by midwives for taking the baby to the intensive care unit to bond with B, and the lack of contact and monitoring when B returned to the ward after several days. B felt that she would be just as well off at home, but was told that she shouldn't leave, because she was *"like a broken car that we've fixed up and if you leave you might just break down again*". B realises that it was the doctor's way of trying to explain things, but she found it very insensitive and has not been able to forget what they said. *"In that moment, when I wasn't really being looked after, was I just going to break down, was I just going to die?"*

After they sent a letter of complaint, B and her mother were told that the unit was safe, with mortality rates below the national average, and that B's care would be reviewed because there was a good governance system for reviewing cases. B's family asked for the review to be shared with them but were told: *"It doesn't happen like that; the team sit round and read through the notes to check that the haemorrhage was managed correctly."* They also asked if the review would consider whether the haemorrhage could have been avoided and were told that it would not. Later, they found out that the case had not been recorded as a serious incident because the haemorrhage had been managed correctly and it was not an unexpected admission to intensive care. *"Nothing seemed to ring true"* to B and her mother.

B and her family found the lack of care and compassion to be the most distressing feature. *"The whole thing was 'you're lucky, you've got a baby, you're alive, you didn't die, your baby didn't die; you need to brush yourself down, get on with it and go on and have another baby'; it was really insensitive to the problems."*

B was advised to go and see the midwife to talk through her birthing story. She understood that this would be a therapeutic exercise that would help her understand what had happened. However, the midwife read her notes and said: *"I don't know why you're here, you're really lucky, you're alive, your baby's alive."* There was no recognition

of B's obvious guilt over feeling upset about what had happened when her baby had survived. She received only reinforcement that she should feel lucky to be alive. The impact on her mental wellbeing was not considered.

B had another appointment with her consultant. They told her that they fully expected to see her in a few months, because *"you've still got everything, you can still have a baby, we'll look after you".* But the experience has left B terrified about becoming pregnant again. It appears that at no point was any explanation given that her continued bleeding had been due to surgical injury to her cervix and vagina.

"It just seemed that people would think that everything would be fine because I was alive and I would just move on and I shouldn't be sad or upset or mentally scarred from it, from a traumatic experience, and for me I was robbed from having my second baby. I've always wanted a second baby and I will never do that, ever, and no one appreciates that side to it."

This case illustrates clear problems of teamworking, professionalism, lack of compassion and failure to listen. B was made to feel ignored, marginalised and disparaged after the event. Also striking are the lack of frankness about what had happened and the failure to report and investigate a serious incident.

Failure in the Trust's response, including at Trust Board level

1.40 In specific instances where things have gone wrong, the Trust has found it easier to attribute the causes to individual clinical error, usually on the part of more junior staff, or to difficulties with locum medical staff. But we have found that these are symptoms of the problems, not the root causes. This has been combined with the disposition to minimise problems, so it is unsurprising that the Trust has given the appearance of covering up the scale and systematic nature of those problems.

1.41 The problems among the midwifery staff and the obstetric staff were known but not successfully addressed. The failure to confront these issues further damaged efforts to improve maternity services and exposed critical weaknesses in the Human Resources (HR) function. When bullying and divisive behaviours among midwives were challenged, the staff involved began a grievance procedure, following which, it appears to us, the Head of Midwifery was obliged to leave and not speak out. The bullying and divisive behaviours were not addressed.

1.42 One critical weakness was the lack of control that could be exercised in relation to consultants. We have found that experience in East Kent demonstrates the problems that occur when some consultants stubbornly refuse to change unacceptable behaviour. In these circumstances, the mechanisms that trusts are able to deploy to address such behaviour, either through professional regulation or HR processes, may prove frustratingly ineffective.

1.43 It seems to us that the Trust was disposed to replace staff in key managerial roles who identified and challenged poor behaviour. The staff who remained were those who either personified the poor culture or were prepared to live with it rather than question it.

1.44 We have found that the Trust Board itself missed several opportunities to properly identify the scale and nature of the problems and to put them right. These opportunities are described later in this chapter.

1.45 The Trust Board was faced with other challenges. Some of these concerned other hospital services, particularly the Accident and Emergency department, and the failure to meet targets. But those other challenges, though considerable, do not constitute a good enough reason for failing to put right the way in which maternity and neonatal services were operating.

1.46 The Trust Board did endorse a succession of action plans. It was said to us that *"if there is one thing East Kent can do it's write an action plan"*. But these plans and the way in which the Trust Board engaged with them masked the true scale and nature of the problems. Instead, the plans supported an imagined world where there were fewer problems, and where the plans associated with newly appointed staff were deemed to be sufficient despite the previous recurring pattern of failure. Individuals were lauded only to fall out of favour, sometimes quite quickly.

1.47 The repeated turnover of staff at many levels, including Chief Executive, served to encourage this cycle; each time it was believed that this time things really would get better. Looking at cases to the end of 2020, we have not seen evidence to convince us that this cycle has ended.

1.48 Treating problems as limited one-off issues susceptible to being picked off by the latest action plan or new manager, rather than acknowledging their full extent and nature, has got in the way of confronting the issues head-on. Where issues have been brought into public focus by the efforts of families or through the media, too often the Trust has focused on reputation management, reducing liability through litigation and a "them and us" approach. Again, this has got in the way of patient safety and learning.

The actions of the regulators

1.49 We have reviewed how the Trust engaged with the regulators and others and how those organisations handled the signs of problems with maternity services in East Kent.

1.50 We have found that the Trust was faced with a bewildering array of regulatory and supervisory bodies, but the system as a whole failed to identify the shortcomings early enough and clearly enough to ensure that real improvement followed.

1.51 In practice, there was no shortage of regulatory and other bodies holding relevant information. The list includes:

- General Medical Council (GMC)
- Nursing and Midwifery Council (NMC)
- Local Supervising Authority (LSA; previously performing the role of supervision of midwives)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of Midwives (RCM)
- NHS England (NHSE)/NHS Improvement (NHSI) (merged from April 2019 as NHSE&I; NHSE again from July 2022)
- Care Quality Commission (CQC)
- Healthcare Safety Investigation Branch (HSIB)
- Clinical Commissioning Groups (CCGs)
- Local Maternity System/Local Maternity and Neonatal System (LMS/LMNS)

1.52 Looked at individually, a case can be made that the distinctive role of each organisation should have added positively to identifying and addressing the problems. However, standing back from that detail, it is hard to avoid the impression that, in practice, the plethora of regulators and others served to deflect the Trust into managing those relationships and away from its own responsibility.

1.53 The task of regulators was made more difficult by the extent to which problems were denied; this denial ran right through the Trust, from clinical staff to Trust Board level. Even five years on, the Panel has been told that *"we were not as bad as people were saying we were* [in 2015/16]*"* and that *"it only takes one case* [baby Harry Richford] *to trigger an investigation"*. A critical RCOG report in 2016 (see paragraphs 1.97–1.102) was based on *"hearsay and uncorroborated comments"*. Legitimate challenge by the CQC was *"always met with anger and defensiveness"*.

1.54 There are inherent tensions in the roles of regulators and professional bodies, both individually and collectively. The RCM, for example, combines three functions: that of promoting quality maternity services and professional standards; that of advising and commissioning legal representation for individual members subject to disciplinary and professional processes; and that of a representative body for its membership. We found that these functions became entangled when the RCM was involved in problems relating to midwife behaviour in East Kent, and it was not possible to tell in what capacity it was operating at any one time, fuelling the perception that these problems were too difficult for the Trust to resolve.

1.55 The actions of the regulators and others are set out in Chapter 5.

1.56 We have found that NHSE&I did seek to help bring about improvements in the Trust. We have heard that a Quality Surveillance Group was established at least as early as April 2014. This followed identification of concerns by the CCGs (see paragraphs 1.75–1.81). As with the other regulators, we have found that the intervention of NHSE&I and its predecessors failed to secure the necessary improvements in the services provided.

Missed opportunities

Illustrative Case C

1.57 A young mother (C) arrived at the hospital having had a healthy pregnancy. She had been told by a community midwife that the slowing down of her baby's movements was not a reason for concern. Following a scan late on in the pregnancy, C was further reassured that there were no underlying problems with her baby.

1.58 When C went into labour late in the evening, she was told to wait until her contractions were stronger and more frequent before travelling to the hospital. She felt discouraged and waited until the following afternoon, despite the altered movements of her baby. On arrival, she vomited in the corridor, often a sign of a rapidly progressing labour. The first midwife on the scene could not tell how dilated C's cervix was and brought in another midwife.

1.59 The standard method for checking a baby's heartbeat is by using what is known as a doppler. The staff present followed this practice but detected C's heartbeat instead. The midwife left for a break and another one was brought in from the labour ward. The new midwife spotted that the baby's own heartbeat was not recovering quickly enough after the contractions. The first midwife was called back and, following discussions, C was taken to the labour ward.

1.60 C wanted to push but had been told not to do so. But now she was told to push and the baby was delivered with forceps without additional pain relief. C remembers seeing her baby in the resuscitation cot in the corner of the room. She felt euphoric at having given birth but also concerned by what she saw. She assumed that her baby would be resuscitated and that she would be able to hold the baby at any moment. She remembers being told that her baby was breathing before then seeing her baby being taken away to the neonatal intensive care unit.

1.61 C was left in the room with her family – her parents and partner. No member of staff stayed with them or joined them, and they were not told what was happening. C remembers that she was bleeding profusely and that her father left the room in order to ask whether somebody could attend, only to be told that *"they are all in the staffroom having a cup of tea to recover from the shock".*

1.62 When the consultant obstetrician arrived, C remembers being told that her baby was being cooled on a life support machine, because of the effects of a lack of oxygen. She was also told that the baby had too much acid in her blood as a result of distress in labour. And then the awful news. Her baby might not survive, or might survive with brain damage.

1.63 For a time, as any parent would, C and her partner were hopeful that their baby would indeed recover. C was expressing milk for her newborn child, who was well grown and had appeared healthy.

1.64 In the coming days, C and her partner would see the effects of their baby's organs shutting down. They stayed up all night with their baby not knowing when the baby's last breath would be. The baby passed away in C's arms the following afternoon.

1.65 Some months later the family had a meeting with the Head of Midwifery and with the head of the MLU. They remembered being told that *"many many mistakes had been made"*; their baby's death could have been prevented had delivery been only a matter of hours earlier. In response to a question, C was told that ten babies had died since her baby.

1.66 As well as the Trust admitting negligence, C recalls being told that if the family wanted to take any legal action the hospital would be supportive. C and her partner considered carefully what to do and came to their decision. They would pursue the case in order to highlight the issue higher up in the NHS, with the aim of preventing similar outcomes in the future.

1.67 Concern about the death of baby Harry Richford in November 2017 precipitated our Independent Investigation. But this is not Harry Richford; it is baby Amber Bennington, who was born seven years earlier, in August 2010, and who died nine days later.

1.68 There are similarities between the two cases. One is that the Panel has found that in both cases different clinical management would have been expected to have made a difference to the outcome.

1.69 Another similarity is that both families have wanted their experience to be considered in order that the services be improved. The fact that it took the experience of Sarah and Tom Richford, seven years after the experience of Lucy and David Bennington, to bring East Kent maternity services into national focus suggests that the issues are deep and entrenched, and that the Trust has not been ready to look for signs of problems.

1.70 It is clear that concerns have arisen throughout the period since 2009 when the Trust was constituted, and that numerous opportunities have been missed to rectify the situation that had developed. It is likely that the sooner this was tackled, the more straightforward it

would have been, before problematic attitudes and behaviour, and dysfunctional teamworking, became embedded. Yet each of these opportunities was missed in one way or another, and the consequences continued. The most significant are set out here.

Missed Opportunity 1: Internal review and report, 2010

1.71 On 24 September 2010, Dr Neil Martin, the Trust's Medical Director, gave a presentation to the Board on a recent serious untoward incident within maternity services. He also reported that the Trust's internal monitoring process had highlighted an increase in the number of babies showing symptoms of hypoxic ischaemic encephalopathy (HIE), a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain. An internal review was being undertaken and external midwifery support had immediately been put in place at WHH due to a concern about a decrease in the skill mix at the unit.

1.72 The review examined the antepartum management of 91 babies who had an unexplained admission to the neonatal intensive care and special care baby units within East Kent between January and September 2010. In 40% of the cases examined, the review highlighted the presence of suboptimal care, and in a third of those cases the suboptimal care was considered possibly, probably or likely to be a factor that was relevant to the outcome. Of the 91 cases reviewed, there were 16 perinatal deaths; significant or major suboptimal care was noted in 4 of those cases. Six babies were identified as likely to have what the report described as "long-term handicap"; significant suboptimal care was identified in three of those cases.

1.73 More broadly, the review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of a shortage of oxygen. The review identified a number of themes, many of which are recurring issues in the inspections that took place and in the reports and findings published between 2010 and 2020. The main themes were poor identification of fetal growth restriction, failure to diagnose labour leading to inadequate fetal monitoring, incorrect intermittent fetal monitoring, poor practice of continuous fetal monitoring with failure to correctly identify pathological traces and escalate concerns, and failure to follow guidelines.

1.74 The outcome of the review was to move the standalone midwifery units at Canterbury and Dover and to locate them alongside the obstetric units at Margate and Ashford. Recommendations were made to remind staff to practise within guidelines, to improve diagnosis of labour in low-risk settings, to improve standards in fetal monitoring, to review clinical guidance and resuscitation arrangements where meconium is present, to review the process by which medical staff of all grades learn from adverse events, and to review the process of escalating concerns about the progress of labour to more senior staff on call. We could find no evidence that these recommendations were followed up.

Missed Opportunity 2: Clinical Commissioning Group reporting to NHS England from spring 2013

1.75 The CCGs were created and commenced oversight from 1 April 2013. From the very outset, East Kent CCGs raised concerns about the Trust, including concerns about maternity services; they included these concerns in monthly written reports to NHSE. For example, in the June 2013 Quality Report to NHSE, the CCGs noted:

> *There is concern about the number of Serious Incidents (SIs) relating to maternity services at the Trust. Prior to April 2013 there were five SIs relating to maternity still open and in April 2013, two more were logged.*[1]

1.76 These concerns were repeated in the August 2013 Quality Report to NHSE:

> *The quality group and the Kent and Medway Quality Surveillance Group have both expressed concerns in relation to the number of serious incidents and the severity and trends within serious incidents related to maternity services within East Kent. Site visits have already taken place to both maternity units and further work with the trust and members of the quality surveillance group will now be taking place to further explore these issues.*[2]

1.77 The Panel heard that the CCGs were *"met with anger and defensiveness by the Trust, always, no matter whether it was a financial challenge or clinical challenge" – "you took a deep breath to have the conversations before you picked up the phone or you met with them"*.

1.78 Another interviewee said:

> *The Trust thought they were exemplars of best practice and there was a real arrogance back in 2013 … they would say it in public meetings, "we are the best acute trust in the country, we are innovative, we are clinically excellent, we are the safest place to be" … they would narrate it … over and over to try and make it become fact … you then had NHSE saying, "yeah we haven't really got any specific issue" … and then you had us* [CCGs] *… shouting, "… they're not financially stable, their leadership is falling apart … they're not a cohesive leadership team … they're not safe from a clinical and patient safety perspective … there are many gaps, and then they've got big cultural issues, huge cultural issues …"*

1.79 These differences between the Trust and the CCGs were recognised by a member of the Trust Board and the Executive, who spoke of their astonishment at the level of antagonism in the room when attending their first Quality Surveillance Meeting with the CCGs.

1.80 The CCGs found it difficult to gain recognition of their concerns within NHSE. It is not clear whether this was because the CCGs were able to bring fresh eyes to bear on the situation, or whether there had been rapid deterioration, but the existence of problems identified in 2010 makes rapid deterioration an unlikely explanation.

1.81 Having failed to gain traction with NHSE, the CCGs approached the CQC, and the Panel heard that it was this engagement that contributed to the CQC inspection in 2014. In the meantime, however, both the Trust and NHSE failed to accept that the CCGs had grounds for concern – another missed opportunity to recognise and address what was happening.

Missed Opportunity 3: Care Quality Commission report and governance issues, 2014

1.82 The CQC inspected the Trust over six visits in March 2014 and published its findings on 13 August 2014. The overall rating for the Trust was "Inadequate", with findings that the Trust was "Inadequate" in the domains of providing safe care and being well led, and a finding of "Requires Improvement" for effective and responsive services. Again, there are significant similarities between some of the CQC findings and those in previous and subsequent reviews.

1.83 Key findings from the CQC included the divide between senior management and frontline staff, governance and assurance processes that did not reflect reality, very poor staff engagement, poor reporting and investigation of safety incidents, and limited use of clinical audit. The CQC noted an unusually high number of staff raising concerns about safety directly with its inspectors.

1.84 Maternity services were given a less stringent rating: "Requires Improvement". Unfortunately, this implied that problems in maternity care were not as bad as elsewhere, not only downplaying the very significant problems that had existed for several years, but also deflecting attention to those areas seen as higher priorities.

1.85 The reaction of the Trust was again one of defensiveness and disbelief, and we found that there was a very tense and difficult relationship between the Trust and regulators throughout. One former member of the Board and Executive told us that a decision had been taken by the Trust to *"fight the regulators"*. We heard that the Trust reacted very badly to the CQC report, sending back hundreds of minor challenges, including grammatical and spelling issues, rather than addressing its substance. Despite issues being flagged as poor by the CQC during its inspections and reported back to the Trust each day, there was still disbelief when the report came in. Six months were spent quibbling over it, and when action plans were drawn up, they were of poor quality and not effectively followed up. This was another significant missed opportunity.

Missed Opportunity 4: Bullying and inappropriate behaviour within the Trust and maternity services, 2014/15

1.86 Bullying and harassment have been prevalent features in the Trust's maternity services over a prolonged period, as reported by many staff with whom we spoke. Staff surveys confirmed that staff felt disengaged, and reports of bullying and harassment were numerous. Some interviewees were explicit that the effects of this behaviour put the safety of care at risk.

1.87 This issue came to a head in 2014/15, initially when the Trust's Chief Nurse received an anonymous letter:

> *I work on maternity at the William Harvey. I'm ashamed to say that I feel intimidated at work. I have been made to look stupid in front of patients and other staff at work. I feel completely unsupported by our most senior staff. At times I dread going to work with certain people … Management and those with authority are not approachable, there is a blame culture, a just get on with it and shut up attitude, slog your guts out and still get grief. It's ok if your face fits, we operate a one rule for one, and another rule for everyone else on maternity … you need to know that at times the unit is* [an] *awful place to be.*

1.88 In response to this and to other evidence of staff unhappiness, the new Head of Midwifery undertook a review, working alongside the Trust's HR department. In all, 110 staff were interviewed. There were consistent reports from over half of these staff of abrupt and sarcastic senior staff, junior staff being shouted at and humiliated in front of others, staff feeling intimidated and undermined in front of patients, alleged racism, and a daunting and frightening work environment.

1.89 The Head of Midwifery decided, with HR, that some senior midwives who were repeatedly identified as central to the issues should be relocated or suspended pending further action. A collective letter of grievance with 49 signatories was subsequently submitted via the RCM, alleging failures of process in the review. It is notable that this letter admitted that the unit was *"dysfunctional"*.

1.90 We heard that, as a result, the Trust withdrew support from the review process and from the Head of Midwifery. Consequently, she resigned from her post in August 2015. She requested advice from the RCM on whistleblowing about the culture of bullying and intimidation prevalent in the unit and was advised against disclosure in the interests of patient safety because of the

risk this posed to her future career prospects. It is notable that the RCM was already aware of the dysfunctional behaviours at the Trust.

1.91 The Panel heard of no further efforts to address the bullying behaviour, which, we heard, persisted. This was another significant missed opportunity.

Missed Opportunity 5: *The Report of the Morecambe Bay Investigation*, 2015

1.92 The report into the serious failings in Morecambe Bay maternity services was published in early 2015. It identified, among other issues, failings of poor working relationships and dysfunctional teamworking, failures of risk assessment and planning, and failure to investigate properly and learn from safety incidents. All of these features were already evident in East Kent maternity services.

1.93 In May 2015, the Head of Midwifery at the East Kent Trust had already noted the similarity of issues and lessons identified within the Morecambe Bay report and sought to raise similar issues of concern with the Trust leadership. She was not heeded.

1.94 When we interviewed staff in 2021/22, some told us that they still believed the comparison to be misplaced. The Trust had commissioned a report later in 2015 specifically addressing this question; it found that the East Kent Trust *"was not another Morecambe Bay"*.

1.95 Given what the Trust knew about its own services at this point, this is an extraordinary conclusion; we can only suppose that it reflects the pattern of false assurance and defensiveness that characterised much of the Trust's behaviour.

1.96 The Morecambe Bay report included a message for other trusts in 2015:

> *It is vital that the lessons, now plain to see, are learnt and acted upon, not least by other Trusts, which must not believe that "it could not happen here". If those lessons are not acted upon, we are destined sooner or later to add again to the roll of names* [of dishonoured trusts].[3]

Missed Opportunity 6: Report of the Royal College of Obstetricians and Gynaecologists, 2016

1.97 In 2015, concerned about accumulated evidence on the working culture in maternity services, the Medical Director, Dr Paul Stevens, commissioned a review by the RCOG. He specifically identified for review the poor relationship between obstetricians and midwives, compliance with clinical standards, poor governance and response to safety incidents, supervision of trainees, consultant accessibility and responsiveness, and consultant presence on the delivery suite.

1.98 The RCOG review reported in February 2016 and made serious criticisms of the maternity services in East Kent. Among other things, the report was critical of the lack of engagement of obstetricians in drawing up guidelines, which were of poor quality as a result. Safety incident investigations were inadequate and failed to identify areas where obstetric practice could be improved. Some consultant obstetricians at QEQM consistently failed to attend labour ward rounds, review women in labour, or draw up care plans; they also refused to attend when asked to when on call out of hours. Although these consultants were clearly contravening their duties to the Trust and to their profession, the RCOG review found that *"this unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants"*.[4]

1.99 As a result of these appalling patterns of behaviour, trainees were under pressure to cope with clinical issues they were not competent to deal with unsupported, and midwives felt that there was no point in escalating emerging urgent clinical concerns. In addition, both groups of staff had given up reporting concerns about unacceptable behaviour, as no action was taken. Educational supervision of trainees was inconsistent, posts were often filled by locums, and morale was poor.

1.100 In keeping with the familiar pattern of defensiveness, the Trust told the RCOG that it would not respond to the report in light of an anticipated CQC inspection. When this occurred, the RCOG report was not shared with the CQC. Within the Trust, the RCOG review report was not widely distributed and was dismissively described as *"a load of rubbish"* by some senior obstetricians. A meeting of the Trust Quality Committee heard that *"initial information from the recent* [RCOG] *Maternity Review report is clear – the Trust does not have an unsafe maternity service but there is improvement work to do around how the service is run in some areas"*.

1.101 There was, however, sufficient pressure that maternity services were recognised as presenting an "extreme" risk, with potential harm to both pregnant women and neonates, in the Corporate Risk Register in June 2016. The resulting action plan, heavily process-oriented, was subsequently merged with a general improvement plan in response to the national Maternity Transformation Programme, diluting it and losing some of the specific elements prompted by the RCOG report. Fewer than a quarter of the action points had been completed when the risk was removed from the Register in 2019.

1.102 Most obviously, at no time was there an explicit plan documented or actioned to address the identified failure of some consultants to fulfil their professional duties. We heard that it was a *"difficult area"*, that *"quiet words"* were had, that two consultants had moved on or retired, and that another had a modified job plan that excluded overnight labour ward cover. While we recognise the constraints, and will comment elsewhere on them, the failure to tackle this explicitly or visibly has left echoes in the unit that still persist. This was another significant missed opportunity.

Missed Opportunity 7: The death of baby Harry Richford

1.103 Baby Harry Richford died on 9 November 2017 in the neonatal unit at WHH in Ashford, seven days after he was delivered at QEQM in Margate. The cause of death was recorded as hypoxic ischaemic encephalopathy (HIE).

1.104 Many of the same red flags that had shown themselves in the litany of previous inspections, reviews and reports appear again in baby Harry's case. Not only does this apply to the clinical care given to his mother, Sarah Richford, it is also evident in the way that the whole family were treated after his death. The patient safety issues echoed the problems that had been highlighted first in the Trust's internal review of 2010 and most recently again in the RCOG report, published 18 months before Sarah attended QEQM.

1.105 Sarah witnessed conflict and disagreement between the obstetric and midwifery teams about the way that oxytocin was being used to augment her labour. Midwives were concerned about changes to the continuous heart trace of the baby, but the obstetric team disagreed.

1.106 Obstetric cover on the labour ward was provided by a locum specialist registrar, whose knowledge and experience had not been assessed by a Trust consultant. When there was disagreement over Sarah's care plan, neither the locum registrar nor the midwifery team escalated this to the consultant on call, contrary to guidelines. Sarah was not reviewed by an obstetric consultant during either the 1pm or 6pm assessment rounds, contrary to unit protocols.

1.107 There were further features of concern over the baby's condition coming up to delivery, and the locum registrar undertook to expedite delivery, either by forceps delivery or, if this was not possible, by a caesarean section. It appears that the locum registrar discussed this by telephone with the consultant on call, who agreed with the plan but did not attend, although it was likely to present challenges to an inexperienced obstetrician.

1.108 After an unsuccessful attempted forceps delivery, a caesarean section was undertaken. Unsurprisingly, in view of the descent of the baby's head, this proved very difficult; several attempts were made to dislodge the head from the pelvis, including by applying pressure vaginally. The consultant on call was contacted by telephone and offered advice but was still not in attendance.

1.109 There were major difficulties in resuscitating baby Harry after delivery, including delay in establishing an airway, together with delay in escalating concerns to a consultant paediatrician on call.

1.110 In keeping with the familiar pattern of downplaying problems and seeking to avoid external scrutiny, the Trust classified baby Harry's death as "expected" on the basis that he was admitted to the neonatal unit at WHH with severe HIE, and therefore death was not an unexpected outcome. For that reason, the Trust initially refused to refer baby Harry's death to the coroner for investigation. There were errors in the data sent to the national audit, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

1.111 Baby Harry's family faced great difficulty in finding out what had gone wrong, although they were sure that something had, and they began to distrust any information they received from the Trust. The weeks, months and years that followed baby Harry's death involved sustained efforts by his family to seek understanding and truth about what had happened during his delivery. Their efforts included referring the case to HSIB and to the CQC for investigation and pressing to have a full inquest into the circumstances of his death.

1.112 This pattern of behaviour by the Trust, clearly evident in this case, recurred in many others that we examined. It included denying that anything had gone amiss, minimising adverse features, finding reasons to treat deaths and other catastrophic outcomes as expected, and omitting key details in accounts given to families as well as to official bodies. Although we did not find evidence that there was a conscious conspiracy, the effect of these behaviours was to cover up the truth.

1.113 Even had none of the previous failings been known – and they were – baby Harry's death should surely have been a catalyst for immediate change. In fact, it required public remonstration by a coroner over two years later, precipitated by the persistence, diligence and courage of baby Harry's family, to reveal an organisation that did not accept its own failings, considered itself above scrutiny or accountability, and consistently rejected the opportunity to learn when things went wrong.

Missed Opportunity 8: Engagement with the Healthcare Safety Investigation Branch from 2018

1.114 HSIB was established in 2017 in response to widespread concern that the NHS was not learning consistently from safety incidents. Its brief is to carry out independent investigations into safety incidents, focusing on systems and processes, to identify learning. In light of previous issues, most obviously at Morecambe Bay, HSIB was given a special brief to look at all maternity incidents that fulfilled certain harm criteria. In 2018, it became evident that East Kent

maternity services were an outlier because of the rate of occurrence of safety incidents resulting in serious harm.

1.115 From the outset, HSIB experienced difficulties in its dealings with the Trust, including problems obtaining information, staff attendance at interviews, and support for the process from the Trust's senior leadership team. HSIB found this to contrast sharply with the response of other trusts in the region, which generally welcomed the opportunity to have "fresh eyes" on any problems. The East Kent Trust, on the other hand, challenged HSIB's right to carry out investigations and its credentials to act as what the Trust saw as another regulator.

1.116 HSIB's concerns increased over the course of 2018, particularly over failures to escalate clinical concerns, unsupported junior obstetric staff, the use and supervision of locum doctors, management of reduced fetal movement, neonatal resuscitation, and fetal monitoring and its interpretation. In light of its *"grave concerns"*, HSIB sought a meeting with the Trust's senior leadership team, which took place in June 2019.

1.117 The accounts of that meeting that we heard from more than one source left us shocked, given the extent of the problems at the Trust that by then had been evident for almost ten years. The HSIB team was not made welcome but was left waiting in a corridor for an extended period. Senior executives greeted them in an *"incredibly aggressive"* manner, saying *"I don't know why you are here"* and telling HSIB that its recommendations were *"not needed"*. The tone of the meeting was one of defensiveness and aggression, and there was a *"heated discussion"* about a maternal death.

1.118 Although relationships between the Trust and HSIB became more cordial, we heard that the Trust did not achieve the same level of acceptance and learning evident in other trusts that HSIB deals with. This is the most recent in this long series of missed opportunities.

Where accountability lies

1.119 This section has highlighted our findings and set out the series of missed opportunities that has characterised the whole period since the establishment of the Trust in 2009. Any one of these was a chance to rectify a situation that had clearly gone very wrong and was continuing to deteriorate. Had any of these opportunities been grasped, there would undoubtedly have been benefits in terms of death, disability and other harm avoided, and in terms of the mental wellbeing of many families who were disregarded, belittled and blamed.

1.120 We do not blame, or identify, those who have made honest clinical errors. Clinicians should not have to live in fear of clinical error and its aftermath; it is an inescapable accompaniment to practice everywhere. The fundamental point is to recognise and report error, so that it can be investigated and learned from. The route to improved maternity services would be fatally undermined if individuals, be they midwives or consultants, were deterred from reporting, or from entering practice, by the fear that honest clinical errors would result in public or professional vilification.

1.121 We have found that repeated problems were systemic, particularly reflecting problems of attitude, behaviour and teamworking, and they reflect a persistent failure to look and learn. They concerned both hospitals and continued throughout the period we have investigated. They included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose.

1.122 Each of these problems has been visible to the senior management of the Trust. In these circumstances, while it is right that this report should be clear about those systemic issues and how they have been evident through the organisation, we have concluded that accountability lies with the successive Trust Boards and the successive Chief Executives and Chairs. They had the information that there were serious failings, and they were in a position to act; but they ignored the warning signs and strenuously challenged repeated attempts to point out problems. This encouraged the belief that all was well, or at least near enough to be acceptable. They were wrong.

Key areas for action

1.123 It is a privilege to have been asked to investigate maternity and neonatal services in East Kent. But, in doing so, we are faced with a reality of national as well as local significance.

1.124 This Investigation is simply the latest to focus on failings in an individual NHS trust. The list is now a long one, going back at least as far as the 1960s. As the Health Foundation has pointed out, most people think of the inquiry into failures of care at Ely Hospital in Cardiff in 1967 as the first NHS inquiry.

1.125 The period since then has been punctuated by reviews into local circumstances: for example, the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, published in 2013. With maternity services alone, the spotlight has been shone on Morecambe Bay in 2015, on Shrewsbury and Telford in 2021/22, East Kent, with this Investigation commissioned in 2020, and now Nottingham.

1.126 The pattern is now sadly familiar: detailed investigation, lengthy reports, earnest and well-intentioned recommendations – all part of a collective conviction that this must be the last such moment of failure, with the lessons leading to improvement, not just locally but nationally. Experience shows that the aspirations are not matched by sustained improvement. Significant harm then follows, with almost always patients and families the first to raise the alarm.

1.127 In investigating East Kent maternity services and their missed opportunities, we have become all too aware that a conventional report, with multiple recommendations, overlapping with recommendations from other inquiries, other periods and other sources, is unlikely to break free of this pattern.

1.128 For this reason, we have set ourselves the objective of identifying a more limited number of key themes and recommendations, and of not confusing the already difficult – if not impossible – task of making sense of those that already exist.

1.129 Within this approach, we want to tackle head-on the fundamental issue affecting maternity services that this succession of reviews creates. The frequency with which supposedly one-off outliers keep cropping up despite previous investigations and reports makes it, in our view, unsafe to suppose that East Kent is the last one that will be identified. The answer cannot be to hope that individual reviews and multiple recommendations prevent recurrences elsewhere. If that approach were the right one, it would have worked by now. It hasn't.

1.130 We have identified four key areas for action that we believe must be addressed.

Key Action Area 1: Monitoring safety performance – finding signals among noise

1.131 We have come to the view that something more reliable needs to be put in place, not only in East Kent but also elsewhere and nationally, to give early warning of problems before they cause significant harm. The aim must be for every trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time; for the NHS to monitor the safety performance of every trust; and for neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years.

1.132 We are clear that such a mechanism can be developed in order to spot the relevant signals. In Chapter 6, we recommend how this should be done. This is not a toolkit, because it must be nationally standardised, and it is not optional. It will be based on:

- Better outcome measures that are meaningful, reliable, risk adjusted and timely
- Trends and comparators, both for individual units and for national overview
- Identification of significant signals among random noise, using techniques that account properly for variation while avoiding spurious ranking into "league tables".

1.133 In essence, it is clear that in East Kent the Trust too often treated the concerns expressed by families as "noise" when they were in fact an accurate signal of real problems. One example is how the family of baby Harry Richford was treated, particularly when they sought answers to legitimate questions. But that is not the only such example. The accounts we have heard from families show persuasively that the Trust's mindset was too often to be defensive and to minimise problems; and that this mindset was itself a barrier to learning.

1.134 The Trust also took false reassurance from national statistics that appeared to suggest that the number of baby deaths was no higher than in other trusts, underlining the shortcomings of available information. This was very clear from the accounts we have heard from the Trust's staff. For example, a senior clinician accepted that the Richford case was tragic and avoidable but added that, *"however, when you look at the figures it was only in 2017 that* [East Kent] *were slightly outside average Trust behaviour"*.

1.135 Chapter 5 describes how the Trust sought to monitor its performance. By contrast, we have identified a more reliable approach that would utilise the available statistics in the way suggested in Chapter 6, for the use of clinical teams, trusts, regulators and the public, as well as listening to what women and their families say – treating that too as a likely signal, not as noise.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

1.136 The frequent instances we have found of a distressing and harmful lack of professionalism and compassion are of great concern to us. Of course, we are aware that the majority of clinical staff do not behave like this; but, equally, it would be wrong to imagine that these behaviours are confined to East Kent's maternity services.

1.137 This is not a finding of technical incompetence. But the experience shared vividly with us by families and often confirmed by staff accounts has demonstrated that technical competence is not enough. In any clinical situation, not least the stressful circumstances of giving birth, there is an equal need for staff to behave professionally and to show empathy. The evidence of staff

not showing kindness or compassion and not listening or being honest has been both harrowing and compelling.

1.138 Part of a professional approach is explaining what is happening or has happened honestly and openly – at the time, whenever possible, and certainly afterwards. But what we have found is that, too often, the response has been based on personal and institutional defensiveness, on blame shifting and punishment.

1.139 We have found a worrying recurring tendency among midwives and doctors to disregard the views of women and other family members. In fact, in a significant number of cases, the Panel has found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, when they questioned their care, and when they challenged the decisions that were made. Too often, their well-founded concerns were dismissed or ignored altogether.

1.140 A particular area of concern was the telephone advice given to mothers to stay at home if they were not adjudged to be in established labour. It is foolhardy to disregard the woman's voice, especially if she has experience of previous labour, and we saw evidence of distressing births before the mother's arrival in the maternity unit as a result. But it is dangerous when the caller has also reported other problems such as altered movements by the baby, and we saw examples of babies lost as a consequence of such advice.

1.141 We have also found a pattern of particularly stubborn and entrenched poor behaviours by some obstetric consultants, particularly at QEQM. We are clear that this has been damaging, not just to team relationships but also to the safety of women and their babies.

1.142 Some consultants did not attend when requested, although they were on call, and they did not attend scheduled labour ward rounds. They discouraged both junior staff and midwives from calling them at night, leading most staff to conclude that they just had to get on with it without the advice or presence of consultants when those consultants were on call. These concerns were known to the Trust, having been clearly identified in the RCOG report of 2016 and confirmed subsequently by the Trust itself in an audit conducted in April and May 2016. The RCOG did not immediately offer to be involved in how these problems might be resolved, and was rebuffed by the Trust on offering to revisit six months later.

1.143 We note that, in seeking to overcome the reluctance of some consultants to attend when on call, the Trust's actions were weaker than when dealing with midwives. This difference was evident to staff, who put it to us in these terms: *"Nurses would potentially be disciplined … doctors would be asked to reflect on what happened."*

1.144 It is apparent to us that this reflects a much wider difficulty. Any trust seeking to address problematic behaviour by consultants will face significant constraints. Employers effectively have no sanctions short of dismissal against a consultant who defies them, and experience suggests that if employers do act, or if a consultant claims constructive dismissal, the employers are very likely to lose at an employment tribunal. In such situations, external support for trusts is often unhelpful, while defence organisations mobilise their full resources in support of their member. When the GMC was belatedly informed of the unacceptable consultant behaviour in East Kent, it decided that no fitness to practise proceedings were required, and confirmed to us later that it was not able to address *"lower-level behavioural issues, or cultural issues, or attitudinal issues"*. Without wishing to detract from the importance of employment protection, it cannot be right that behaviour which seriously threatens patient safety cannot be robustly addressed.

1.145 There is a pressing need to understand better the gross lapses of professionalism, compassion and willingness to listen that these events illustrate, including their prevalence, the underlying causes, and – most importantly – how they can be changed. Unless we address the balance between the technical aspects and the human kindness needed to care for people compassionately, effectively and safely, the problems evident in East Kent will recur elsewhere.

Key Action Area 3: Flawed teamworking – pulling in different directions

1.146 We have found that teamworking in East Kent maternity services was dysfunctional. This was clear in the accounts we have heard from families and was consistently supported by the evidence of the staff interviews and available records. Many staff described *"toxic"*, *"stressful"* working environments. Arguments between staff were played out in front of families just at the time when truly effective teamwork was required and just when families needed to see that teamwork at work.

1.147 Fundamentally, there were poor relationships both within and between professional groups. There were factions and divisions within midwifery. There was poor working in obstetrics, with a division between consultants and junior staff that left unsupported staff to deal with complex situations beyond their experience. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.

1.148 In sometimes suggesting that the relationships between midwives and obstetricians and neonatologists were satisfactory, staff revealed the limitations in their concept of teamworking. This was, at most, a concept of each discipline doing its own job to an acceptable standard, but within rigidly demarcated and sometimes conflicting roles. In part, this resulted from an inflexible interpretation of a wider maternity debate, positioning midwives as the defenders of women against intervention and obstetricians as the inflictors of over-medicalised models of care.

1.149 This is no basis for effective teamworking in maternity services. Midwives and obstetricians each bring a unique set of skills and experience to maternity care. They should contribute to maternity care as equal and valued partners. But it is inconceivable that they might have objectives that differ. There is not a separate role to promote "normal" birth or to reduce caesarean sections, or to be the "guardians of normality", any more than there is a separate role to promote safety. A team that does not share a common purpose is not a team.

1.150 We have not found any systematic policy in East Kent maternity services of inappropriately favouring either unassisted birth or assisted vaginal birth in circumstances where this would place women and babies at risk. Those we interviewed were careful to say that there was no such policy. We have found, however, that the way in which "normal birth" was spoken about and set out in material for mothers created an expectation that it was an ideal that staff and women should strive to achieve. On some occasions, this pressure of expectation seemed to contribute to staff decisions not to escalate concerns or to intervene, decisions that were otherwise inexplicable.

1.151 One particular example is the Vaginal Birth After Caesarean (VBAC) Clinic, which started at QEQM in 2005 and was operational across the Trust by 2007. The inherent expectation of the clinic was clearly the promotion of VBAC, and it certainly operated in that way. While VBAC is a welcome and appropriate plan for some women, the benefits must be weighed against the risks, particularly of uterine rupture, taking into account any adverse factors. There were clear examples of women who were at high risk from VBAC where we could find no evidence that these risks were discussed, or that a decision which placed a woman at high risk was communicated to her or flagged to inform her future care. Such decisions need to be taken carefully, free from inherent prejudice about the "best" method of delivery.

1.152 We believe that insufficient attention has been given nationally to the language that is used around "normality" and to the presentation of information, or to the expectations that both can create among both maternity staff and mothers. Language and information that are helpful in the majority of cases can have disastrous consequences when labour does not progress physiologically. We are aware that some recent steps have been taken to improve this, but these are insufficient in our view to remove the risk of misunderstanding and misinterpretation.

1.153 Trainees in all disciplines contribute significantly to the work of maternity teams, providing care while gaining experience. For this to be effective, they need to feel supported, both by their peers and by senior staff, and they also need to take part in supervised learning. We found that clinicians in training did not feel supported; they felt isolated, exposed and vulnerable, and they sometimes worked unsupervised in complex situations beyond their experience. This applied equally to midwives and obstetricians, as well as to paediatricians in some cases.

1.154 We found that bullying and harassment were frequently reported, working relationships with other disciplines did not feel comfortable, and more senior staff could be undermining and unhelpful. There were shortages of junior medical staff and posts often had to be filled by locums, further impeding the development of teamworking. New staff were made to feel unwelcome, were excluded from cliques, and were given challenging cases and expected to manage them without support.

1.155 In part, this can be related to national changes in the training of junior medical staff brought about by the need to reduce working hours and compress training. While both of these have welcome consequences, principally in reducing fatigue and unjustifiably extended training, they also have unwelcome consequences. Shift working reduces continuity of care and increases the likelihood of information loss or error at handovers. The loss of the former "firm" system, in which junior medical staff were part of a stable clinical unit headed by one or more consultants, has reduced the feeling of belonging for staff, as well as the opportunity for staff to develop trust and knowledge of colleagues' capabilities. It is important that we find ways to counter these unwelcome features and improve the sense of belonging among staff.

1.156 A more longstanding difficulty is the separation of early training into different clinical disciplines, when staff's future ability to work in teams in a mutually supportive way will be crucial. Staff who work together should train together from the outset, at least in part, and not just in rehearsing emergency drills (which is the most common form of joint training claimed).

1.157 We believe that there is a pressing need to understand the effects of the dynamics of training and education, and how changes made for good reasons have had unintended consequences. More generally, we believe that it is time to think about a better concept of teamwork for maternity services – one that establishes a common purpose across, as well as within, each professional discipline.

Key Action Area 4: Organisational behaviour – looking good while doing badly

1.158 Throughout the period we have investigated, it was clear that the Trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others.

1.159 With families, this was evident in the way in which their concerns were dismissed. Where there were complaints, too often the Trust's instinct was to manage those complaints rather than to consider what was being said as feedback and learning.

1.160 With regulators and others, we have found that too much effort was consumed in seeking to challenge and undermine any scrutiny. For example, it is revealing that when the CQC report became available in 2014, the Trust *"went through every line, every word of* [it] *and came up with hundreds of challenges to the report, grammatical, spelling … rather than actually going to the essence of the report and seeing 'what do we do'"*, as a member of staff put it to us.

1.161 Unfortunately, these problems are far from restricted to East Kent. Indeed, reputation management could be said to be the default response of any organisation that is challenged publicly. When the end result is that patient safety is being damaged, unrecognised and uncorrected, however, it is especially problematic. At present, the benefits of inappropriate and aggressive reputation management outweigh the meagre risks to an organisation of behaving in this way. This balance must be addressed.

1.162 We have found at Chief Executive, Chair and other levels a pattern of hiring and firing, initiated by NHSE. The practice may never have been an explicit policy, but it has become institutionalised. In response to difficult problems, pressure is placed on a trust's Chair to replace the Chief Executive, and/or to stand down themself.

1.163 There may be organisations in which the frequent and short-term appointment of key staff proves effective. It is clear that this approach was not just ineffective in East Kent, but wholly counterproductive. These decisions appear to us to have been made separately from any question of accountability: the effect was simply to rotate in a new face and rotate out the previous incumbent elsewhere.

1.164 In practice, the appointments that were made led the Trust, and NHSE, to believe that things were changing when in fact the underlying shortcomings remained. This approach also led to the term of the then Chief Executive being cut short in 2017, when some of our interviewees suggested that improvements were beginning to be made.

1.165 We are conscious of the damage caused by the succession of appointments as Chief Executive, Chair and Head of Midwifery, but also in other posts. Enthusiasm for the newly appointed individuals created unrealistic expectations that only fuelled criticism when those expectations were not met; this was described to us as a flawed model based on *"heroic leadership"*. NHSE and the Trust have not yet been able to break free of this unproductive cycle.

1.166 The problems of organisational behaviour that place reputation management above honesty and openness are both pervasive and extremely damaging to public confidence in health services. A legal duty of truthfulness placed on public bodies has been proposed as one of the responses to the Hillsborough disaster. It seems that NHS regulation alone is unable to curtail the denial, deflection and concealment that all too often become subsequently clear, and more stringent measures are overdue.

Conclusion

1.167 The Independent Investigation into East Kent Maternity Services has been a challenge to carry out, and at times difficult, but the Panel has never once doubted that it has been so very much more challenging, difficult and personally demanding for the families without whom it would not have been possible.

1.168 We have set out in this chapter the stark findings of deep problems at every level in the Trust, from labour ward clinicians to the Board and external relationships. We have summarised the shocking consequences for the lives of women, babies and families, their health and their wellbeing. We have identified the significant missed opportunities stretching back to 2010 to prevent the continuing toll. We have introduced the four areas for action that we believe are essential to correct the underlying problems in East Kent and elsewhere, and to prevent recurrence. These are considered further in Chapter 6, with a route to taking action in each area.

1.169 Our lasting gratitude goes to the families who put aside for a while the cares they should not have had to bear, to help us to understand the events, and to make the Investigation happen in the first place. We all owe them our undertaking to make things better. It is essential that the findings of this Report are heard, and the necessary actions heeded, around the NHS as in East Kent.

Chapter 2: The Panel's assessment of the clinical care provided

This chapter explains that, had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases the Panel assessed (48%), and it could have been different in 45 of the 65 cases of baby deaths (69.2%).

In the 25 cases involving injury to babies, 17 involved brain damage. This included hypoxic ischaemic encephalopathy (HIE, a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain) and/or cerebral palsy attributable to perinatal hypoxia (insufficient oxygen). Had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%).

In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%), had care been given to nationally recognised standards, the outcome could have been different.

The Panel has not been able to detect any discernible improvement in outcomes as evidenced by cases over the period within our assessment (2009 to 2020). Our assessment has also indicated that the outcomes and patterns of suboptimal care concerned both the Queen Elizabeth The Queen Mother Hospital at Margate (QEQM) and the William Harvey Hospital in Ashford (WHH).

Introduction

2.1 We have conducted a review of each of the 202 cases where the families involved asked to participate in this Independent Investigation, and where their care by the maternity and neonatal services of East Kent Hospitals University NHS Foundation Trust (the Trust) fell within the scope of the Investigation's Terms of Reference. This chapter describes the review undertaken, our sources of evidence and its results.

2.2 We have reviewed 202 cases, identified using our Terms of Reference and via families who had approached us to participate in the Investigation. In focusing on reviewing what happened in these participating cases, we have had the benefit of richer sources of evidence than we would have had by looking at, for example, clinical records in isolation. Specifically, our review draws upon the following three sources of evidence:

- **Family listening sessions:** In the great majority of the participating cases (189 out of 202), the family was prepared to relive their often traumatic experience for the benefit of this Investigation. In a minority of cases (13), the family wanted their experience to be heard without going through the distressing process of retelling what had happened. In these cases, the Panel focused on the information available in the clinical notes. We wish to place on record our thanks to each and every family, regardless of the decision they took on this point. The family listening sessions have provided a wealth

of evidence, expressed in a compelling way and creating a clear and vivid picture of what happened. In many cases the family listening sessions have included the husband or partner. Where they were present for the birth, their account as witnesses to what happened has proved to be invaluable, often including details which go beyond those available from other sources. In addition, the accounts of husbands and partners are testament to their own personal experiences as events unfolded; they are considered further in Chapter 3.

- **The clinical records:** We have had full access to the records we needed to conduct our review of the 202 cases. We would like to thank the team in the Trust who have made this possible in a full and timely fashion. In every case where the participating families have themselves been given documents, they have been ready and generous in making these available to the Investigation.
- **Interviews with clinical staff and others:** Chapter 4 sets out what we heard more generally from the staff at the Trust, past and present, and from others whose role has shed light on the maternity and neonatal services provided. In conducting our clinical review, we were able to invite to case-specific interviews the staff involved, including midwives, doctors and managers, where we judged that it would be helpful to do so. We are pleased to report that in every such case the person involved agreed to participate. This too has provided a very rich vein of evidence, largely confirming what the families witnessed and were able to recall in their accounts. Some of those interviewed provided additional documents which have helped to complete the picture.

2.3 Drawing upon these sources of evidence, this chapter explains how the clinical review was conducted. It also sets out its results, both in terms of the grading of suboptimal care (using the standardised scoring system developed for the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)) and the associated harm in each case (adapted from the NHS National Reporting and Learning System (NRLS) definitions of degrees of harm). A fuller description of our process of clinical assessment is given in Appendix B.

2.4 Alongside the clinical review, the Investigation has witnessed the wider range of harm which followed from the experience of the participating families. That wider experience, described in Chapter 3, is no less significant than the clinical outcomes.

Clinical review and grading of cases

2.5 The Investigation spans the period from 2009 – when the Trust achieved foundation status, so acquiring a new degree of autonomy and financial independence – to the end of 2020. A number of women came forward whose pregnancies fell outside the timeline set out in the Terms of Reference or whose approach to the Investigation came after we had completed this phase of our work. The Panel considered information about these cases, for background, but they do not feature within the grading of cases.

2.6 Figure 1 does not show the total number of births in the Trust or indicate where the births relate to suboptimal care or a poor outcome. It does show how the participating cases span the period covered by the Investigation.

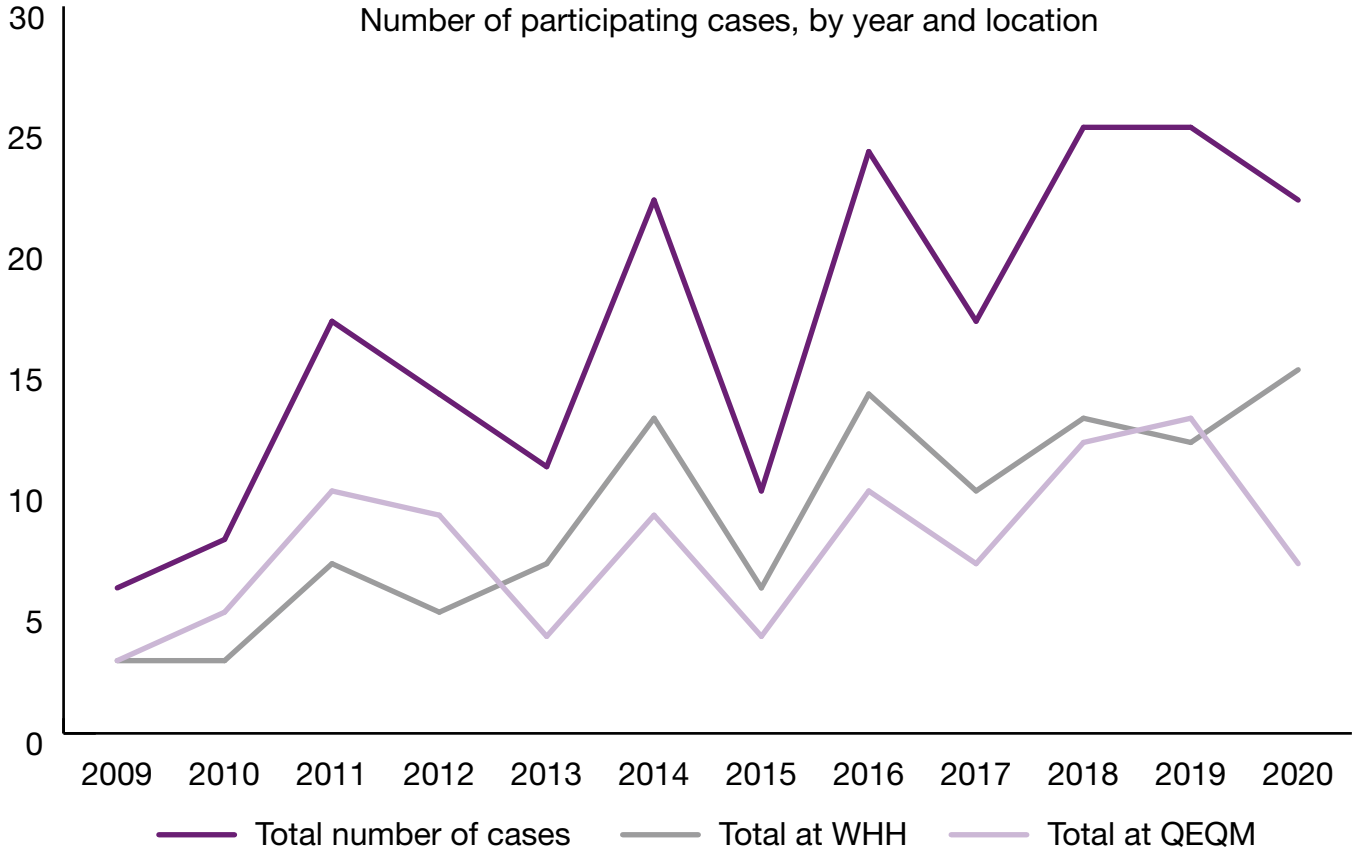


Figure 1: Cases reported to the Investigation by year and location

2.7 With the consent of the families involved, we carried out a thorough review of the clinical records of each woman and baby's care by the Trust's maternity services, adopting a systematic approach (as described in Appendix B). In addition to the clinical records, the Trust provided other documentation such as complaints correspondence, investigation reports and exchanges with GPs.

2.8 The Panel reviewed the records primarily to identify the presence of suboptimal care that might have led to a poor outcome in the period of pregnancy up to labour (antenatal), from the onset of labour through to delivery of the placenta (intrapartum) and in the hours and days after delivery (postnatal for mother; neonatal for baby).

2.9 The Panel came together to consider the evidence contained in the clinical records, with our understanding enhanced by what we had learned from the other sources of evidence. As a result, the assessment of each case reflects the judgement of the Panel collectively.

2.10 All the cases were graded using the CESDI scoring system previously used in *The Report of the Morecambe Bay Investigation*, published in March 2015. This defines four levels of suboptimal care based on their relevance to the outcome (see Table 1).

Table 1: CESDI scoring system

Level of suboptimal care	Relevance to the outcome
Level 0	No suboptimal care
Level 1	Suboptimal care, but different management would have made no difference to the outcome
Level 2	Suboptimal care, in which different management might have made a difference to the outcome
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome

2.11 In addition to grading the level of suboptimal care, the Panel determined the degree of harm in each case, using a classification adapted from the NHS NRLS definitions of degrees of harm (see Table 2).*

Table 2: Degrees of harm

Degree of harm	Outcomes	Impact on woman and/or baby
None	No harm	There was no impact on the woman or her baby
Minimum	Maternal injury; baby birth injury	The woman or her baby required extra observation or minor treatment
Moderate	Maternal injury; baby birth injury	There was short-term harm and the woman or her baby required further treatment or procedures
Severe	Maternal injury; brain damage, including HIE and/or cerebral palsy attributable to perinatal hypoxia	The woman or her baby suffered permanent or long-term harm
Death	Stillbirth; neonatal death; late neonatal death; maternal death	The woman or her baby died

* Although there are plans to replace the NRLS with the Learn from Patient Safety Events (LFPSE) service, which does not define degrees of harm in the way the NRLS does, the Panel found it helpful to use a form of assessment of harm that is recognisable and understood when reviewing the cases subject to our Investigation.

What the numbers tell us

Suboptimal care and associated outcomes: summary of the Panel's findings

Table 3: Degree of suboptimal care, Trust-wide

Suboptimal care	Relevance to the outcome	No. of cases Trust-wide	No. as a percentage
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome	69	34.2%
Level 2	Suboptimal care, in which different management might have made a difference to the outcome	28	13.9%
Level 1	Suboptimal care, but different management would have made no difference to the outcome	54	26.7%
Level 0	No suboptimal care	51	25.2%
Total		202	100%

2.12 The Panel's findings, set out in Table 3, mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases reviewed (48%).**
- **In 69 of these 97 cases, the outcome would have reasonably been expected to be different.**
- **In 28 of these 97 cases, it might have been different.**

2.13 The Panel found no differences to the outcomes or occurrence of suboptimal care over the time period covered by the Investigation (2009 to 2020). That is to say, we have not been able to detect any discernible reduction in suboptimal care or adverse outcomes over time, as evidenced by the cases we have assessed. Our assessment has also indicated that the outcomes found and patterns of suboptimal care concerned both QEQM and WHH.

2.14 Table 4 gives a breakdown of the range of outcomes in the assessed cases.

Table 4: Outcomes as reviewed by the Panel

Outcome	Total number of cases
Baby death (stillbirth or neonatal death)	65
Baby sustaining hypoxic or other injury during labour or birth	25
Maternal death	4
Injury to mother	28
Other physical harm (psychological harm is considered separately in Chapter 3)	32
No death or injury	48
Total	202

2.15 In relation to baby deaths, drawing upon our assessment of suboptimal care and the breakdown of outcomes, the Panel's findings mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 45 of the 65 cases of baby deaths (69.2%).**
- **In 33 of these 45 cases, the outcome would have reasonably been expected to be different.**
- **In 12 of these 45 cases, it might have been different.**

2.16 In relation to cases of injury to babies, drawing upon its assessment of suboptimal care and the breakdown of outcomes, the Panel's findings mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 12 of the 17 cases of brain damage (70.6%), including HIE and/or cerebral palsy attributable to perinatal hypoxia.**
- **In 9 of these 12 cases, the outcome would have reasonably been expected to be different.**
  - **In three cases, it might have been different.**

2.17 In respect of cases involving maternal injuries and deaths, drawing upon its assessment of suboptimal care and the breakdown of outcomes, the Panel's findings mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 23 of 32 such cases (71.9%).**
- **In 15 of these 23 cases, the outcome would have reasonably been expected to be different.**
- **In eight cases, it might have been different.**

Illustrative cases of suboptimal care

2.18 The findings set out above are stark. But the impact of suboptimal care, while suggested by these findings, goes beyond mere numbers and can best be conveyed through a series of illustrative cases. These are just a few of the examples the Panel has studied, but serve to highlight some of the points that arose in many further cases. The first set comprises three examples of neonatal death (Illustrative Cases D, E and F) and one of antepartum stillbirth (Illustrative Case G).

Illustrative Case D

D's pregnancy was uneventful and she went into spontaneous labour around her due date. Progress was slow, and her baby developed signs of oxygen shortage. After significant delay in recognising the need for urgent delivery, an inexperienced locum doctor attempted an instrumental delivery, which was difficult and hazardous as the baby's head remained high. When this failed, D's baby was delivered by emergency caesarean section, with considerable damage and bleeding. The baby was in poor condition at birth. Resuscitation was inexpertly carried out, with significant delay in establishing an airway, and he died after a few days due to severe hypoxic brain damage.

Illustrative Case E

E gave birth to twins after an uncomplicated pregnancy and induced labour. After a few hours, she reported that the first twin's breathing was laboured and noisy, only to be told by a midwife that *"he's not grunting, he's singing".* His temperature later dropped, suggestive of infection, and a medical assessment was requested. A middle-grade paediatric trainee attended two hours later but saw no grounds for concern, and significant further delay ensued before a consultant neonatologist initiated investigation and treatment for neonatal sepsis. The delay proved too much, however, and despite transfer to a specialist centre, the baby died of overwhelming streptococcal infection.

Illustrative Case F

F's first child was born by caesarean section following lack of progress after full dilation of her cervix. When she became pregnant again, F was keen to have a vaginal birth with as little intervention as possible. At her first meeting with her consultant, F and her partner were deeply disappointed to be advised that she should give birth in an obstetric unit, where she could be monitored effectively in view of the risk of uterine rupture.

The couple deferred their decision, but as F's due date approached, they decided they wanted their baby to be born in a midwifery-led unit alongside an obstetric unit, with a doula present. They were aware that this was against recommendations because of F's high-risk status. The couple met with the consultant midwife at the Vaginal Birth After Caesarean (VBAC) Clinic, who refused to book F for delivery in the midwife-led unit on the grounds of safety. When the couple resisted the recommendation of delivery in the hospital's obstetric unit, the midwife suggested that in that case they should consider a home birth.

The couple remained very averse to the obstetric unit, and a plan was drawn up with midwifery staff for a home birth. Despite the obvious risks, which had already been regarded as sufficient to close off the option of birth in a midwifery-led unit, no formal assessment of the risk to mother and baby of a home birth was made. Neither was any consideration given to allowing F to give birth in a midwifery-led unit as an exception to protocol.

F went into labour a few days after her due date and her contractions soon became strong. After some time, progress in labour slowed and F was transferred by ambulance to the nearest hospital obstetric unit. Once there, concerns about the baby's heart rate resulted in F being taken to theatre for an emergency caesarean section. Baby F was born with signs of brain damage and required specialist care. She died soon after.

Illustrative Case G

G progressed fairly uneventfully in her second pregnancy up to 36 weeks, when an ultrasound scan showed an excess of amniotic fluid around her baby. At 38 weeks, she reported reduced fetal movements, and although the baby's heart rate record (cardiotocography or CTG) showed no adverse features, she had a second episode of reduced movements two days later. A repeat ultrasound scan showed marked levelling off of the baby's growth. G recalls induction of labour being discussed in general terms, but felt concerned about the risk of cord prolapse, which she had been told was raised because of the excess amniotic fluid. There is no record of discussion of the risk of continuing with the pregnancy in light of the adverse findings of reduced growth, reduced fetal movements and excess amniotic fluid. Despite these obvious adverse factors putting her baby at risk, G was sent home with an appointment to return at 41 weeks. Two days before term, she attended again, having felt no fetal movements for a period of six hours. No heartbeat could be found.

2.19 The second set of illustrative cases comprises examples of HIE (Illustrative Case H) and maternal injury (Illustrative Case J).

Illustrative Case H

H experienced reduced fetal movements and attended QEQM. The CTG showed very abnormal features from the start and was seen by an obstetrician who recognised its nature but who was about to start another caesarean section. This situation should have been escalated immediately to the consultant on call but was not. In all, it took 70 minutes before the decision that an emergency caesarean section would be necessary was confirmed, the need for which should have been obvious to clinicians from the outset. Meanwhile, the baby's heartbeat had slowed significantly, and was undetectable as the caesarean section was about to commence. The baby was in very poor condition at birth, with profound hypoxia. There was delay in establishing an airway because the correct tube for intubation was not immediately available, but after eight minutes pulse and respiration had become established. The baby was cooled and transferred to WHH for neonatal intensive care. He suffered further problems related to severe HIE and has been left with significant brain damage.

Illustrative Case J

At 41 weeks, J attended for a booked induction of labour. Progress was slow in labour, and a caesarean section was undertaken. The baby was delivered in good condition, but there was significant bleeding from J's uterus because the incision had extended into the uterine artery on one side. The surgeon was inexperienced, and did not recognise the dangerous nature of the situation at first or the need to escalate to consultant level immediately. In trying to control the bleeding, a stitch was wrongly placed around the ureter on that side, jeopardising kidney function. J required emergency intervention by a urologist to conserve kidney function and by an interventional radiologist to embolise (create a blood clot in) the uterine artery to control bleeding. She recovered after a difficult postoperative course, including the need later to remove part of the placenta from her uterus, but was left with prolonged pain.

2.20 The final set of illustrative cases in this section comprises examples of maternal death (Illustrative Case K) and intrapartum stillbirth (Illustrative Case L).

Illustrative Case K

K was booked for an elective caesarean section. She had previously had an emergency caesarean section following a complicated pregnancy, and was at raised risk of venous thromboembolism, blood clots that may travel to the lungs and cause pulmonary embolism (a serious emergency). K's raised risk was not identified before the elective caesarean section, but it was noted on medical assessment on the first postoperative day, with an instruction that she should have ten days of preventive treatment with an anticoagulant. This was not acted upon, and K had no preventive treatment after the first postoperative day. Her discharge notification incorrectly stated that thromboembolism prevention was not required. Three weeks after the caesarean section, K collapsed at home and subsequently died from extensive pulmonary embolism.

Illustrative Case L

L, an older mother with a raised body mass index (BMI), was in her sixth pregnancy. Her last pregnancy had ended with an emergency caesarean section after prolonged spontaneous rupture of the membranes, with sepsis. As was routine, she was referred to the VBAC Clinic to discuss having a vaginal birth. There is no record that any of the additional risk factors particular to L were recognised or discussed with her, and she chose to follow the VBAC pathway. At two days post term, she had an induction of labour with a prostaglandin pessary. L reported excessive pain from the outset, which was unresponsive to tramadol and pethidine administered without an obstetric assessment. After four hours, labour was not progressing and she was still reporting excessive pain. She asked for a caesarean section, but her request was denied. After another four hours, a trace of the baby's heart was attempted (monitoring had been only intermittent despite the risk factors), but no heartbeat could be detected, and the death of her baby was confirmed. A consultant discussed the intended mode of delivery and offered a caesarean section, without apparently recognising the implications of the intrapartum death and L's severe pain. At caesarean section, three hours later, her uterus was found to be ruptured and her abdomen full of blood. L recovered after a difficult postoperative course.

Narrow escapes

2.21 The Panel found that, in a few cases, there was suboptimal care that did not lead to a poor outcome or which led to an outcome that could have been much worse. We do not consider these to be "near misses", things that were prevented from happening because they were identified in time and action taken; rather, they are examples of suboptimal care that went unnoticed, which purely by chance did not result in a poor or even grave outcome for the woman concerned. They are "narrow escapes". As such, they too have informed our view about the Trust's failure to ensure the provision of safe care to families. This point is exemplified by the following illustrative case, an example of a maternal injury considered by the Panel to be a narrow escape.

Illustrative Case M

When M's labour began, at 41 weeks in her first pregnancy, she went to hospital where her cervix was found to be almost fully dilated. She was pleased to be able to use the birthing pool, and soon began pushing. After about two and a half hours, her cervix was confirmed as fully dilated. However, there was no progress apparent and she began to become exhausted. She was transferred to obstetric care. Three hours after confirmation of the second stage of labour – which should not normally last for more than two hours in a first pregnancy – a plan was made to allow a further hour for the baby's head to descend. An epidural was then set up, and a further hour *"allowed for descent"*. After five hours of confirmed second stage labour, with the baby's head in a transverse position and still not descended into the pelvis, a trial of instrumental delivery was undertaken. There was no descent of the baby's head with four pulls on the forceps, and a caesarean section was undertaken after six hours of confirmed second stage labour. The mother suffered perineal damage from the attempted instrumental delivery, but fortunately her baby remained in good condition.

Failure to listen to parents

2.22 In assessing cases, it has been striking how the avoidable factors we identified match many of the issues of concern that families themselves brought to our attention in the listening sessions we held with them. It is clear to the Panel that women had raised many of these concerns with their doctors and midwives while they were receiving their care. This is an important point, not least because it emphasises the role of women themselves in achieving a good outcome.

2.23 An overriding theme to have come from the listening sessions is the tendency of midwives and doctors to disregard the views of women. In fact, in a significant number of cases, the Panel found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, their concerns often dismissed or ignored altogether. In at least some of these cases, the Panel was able to draw a connection between that failure to listen and an adverse outcome.

2.24 The illustrative cases below provide examples of this theme. They describe the circumstances surrounding an antepartum stillbirth (Illustrative Case N) and a failure of neonatal diagnosis (Illustrative Case O). These are further examples of what the Panel found to be a failure to listen to women or other family members that contributed to an adverse clinical outcome.

Illustrative Case N

N's first pregnancy progressed normally until 37 weeks, when she reported abdominal pain and altered movements by her baby. She was admitted to hospital for observation. She was not in labour, and intermittent CTG recordings of her baby's heart were within normal limits. A blood test indicative of infection was noted in her records but was not followed up, and she was allowed home the following day with no further arrangements or follow-up scheduled other than a routine appointment in two weeks. When she attended at 39 weeks, N reported reduced movements again, and her baby's heart was not heard. A stillborn baby was delivered the following day. Subsequent post-mortem examination confirmed the presence of an acute infection of the membranes inside the uterus.

Illustrative Case O

Baby O was very quiet and lethargic, and hadn't fed since he was born. Just after 11pm, about three hours after delivery, he started to vomit and O called for help and asked for clean bedding. By 1am, he still hadn't fed and vomited again. O called for help again and told the midwives that something was wrong, that her baby hadn't fed and was vomiting green bile. She was told this was normal, and no checks were done or further enquiries made. In the morning, O told the nurse that she was really concerned, that her baby had been sick all night and still hadn't fed. This was at the change of shift and the sister who came on duty raised the alarm. Doctors attended immediately and inspected the sheets, removed the baby's nappy and asked whether he had passed a stool, which he had not. He was then transferred to the Intensive Therapy Unit. Baby O had been born with no anorectal canal and complete intestinal obstruction. It had taken 14 hours from his birth to identify this condition, rather than it being picked up by the midwife at the newborn check or later in response to the mother's concerns about his bilious vomiting. During this time, baby O's condition had deteriorated significantly because his developing electrolyte imbalance had not been corrected with intravenous fluids and attempted feeding had continued. He required specialist surgery at another hospital and prolonged follow-up.

Conclusion

2.25 This chapter has set out the Panel's assessment of the clinical outcomes experienced by the women and their families who contributed to our Investigation, and the extent to which these outcomes could have been different in the absence of suboptimal care. It shows that, in nearly half of the cases assessed by the Panel, the outcome could have been different had care been given to the standards expected nationally.

2.26 The findings on clinical outcomes are stark. But the issues go wider and deeper than the clinical practice evident in the cases we have assessed. In other cases, including the 54 where the assessment of suboptimal care was at Level 1 and different management would have made no difference to the clinical outcome (see Table 3), or in the 48 cases where the Panel found that there had been no injury to the mother or baby (see Table 4), the care provided fell short of expected standards of service. We repeatedly heard that women's confidence in their care, and in the Trust more widely, was lost because of poor communication, a failure to engage and an unwillingness to involve women in decisions about their care.

2.27 In particular, an overriding theme, raised with us time and time again, is the failure of the Trust's staff to take notice of women when they raised concerns, when they questioned their care, and when they challenged the decisions that were made about their care. This is considered in more detail in Chapter 3, along with other aspects of the families' experience.

Chapter 3: The wider experience of the families

"You go to hospital to trust people, because your life is in their hands, and you never expect one of your family members or you to be let down by the system like that; it's really scary."

"The experience has affected all of our family but particularly myself and [my daughter] *… she is my baby and I cannot do anything to take her pain* [of her lost baby] *away."*

"We want to move forward and actually live our lives a little bit. We don't want this to be our lives … we want to move on. It's difficult; you're stuck. You lose whatever you do. We feel like we're not doing H justice or we're not doing ourselves justice. Whatever you do, you can't win."

This chapter describes the wider experiences of the families beyond the clinical outcomes described in Chapter 2. It identifies six common themes:

1. Not being listened to or consulted with

2. Encountering a lack of kindness and compassion

3. Being conscious of unprofessional conduct or poor working relationships compromising their care

4. Feeling excluded during and immediately after a serious event

5. Feeling ignored, marginalised or disparaged after a serious event

6. Being forced to live with an incomplete or inaccurate narrative.

Illustrative cases show how these themes featured in individual situations. These are just a few of the many accounts that we heard. The Panel has been struck by the extent to which there has been a deep impact on the wellbeing of families that continues to this day, sometimes many years after the birth. This is described towards the end of the chapter.

Introduction

3.1 In this chapter, we set out what we learned from the families we spoke to about what was important to them while they were under the care of East Kent Hospitals University NHS Foundation Trust (the Trust); how they felt they were treated by the midwives, doctors and others who looked after them; and in what ways they felt let down. It should be said that, among the stories of individual and systemic failures, there were also examples of good care by individuals, as well as compassion and kindness.

3.2 Our starting point for the Investigation, and a core principle underpinning our work, was an acknowledgement that the experiences of women and their families were key to our gaining an understanding of what was happening in the Trust's maternity services during the period under scrutiny.

3.3 Equally important was the Panel's undertaking to carry out an expert clinical review of what had happened in each case, including selected interviews with staff. The Panel's meetings with families, referred to as family listening sessions and described below, provided the contextual information and a sense of families' own experiences. Both these were invaluable to the Panel in its later review of individual clinical notes and its ability to make broader judgements about women's clinical care and any consequences.

How we engaged

Family listening sessions

3.4 The women and their families were a primary source of evidence. In family listening sessions with Panel members, they shared their knowledge, experience and perceptions of the care they received, often providing poignant and moving descriptions of their treatment by those responsible for their care, in whom they had placed their trust. This process was sometimes difficult and painful and we are indebted to them for their courage and willingness to engage fully with the Investigation. Their accounts tell us much about the Trust's culture and organisational values throughout the period under scrutiny, as practised rather than espoused: in other words, the gap between what the Trust said it did and what it actually did. We believe that this gap itself contributed to the poor outcomes experienced by the women and their families who participated in our Investigation.

3.5 It is important to acknowledge the experiences of the husbands and partners whose contributions, in themselves, have been invaluable. Not only have they had to deal with their own sense of pain and personal loss, but they have also had to provide ongoing care and support to their wives and partners, many of whom continue to have difficulties. In addition, some of our couples have experienced relationship difficulties – particularly around intimacy – greater than those that might be expected following a normal pregnancy and birth, and continue to do so.

3.6 Every family was given the opportunity to meet members of the Panel in a family listening session, either by video (an imperative in the early months of the Investigation because of the Covid-19 pandemic) or, if they wished and it was possible, in person. Our early reservations about using video for such sensitive encounters were soon allayed, as the benefits of allowing people to contribute from the safety and security of their own homes became apparent and, without exception, they spoke freely and candidly about what had happened to them.

3.7 We were also careful to correlate what we heard in family listening sessions with what was recorded in the clinical notes in each case and, where necessary, to interview relevant staff about the events.

Trauma-informed counselling

3.8 Mindful of the additional anxiety and distress that might be caused to them by having to recount and possibly relive their experiences, we offered each family the opportunity to attend a session with an expert counsellor.

3.9 Like many who have experienced trauma, our women and families frequently described a sense of not being able to cope or to live their lives as they had before because of what had happened to them. The aim of our counselling was to support families as well as possible after they had relived their experiences with the Panel, seeking to increase their personal confidence in making decisions about how to manage the impact of the harm done to them. The counselling was the start of this process for some, while others were further on in their journey. For all, it was an opportunity to reflect and take stock.

3.10 We were struck by how many families took up the offer of counselling as a result of participating in a family listening session. We believe this, in itself, is a sign that these families had experienced a significant effect on their wellbeing. In total, 54 families (more than a quarter) attended counselling sessions, some more than once. In some cases, families were signposted to other counselling services for further suitable support.

Themes and behaviours

3.11 Putting aside issues relating to the technical aspects of clinical care, which are covered in Chapter 2, there are a number of overarching themes that characterise the experience of the participating families. This is particularly concerning, given that the cases span an 11-year period up to as recently as 2020. It suggests that the themes are symptomatic of deep-rooted and endemic cultural problems across the Trust, which continue to hamper staff and compromise the safety of maternity services.

3.12 Although there are overlaps across the range of themes in this context, they can be grouped into those that feature in the period up to and immediately after birth, and those that relate to families' experiences after a poor outcome.

3.13 From our analysis, each theme can be characterised by particular indicative behaviours. We believe these have been detrimental to the quality and safety of the care given to women, and to the overall experience of them and their families (see Table 5).

Table 5: Themes arising from family listening sessions

Theme: experience of women and their families	Indicative behaviours of staff
1. Not being listened to or consulted with	• Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation • Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care • Failing to keep accurate notes about what women themselves were saying and how they were feeling
2. Encountering a lack of kindness and compassion	• Showing a basic lack of kindness, care and understanding to women and their families • Making unkind or insensitive comments to women and their partners • Showing an indifference to women's pain • Failing to ensure or preserve women's dignity or provide for their basic needs • Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event • Putting pressure on families to consent to a post-mortem examination
3. Being conscious of unprofessional conduct or poor working relationships compromising their care	• Making rude, inappropriate or offensive comments to women and their partners • Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care • Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages • Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services • Shifting the blame for a poor outcome onto colleagues
4. Feeling excluded during and immediately after a serious event	• Not being told what was happening, or what had happened, when things went wrong • Leaving family members waiting and anxious for news

Theme: experience of women and their families	Indicative behaviours of staff
5. Feeling ignored, marginalised or disparaged after a serious event	• A collective failure to be open and honest or to comply with the duty of candour • A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints • A tendency for the Trust to fail to take responsibility for errors or to show accountability • A failure to provide adequate follow-up support, including appropriate counselling
6. Being forced to live with an incomplete or inaccurate narrative	• Blaming women and families, or making them feel to blame, for what had happened to their baby • Not giving women and their families answers or reasons for why things had gone wrong

3.14 Each of these themes is considered in turn in the following pages. We have included a selection of illustrative cases and direct quotations from families relating to each theme, to add weight to our findings and because they speak for themselves.

3.15 It was common for families to experience behaviours spanning the range of the themes we identified, which had an additional and cumulative impact on them. A more in-depth illustrative case is included later in the chapter to demonstrate this.

Theme 1: Not being listened to or consulted with

3.16 As in previous investigations into maternity services, we have found strong evidence at East Kent maternity services of a failure to listen to women and their families.

3.17 We saw in Chapter 2 that not listening to women and their partners risks there being a poor clinical outcome, with the Panel finding examples of a clear link between a failure by clinical staff to take notice of women's concerns and the poor outcome they experienced. However, this recurring theme emerged from our review not just as one that had potential clinical consequences, but as one that had a broader and deeper impact on the families concerned.

3.18 Not being listened to or not feeling that they were involved in decisions about their care undermined women's confidence in those providing that care and caused them to feel uncared for and, in some cases, unsafe. This was particularly the case when the woman was aware that she was high risk or had been told by a doctor that her pregnancy was considered to be high risk.

3.19 This "not being listened to" took several forms. We saw a pattern of women, particularly first-time mothers, being made to feel patronised and demeaned when their concerns were dismissed as overreactions and unnecessary anxieties based on "first-time nerves". There were women whose concerns about the wellbeing of their unborn babies were ignored; and women on their second or later pregnancies whose personal knowledge, experience and understanding of their own bodies informed their convictions that something was wrong, but whose concerns were either ignored or dismissed. There were also women whose legitimate concerns about their newborn babies were not taken seriously.

Indicative behaviour: Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation

3.20 We heard about:

- Women's feelings or concerns about their symptoms being dismissed:
  - *"A lot of it was that no one listened, every time I went to hospital. If they had, it might have been a very different outcome."*
  - *"I know I haven't had a baby before but this is my body and I know what's going on, and this doesn't feel right, this doesn't feel safe. I was expecting to be in pain, I'm not stupid, but this feels unsafe, this amount of pain; and being told, 'you've never had a baby before, I don't know what you expected'."*
  - *"I was saying 'look, I'm really swollen', but they didn't listen, they didn't take on board the things I was pointing out."*
- Women's concerns about reduced fetal movements being ignored:
  - *"I just wish so hard that when I went and said she was not moving the way she should be, that if they'd listened to me seriously …"*
  - *"I had gone into day care with reduced movements; having had babies before, I knew that was a big no-no and I was shocked really, the whole approach was very dismissive, I felt like I was wasting their time for being there."*
  - *"The last thing I wanted was to be sat at the hospital, when I already had a three-year-old at home. I wasn't there to waste their time. I was there because I thought something was genuinely wrong. Even if there was nothing wrong, and I was just being neurotic, they still could have done things to support you rather than just be completely dismissive … There were so many things that could have been different, that would have helped me feel like I wasn't going completely mad and maybe prevented the outcome."*
- Women's assertions that they were in labour or that their waters had broken being dismissed:
  - *"My waters went at 18 weeks and I went to* [the hospital] *and told them and the whole time I was there, they just told me that they hadn't gone and I was like 'I think they have' but they didn't believe me at all; I think it was that night that they did a scan, and it came back that my waters had gone, so quite a distressing time, and all I was told was 'it's not too late to have an abortion if you want to'; the whole day, the whole night, that's all they kept offering me."*
  - *"My waters broke when I came out of the shower and I mentioned it to the nurse, and she was quite dismissive of it, thinking it was just water from the shower dripping off my body … and I don't feel that anything was picked up then; obviously now, looking back, that was really key, for me to be monitored after that particular time."*
  - *"I was in a side room on a bed waiting for obs, but as I stood up, there was this big gush, you know, like water, and they told me I'd weed myself; and I said, look, I have not weed myself, I'm so sure this is my waters gone, I would know if I'd weed myself … again, I'm still being dismissed."*

- Women's concerns about the progress of their labour or the delivery of their baby being dismissed:
  - *"No one was trying to make the situation any better, apart from telling me that I was doing it wrong, and I wasn't doing enough to get the baby out … I didn't feel supported by anyone in the room or that anyone really cared when I was telling them 'my body is telling me this isn't going to happen'."*

- Women's concerns about their newborn babies being disregarded:
  - *"I felt everyone was quite patronising and playing it down and we were trying to tell them that something was wrong … We could see the deterioration. We never saw the same midwife. When he didn't open his eyes, I spoke to two midwives, one said to the other 'first-time parents'."*

Indicative behaviour: Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care

3.21 We heard about:

- Women being left frightened or uncertain because of a failure to communicate with them effectively:
  - *"We weren't really told much but I was told that sepsis is the main killer of babies and as a new mum I was petrified."*
  - *"No-one was telling me what was actually going on, they were just telling me what they were doing. They weren't explaining things. I was clueless."*
  - *"Although they tell you things, they don't tell you things how you need to hear them."*
  - *"Every time I tried to sit up, I was physically forced back, to lie back down. I was having flashes in my brain of old films about mental hospitals and things where people are forced to lie down and strapped in, and that's what it felt like especially with all the wires."*

- A failure by doctors and midwives to explain risks and ensure that women were fully informed, including when seeking consent:
  - *"Nobody talked through the risks of a VBAC* [vaginal birth after caesarean]*. Had I known, I would not have put my baby at risk and would have elected for a C-section … there was no discussion about any risks associated with VBAC induced pregnancies, or the fact that I was an older mum and overweight."*

- Women feeling patronised and that they were not getting answers to their questions:
  - *"Because of my age, I was 19, I think that made her feel she could get away with not explaining things to me; it was like she thought I was stupid and she knew better."*
  - *"She didn't give me any answers, which I think is a massive thing. If she had just explained her thought process, it would have helped so much."*
  - *"Above all, no matter how old you are, you should be listened to."*
  - *"My midwife wasn't interested in talking to me … she would just say just speak to your doctor or have you had a look on Google; but you want reassurance."*

- A reluctance of staff to discuss women's birth plans or to try to comply with their wishes:
  - *"I got the impression that the decision was made there and then, anything I thought was pretty silly because she's the nurse and she knows better than me, because I'm just the mother; I came out thinking that I was banging my head against a brick wall, she just wasn't listening."*
  - *"It was a battle to be heard from day one, it was 'I'm the clinician, I'll make the clinical decision'."*
  - *"I didn't think they could do things to you after you said 'no', but they did. It makes me scared to give birth in future; it makes me feel like I would end up giving birth at home with no one there because I'm so scared of midwives just doing what they want and not having my best interests and not listening."*
  - *"When I asked about alternatives to induction, I was met with 'if you don't get induced and if anything happens, it'll be your fault'."*
  - *"It very much felt like it was something being done to you, and not something we were involved with. 'This is what has to happen, and because it has to happen it doesn't matter what you think. This is what the list says we need to do.'"*

- Women feeling pressured about the mode of delivery:
  - *"The sister just looked at her and she said 'that's a swear word in my ward; we don't talk about C-sections in this ward, you'll be alright, you will be able to push this baby out'."*
  - *"It felt a little bit like the choices were out of my hands; as a patient, you know nothing and they know everything."*
  - *"I can't explain it, but I had this feeling that I wanted the babies to be delivered and I wanted a C-section; I asked the staff and was told we don't do C-sections because the mother is uncomfortable, it's not about the mother."*
  - *"They threatened me, it felt like, with a caesarean. 'If you can't be bothered to deliver this baby on your own, we'll have to do a caesarean. Is that really what you want out of this situation?' As if I was somehow being lazy, or just not doing what I needed to do."*
  - *"At one point, X said to her, 'hang on, why are you going to try forceps now when we've just agreed to a C-section? My wife has said she doesn't want forceps, she would much prefer a C-section.' Maybe we were being naïve that we had some sort of a say in this. She turned around and really snapped back and told* [him] *off saying, 'I'm the clinician, I'll make the clinical decision', and then stormed out."*

- Women being poorly communicated with and browbeaten to give consent in emergency situations:
  - *"That ultimatum on the operating table with someone stood over you with a scalpel in one hand was just like something from a horror film. It was so scary. These women who had been treating me, by this point I thought that they would do anything to me without consent."*
  - *"The doctors were rushing around, using words that made X anxious and she couldn't understand what they were saying. They wanted her to sign papers to say that she was happy to go to theatre, but she didn't understand what was happening or what she was signing. She was crying and shaking."*

- *"The doctor turned around to me and went 'you need to start thinking about your baby'. I wanted to know what was going to happen. I didn't know if they were planning for me to have a caesarean. I didn't know what I was signing for. I signed the form because I didn't want them to think I wasn't thinking about my baby."*
- *"I remember one of the midwives saying do you understand what's going on? And I just said, C-section … they didn't ask if it was ok to use forceps … and that's what they did. I didn't understand why they did it without asking … I felt violated."*

Indicative behaviour: Failing to keep accurate notes about what women themselves were saying and how they were feeling

3.22 We heard about:

- Women's concerns that their notes were inaccurate, with important aspects of their care missed out or incorrectly recorded:
  - *"So many times throughout the pregnancy I said I'm worried about this, I'm concerned about that, I'm not feeling great, but my notes just seem to say 'mother was happy'."*
  - *"They haven't written any epidural request, any caesarean request, any help request. Nothing. They just did their own thing."*
  - *"He* [the consultant] *went through my notes and said there is nothing in here that tells me about that* [dysphasia]*; and there was nothing in there that told him that her collarbone had broken and that we'd had an x ray – in her maternity notes – the slightly alarming thing for me is that, whatever happened, it hasn't been recorded in the notes. To me, that's alarming and it means that something's wrong."*

3.23 It is the Panel's estimation that, in a significant proportion of cases, this failure by midwives and doctors to listen to what women were telling them was a feature of the care experienced.

3.24 Overall, we found "not being listened to" to be part of a broader tendency of clinical staff to fail to engage women in the management of their care.

Theme 2: Encountering a lack of kindness and compassion

3.25 The Nursing and Midwifery Council publishes professional standards which govern the activities and behaviours of nurses and midwives. Its first standard is *"treat people with kindness, respect and compassion"*.[1] Similarly, the General Medical Council publishes professional standards that govern the activities and behaviours of doctors. It states: *"You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."*[2]

3.26 The public might expect that kindness and empathy would characterise maternity and neonatal services anyway, without reliance upon a professional standard. Given the long-standing existence of professional standards set by regulatory bodies and the legitimate expectations of patients and their families, it is all the more concerning that lack of kindness and empathy features so heavily in our families' accounts. We heard about behaviours of both midwives and doctors that fell some way short of those expected standards and legitimate expectations. In fact, in a majority of cases, families described aspects of their care that they felt were the result of unkindness and a lack of compassion and empathy.

Indicative behaviour: Showing a basic lack of kindness, care and understanding to women and their families

3.27 We heard about:

- Women and families who felt uncared for and unwanted by doctors and midwives:
  - *"They are meant to be there for you … I was a first-time mum; I was worried and I didn't know how it all worked. It was unbelievable how I was treated."*
  - *"There were so many failures that it's hard to sum up … It wasn't even the physical medical things that happened … it was the treatment from the people, the way we were treated, the way we were spoken to, with no human decency whatsoever, no bedside manner, no consistency, no continuity of care, the list goes on and on. And I think that is the culture, that is the culture there. It is this conveyor belt, where they are so immune to it, they forget that the women are even there."*
  - *"If they had just cared, it would have made the blow a little less; a bit of support, a hug, just something, but there was nothing. It was really hard."*
  - *"I came away from the experience very scared and humiliated. That's what I took away from the experience of childbirth."*
  - *"The care for my son was second to none. The care for me was diabolical."*
  - *"I'm a carer and if I had acted like some of the midwives I would have been taken into the office and disciplined."*
  - *"It just felt like a really lonely and traumatic experience, which I feel like maybe if it had been a more experienced midwife or someone else there, that I would have got that reassurance and encouragement that is really important when you're having a baby, let alone in traumatic circumstances."*
  - *"I felt like I was a nuisance."*

- An apparent lack of awareness or a failure to take account of pre-existing mental health conditions or personal histories which made women particularly vulnerable to feelings of fear or anxiety:
  - *"The feelings are so similar to the sexual abuse but this time I'm left with a physical disfigurement as well as the mental side of it."*
  - *"They were going to do an internal; I am a survivor of childhood sexual abuse and it was a male midwife and a male doctor; it's making me sweat just thinking about it … it was horrible."*
  - *"I used to suffer with mental health issues … that was in my notes with my first pregnancy and it went on my notes for my second but my community midwife, who I have to say has been amazing afterwards, she did take it off my notes at one of my appointments and that's concerning for me actually now, looking back … I did bring it up with* [name]*, one of the midwives at the hospital, she did go away and speak to a doctor, who she said said to her, just put her on Sertraline … and I don't want to go back on tablets, I spent a long time coming off tablets."*

- The needs of family members not being met, and in particular a tendency to leave people waiting, knowing that something has gone wrong but not being given any information:
  - *"X was taken back to theatre and I went to the ward to find the rest of the family and the new baby. They had been told to wait in a four-bedded bay; they were standing*

in the space where X's bed would have been, huddled together and crying behind the curtains, surrounded by the three other women in that ward and their babies."

- *"No one said anything to me … I think at that point it probably would have been better if I had been told, look, there is something serious, given I could have probably switched into a more supportive role … I always look back and feel quite guilty that at that time I wasn't supportive enough and actually I was sitting there and I was just questioning everything and thinking well maybe I'm just being overly worried here and there is nothing. I would probably have preferred to have known at that point"* [the reflections of a woman's partner recalling the moment he realised that their baby was ill; it was several hours later that they were told the gravity of the situation].

- Women or their partners calling for help and feeling ignored when no one came:
  - *"Within minutes, I began to feel very unwell and began shaking violently and vomiting. We pressed the emergency buzzer, but no one came. X* [her partner] *then went out into the corridor to try to find someone to help, but could not find anyone, so was left to deal with the situation alone."*

Indicative behaviour: Making unkind or insensitive comments to women and their partners

3.28 We heard about:

- Women and family members feeling patronised, being ignored or "told off", or being subject to hurtful remarks:
  - *"Some parents just aren't supposed to have children"* [a woman recalling the comments of a doctor].
  - *"I was told at one point it was because I was fat. It wasn't even beating around the bush, saying 'because of your weight' or anything like that: it was 'well, because you're fat, that's how it is and we have to do different things'."*

- Women feeling that they were unimportant and too much trouble:
  - *"She said sorry for your loss, but our baby was dead and there were other babies who were still living that she needed to attend to."*
  - *"We have more important people on this ward, you are not the only one who is in need at this point"* [a woman recalling the comments of a midwife made to her while she was waiting for a blood transfusion].
  - *"They would make me feel terrible … every time I went, they would make me feel like I shouldn't be there."*

Indicative behaviour: Showing an indifference to women's pain

3.29 We heard about:

- Women in acute pain feeling ignored and being left without appropriate pain relief, their pain sometimes being dismissed:
  - *"I wanted to die, I was in so much pain."*

  - *"The pain was horrific pain but the midwives who examined me said I was fine. I was in so much pain that I couldn't place my feet flat on the floor, but they just told me I was doing well. I felt like nobody was listening to me and they couldn't be bothered."*
  - *"She said 'you'll have to wait, I'm busy, I've got other things to do'; and I waited two hours, I spent two hours crying in pain before I rang the bell again because I was too scared, in case she started having a go at me again."*
  - *"People give birth in Africa in mud huts without pain relief"* [a woman recalling the comments of a midwife made to her during her labour].
  - *"I still have nightmares to this day, of feeling that pain so vividly."*

- Women feeling pain because of a failed epidural or spinal,* or one that was wearing off:
  - *"He came and did these manual evacuations; my spinal had started to wear off a bit and he was going up with his hand right into my uterus and pulling out all the clots it was the most painful thing I've ever experienced in my whole life … he was looking at me and said to me, Oh, is that painful? And I was like, yeah, your hand's right up there, my spinal's wearing off and I've just had surgery ... He didn't seem to have any feeling … The midwife said to me oh my God, they were looking horrified; they couldn't hide their looks"* [a woman describing how a registrar proceeded with manual evacuation of placental tissue as her spinal was starting to wear off].
  - *"I lay down on the table and they started to do the cold spray, straight away I could feel it … I kept saying I can feel this … they didn't listen to me, I said this about four or five times to the team, I can feel this, it's not right. They didn't listen … They carried on, obviously, to cut me open. I could feel it all. My left side was slightly numb, I could feel everything on my right side. I felt the knife going in; I started to get hot and I could feel the blood draining from my face. I started to really panic and remember trying to push them off me … I felt everything from there on, it was just an absolute nightmare."*

Indicative behaviour: Failing to ensure or preserve women's dignity or provide for their basic needs

3.30 We heard about:

- Women not being able to be accommodated in the labour ward:
  - *"I was told we have no beds and you'll need to wait in the day care waiting area; I had a really bad feeling at that point and burst into tears … nobody reassured me, I felt like there was no sympathy or empathy expressed by anyone. I was told sorry, that's the only place we've got for you, so I sat out there all day. That's basically where I sat for the rest of my time, until I had my daughter at about 4.00 in the afternoon … from 7.00 in the morning, I had been looked at, assessed once … they asked my partner to hold her so she didn't fall to the floor, because I was standing up. There were no midwives around, they had to go and find somebody … I had to ask for blankets … there was no dignity, I had to ask somebody to cover me up."*

* "Epidural" and "spinal" refer to forms of pain relief often used in labour or for obstetric procedures, involving an injection of anaesthetic around the nerve roots.

- Women's distress at their dignity not being preserved, for example by them being left for long periods in soiled bedding or in ward areas which did not provide for their privacy:
  - *"My blood was up the walls, on the ceiling; my sheets weren't changed."*
  - *"I know that doctors and midwives need to come and go, but the door was left open quite a few times, which was not very nice; there was no privacy – I think everyone in that hospital saw me in that bed. That was awful."*

Indicative behaviour: Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event

3.31 We heard about:

- The impact of the limitations of the two hospitals' premises on women who had just lost their babies, which meant they were placed in wards among other mothers with their newborns or had to carry their babies' bodies to other areas:
  - *"It is soul destroying to hear the cries of healthy babies being born knowing that your baby will be born silent."*
  - *"Spending about 24 hours on the labour ward listening to other babies crying was hell on earth."*
  - *"It didn't make it easy for us; having to come out and see lots of happiness and we were going through the worst point ever."*
  - *"As I stepped outside, one of the mums from the nursery next door came up to me and said 'oh, how's he doing', and I looked at her and said 'he's dead'. That should never have happened, for her."*
  - *"They were walking the same way we were going, turning around, staring. That will haunt me for the rest of my life because they knew I was carrying a baby that was not here. They were just watching me the entire time, walk through the corridor. She said to her husband, as I passed them, 'she's carrying a dead baby'. It was awful."*

Indicative behaviour: Putting pressure on families to consent to a post-mortem examination

3.32 We heard about:

- Newly bereaved parents feeling under pressure to consent to a post-mortem examination of their infant:
  - *"The pressure is unreal, for everything. Hours after we delivered him, they're there, 'do you want a post-mortem?'. This is stuff that I have never even thought to have done, and you're bombarding me with these questions."*
  - *"They wanted to know if we were happy for them to do a post-mortem and we were like, no, we don't want to have one, we don't want it to happen … but they were like, ok, but it will really help other parents if you have one, and we were like, please do not ask, we do not want one … and the next day, they asked us again, and we said we've already decided, do not ask us again, we do not want one, and we had to be quite firm … that was quite hard because we felt they were pushing us into it."*

Illustrative Case P

At 29 weeks pregnant, P began to feel unwell with abdominal pains. She called maternity day care and was told to attend for observation and cardiotocography (monitoring of the baby's heartbeat). She told the midwife it felt like she was having contractions but the midwife was dismissive, saying it would be a urine infection and the doctor would give her antibiotics and send her home. P believed the midwife, despite her concerns.

Two hours later, P noticed that she was bleeding and, on examination, was found to be in labour. Baby P was delivered by caesarean section. After initially making good progress, the baby developed a severe infection and his condition worsened.

After ten days, a doctor informed P and her partner that treatment had failed and nothing further could be done.

"[They were] *so blasé,* [they] *got the ultrasound scan and literally just said yes, that's infected, that's infected, his brain's covered in this, his heart's covered in that; I'll come back at ten o'clock when I've done my rounds and take the tubes out."*

Afterwards, P sat with her dead baby in her arms with the other parents in the room listening to her *"howl from her soul"*.

Illustrative Case Q

At 17 weeks pregnant and bleeding heavily, Q was told to attend the maternity department. The person on reception was busy making arrangements to deliver a cake and made her wait. Placenta praevia was diagnosed and Q required an overnight stay.

Afterwards, at home, the bleeding resumed and Q found herself back in hospital. Suffering from a headache and feeling extremely thirsty, she called the midwife, who – in front of all those in the ward – said, *"Aren't you the woman who's going to have an abortion?"* Q was distraught: she had been told when she was first admitted that the viability of her pregnancy might be in question because of the heavy bleeding, but nobody had told her that she was at that stage.

A few hours later a consultant attended, who told her there had been a mistake, the midwife should not have spoken to her in that way and she had no need to worry. On her fifth day in hospital, Q was discharged and told to reschedule her 20-week scan, due in two weeks, because she was high priority. However, when she tried to bring the appointment forward, she was told this could not be done.

For the next three weeks, Q stayed at home, bleeding and suffering from headaches, scared of being a nuisance. She finally returned to the hospital and a scan revealed the presence of two large haematomas. After a week in hospital, she haemorrhaged and woke in theatre to confusion and panic. A consultant was present but there was no anaesthetist and there was a delay in obtaining the blood necessary for a transfusion.

Q's baby had not survived and she required a hysterectomy to control the bleeding; the consultant told her that, in their 30-year career, they had never had to perform one in such circumstances. The midwives told Q's husband: *"We're not set up for this, we haven't got the procedures."*

3.33 What the Panel has learned from its interviews with Trust staff is described in Chapter 4, so will not be covered here. However, we found evidence that the prevalent culture in the Trust has tolerated and fostered the unkind, uncompassionate and intolerant behaviours sometimes experienced by women and their families.

Theme 3: Being conscious of unprofessional conduct or poor working relationships compromising their care

3.34 Team conflicts pose a potential threat to the quality of relationships and communication between patients and staff, as well as to the quality of care. They can also make patients feel unsafe when they perceive that staff are not communicating with each other or working as a team. It is therefore unsurprising that a lack of teamwork and a failure to share information featured in the family listening sessions as matters of concern to the women and families who spoke to us.

3.35 We heard accounts of unprofessional conduct that were alarming to women and their families because they undermined their confidence in the doctors and midwives looking after them and, in some cases, made them question the safety of their care. For one family, these concerns were compounded by the comments of a consultant, overheard in a patient area, who was discussing with a colleague how unsafe the unit was and how they had reported it to senior management but had given up trying to raise it.

Indicative behaviour: Making rude, inappropriate or offensive comments to women and their partners

3.36 We heard about:

- Women or their partners being on the receiving end of inappropriate and unprofessional comments, which they found hurtful or offensive:
  - *"She's making the wrong call here, and it's going to be your wife's fault when it all goes wrong"* [a woman's husband recalling the comments of a midwife].
  - "[They're] *all over the place because* [they've] *just come back from a cruise"* [a woman recalling the comments of a consultant about a colleague].
  - *"Is she normally this dramatic with pain?"* [a woman's husband recalling the comments of a consultant].
  - *"I don't have time for this. I have to get to Canterbury and the parking is bad"* [a woman recalling the comments of a consultant made during a consultation].
  - *"Under no circumstances can you leave this room. If you do, you are putting your unborn child at risk … on your head be it"* [a woman recalling the comments of a consultant].

Indicative behaviour: Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care

3.37 We heard about:

- Midwives complaining about doctors and other midwives behind their backs:
  - In one case, midwives referred to a consultant as having a *"God complex"*.

- Midwives ignoring the advice of doctors and taking contrary action:
  - *"I don't agree with that, this is what we're going to do"* [a woman recalling the comments of a midwife made after a consultant had explained their plan for her care and left the room].

- Doctors showing disregard for their midwife colleagues:
  - "[They] *told the midwives off in front of me."*

- Doctors disagreeing within earshot of women and their families:
  - *"Don't you dare argue this with a patient, this isn't appropriate or professional"* [a woman recalling comments made by a consultant to a colleague, disagreeing about a baby's transfer to the bereavement suite].

- Women being told "on the quiet" that their care had been substandard and they shouldn't accept it:
  - *"There are things that should have been done differently. If you were a member of my family, I would not be happy with the care that you've had"* [a woman recalling the comments of a midwife after a bladder injury during a caesarean section].

3.38 In some cases, these behaviours reflected poor working relationships within and across professional groups. This theme is picked up below in reference to teamworking and information sharing, and in Chapter 4 on what we heard from staff. In any event, the impact of such behaviours on the women who witnessed them was such that they featured heavily in their accounts of what they experienced at the Trust. This laid bare for the Panel the extent and pervasive nature of the poor behaviours and teamworking in both maternity units, which the senior team failed to address with any degree of success.

Indicative behaviour: Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages

3.39 We heard about:

- Doctors and midwives contradicting each other or disagreeing in the presence of women, which caused the women anxiety and made them lose confidence in their care:
  - *"I'm not dealing with this, I'm not going to be here while you do this"* [a woman recalling the comments of a midwife made to two consultants who were about to break her waters].
  - *"Women and their families are set up for misunderstanding. You're on the back foot and need to reinterpret what you've been told."*
  - *"In hindsight, it's easy to see there was a bit of a tug-of-war between the midwives and the registrar."*
  - *"The consultant came to see me and said that they wanted to keep me in overnight, and the midwife sent me home about an hour later. And the consultant had written in my notes that they wanted to keep me in overnight and the midwife sent me home, and there were no notes after that to say why. I had no explanation. They just sent me home."*

Indicative behaviour: Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services

3.40 We heard about:

- Failures to provide sufficient information at handover, or to document information in the notes at shift change alerting staff to a possible risk to mother or baby, resulting in poor continuity of care and compromising safety:
  - *"The shift changes were shocking, there was no communication between teams; the new team didn't have a clue what we had been through during the previous three days."*
  - *"Communication seemed to be the biggest issue on that day … the night shift didn't hand over all the details … there was the potential there to record some things that would have made it an amber alert but it was ten hours before we finally got those antibiotics, which in my opinion was too late."*
- A failure to pass on information to colleagues and teams, including to the delivery ward or community midwives, resulting in upsetting interventions by staff following the death of an infant:
  - *"Calm down everyone, you're going to have a baby today"* [a woman recalling the comments of a midwife made in the delivery suite prior to the planned delivery of her stillborn baby].
  - *"There's no loop, no one communicated properly … they didn't even think to tell my midwife that my baby had died, it took me to do everything …* [they] *signed me up for groups for after I'd had R, being a young mum, and I got letters in the post from them inviting me to mums' groups, because nobody told them that my son had died."*

Indicative behaviour: Shifting the blame for a poor outcome onto colleagues

3.41 We heard about:

- Doctors and midwives trying to abdicate responsibility to others or shift the blame when things had gone wrong:
  - *"You could feel this cultural thing going on, where the consultants were saying 'no, no, no, it's the midwives' and the midwives were saying 'no, it's not us'; and immediately, we got this little window into what was actually going on there."*
  - *"We got taken to this tiny little box room and she just kept saying the whole time, 'as long as you know, it is not our fault. It is no-one's fault. It is just one of those things.'"*

Illustrative Case R

R was pregnant with twins. At her 20-week scan, slight ventriculomegaly (enlargement of the ventricles of the brain) was apparent in twin one, and this had become severe by her 24-week scan.

The consultant told R and her partner there was a 95% chance that twin one would be severely disabled, and it was likely that the other baby would be as well. The consultant also told the couple that they were being unfair on their older children by continuing the pregnancy and that termination of the entire pregnancy was recommended, as it was not viable.

Even though they believed it was no one's decision but their own, the couple felt they would be going against medical advice if they chose to continue with the pregnancy. They were referred to King's College Hospital in London where the range of possible outcomes was discussed, including a positive outcome. They were also told that selective termination of just one twin was an option; this had not been communicated to them before.

The couple moved areas and within a few weeks R had her first appointment at the local hospital. The perinatal and obstetrics and gynaecology consultants advised her that there was a possibility of complications, but that this wasn't guaranteed and every baby should be given a chance. The couple felt that they were being treated as intelligent people who were competent to make their own decisions.

The following week, R had a bleed and was admitted. After a month as an inpatient, she delivered two baby girls by caesarean section. Although one required resuscitation, the twins were both well and continue to thrive.

Illustrative Case S

Towards the end of an uneventful pregnancy, S developed a rash on her body, the cause of which could not be determined, and a decision was made for labour to be induced. The date was set and, early that morning, she called the hospital to check that she should come in. She was told that there were no beds available and to call back later.

Around 20 minutes later, S's waters broke; she called the hospital again and was advised to go to a neighbouring clinic to be checked. From the clinic, she was sent to hospital for additional monitoring, where it was confirmed that the baby's heart rate was slow, but she was wrongly told this was not a cause for concern.

S was sent home to allow labour to develop. That evening, having not felt her baby move for a while, she called the hospital again and was told to attend. She arrived as the night shift changeover was taking place. She was checked and found to be having contractions, but her labour was not progressing. S was attended by a student midwife, who applied Prostin gel to speed up her labour, and arranged for a birthing pool. The student midwife told S that it was likely she would end up having a caesarean section as her waters had broken more than 24 hours previously and her labour was not progressing.

Soon after, S was attended by a different midwife, who disagreed that a caesarean section would be necessary. S was given an epidural and labour augmented with Syntocinon; however, she felt very unwell as a result, and was shaking and vomiting.

The day shift ended, and S's care was handed over to a senior midwife, who told her that she had been left in a *"ridiculous"* situation and that she shouldn't have been kept on a drip, which clearly wasn't working as she was still in the same state of labour as she had been that morning, but was now exhausted and unwell.

Because labour was not progressing, a decision was made that delivery should be by caesarean section. S's epidural was topped up in preparation, but she felt very unwell again. No one seemed concerned or acknowledged that this was the second episode of these symptoms. One of the surgical team said: *"It happens, sometimes people are sick."*

Theme 4: Feeling excluded during and immediately after a serious event

3.42 In several cases, women became aware that something was going wrong in the course of their care, either as it was happening or shortly afterwards. They described a lack of compassion and a sense of being excluded as events unfolded or in the immediate aftermath. Sometimes, this failure to inform and consult them about a deteriorating situation extended to the woman's partner and other family members, who were left waiting for long periods in a state of ignorance and growing anxiety and fear.

Indicative behaviour: Not being told what was happening, or what had happened, when things went wrong

3.43 We heard about:

- Women and their partners or family members not being informed what was happening as events were unfolding:
  - *"No one talked to me at all through the operation … I had the spinal block and no one told me what was happening. I was asking questions constantly … I was trying to make sure that I stayed conscious so I could remember everything, and no one told me what was going on. I kept on peeking up and they kept on telling me to lie down. I just saw them covered in blood, up to their elbows covered in blood, having conversations about me saying, 'oh that's bad, that's bad, that's bad', but not telling me what was going on … I was 100% sure I was going to die."*
  - *"My daughter went one way, my wife went the other, and I was left on my own, not knowing if my wife was alive or my daughter was going to be alive at the end of the day."*
  - *"I was just left for so long to my own devices. When the doctor came in, it was like no one wanted to tell me that he had died. They waited for me to go down to ultrasound, but by this point I knew something was up. I used to find* [his heartbeat] *at home on my own so I knew something wasn't right, but nobody was telling me."*

Indicative behaviour: Leaving family members waiting and anxious for news

3.44 We heard about:

- Women and their partners or family members not being informed after a serious event about what had happened:

- *"When I came around in recovery, I kept saying to them, 'where is he, where's my baby'. Nobody would look at me, nobody would tell me anything. It was only when X came in and I saw his face that I knew he was gone. They knew there and then that things had been done badly, because they wouldn't even look at me."*
- *"What was really strange, and what I really didn't understand, is that no one was really willing to tell me anything, to explain to me what happened. They were really vague, and you would get different versions depending on what doctor you spoke to."*

Illustrative Case T

T had had three previous caesarean sections and knew what to expect, but her reception at the hospital unsettled her. She and her partner found the surgeon arrogant, rude and unreceptive to questions, though the anaesthetist was more reassuring.

T was given pain relief and a screen was put up, but no one provided any explanation about the procedure and T wasn't even aware when it had started. Then, as the baby was delivered, a midwife leaned over and said: *"I'm really sorry the paediatrician is not here yet, but he will be here."* T didn't know what to make of that.

The infant was born translucent, pale and white. He was taken away and T knew that something was wrong. She asked what was going on and what had happened, but was not given any information other than that it was a *"freak of nature"*, an *"accident"*.

It was nearly an hour before T was able to hold her baby. When he was put into her arms, she was shocked at his pallor. He was then taken for a blood transfusion. T asked for information and was told that the clinicians had cut through the placenta; she knew there had been a ten-minute gap between knife to skin and the baby being delivered, and felt panic at the thought that he had been without oxygen for ten minutes.

The hospital staff said they had performed a computerised tomography (CT) scan and the baby's brain was fine, but T was worried about the possibility of brain damage. She kept asking if he was OK and was told that he had been given a CT scan which had come back clear. She later found out from her notes that he had received a cranial ultrasound, not a CT scan. After discharge, T contacted the hospital to inform them that her baby was *"juddery"* and his eyes weren't right; she was told *"boys are lazy"*.

At the two-month check-up, T asked whether the ultrasound would definitely have detected damage and was told by the sonographer that this was not necessarily so. With a great deal of effort, T managed to secure a magnetic resonance imaging scan for her baby. The couple were informed on the telephone that their baby had suffered a cerebral infarction. They attended the William Harvey Hospital in Ashford (WHH) to see the scan and were shocked at the very large area of baby T's brain that had been affected. They asked how extensive the damage was and were told *"work it out yourself"*. The hospital has never provided an account of what happened.

Theme 5: Feeling ignored, marginalised or disparaged after a serious event

3.45 As well as their frustration and anger about not being informed as events unfolded, families described a range of experiences of the Trust's investigations process that followed. Some felt that the process had been reasonably open and fair, while others felt deeply distressed and aggrieved by it. Sometimes, where there had been a very serious adverse outcome, families lacked information about what to expect and what processes should and would be

followed, including how they would be involved. In general, there appears to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place.

3.46 We also heard about the downgrading of incidents without proper explanation, and families' concerns about deaths that should have been reported to the coroner but were not.

3.47 It is clear to the Panel that this failure to engage with women and their families after a serious event – or to do so in a manner that did not take into account either their distress or their concerns about their care, or to provide appropriate and timely support – caused them additional harm. These types of responses, illustrated by the indicative behaviours for this theme, made it harder for women and their families to work towards regaining a sense of being able to cope or to return to the kind of lives they had prior to what happened to them.

Indicative behaviour: A collective failure to be open and honest or to comply with the duty of candour

3.48 At the time of writing this Report, it has been confirmed that, for some women, the Trust's failings have contributed to or caused the poor outcome experienced by them or their baby. In a few cases, this has been as a result of the Trust's own investigation; in others, it has followed a coroner's inquest or the interventions of a third party such as the Healthcare Safety Investigation Branch. However, there are many families who remain in the dark and who seek long overdue answers to their questions, as well as confirmation that any lessons learned have resulted in improvements.

3.49 We heard about:

- Failures to explain to women or their families what had happened or to apologise, and families being "fobbed off" when they sought answers to their questions:
  - *"When things go wrong, people should talk about it and learn. Nobody thought I was in labour, nobody said they had made a mistake, and these are the consequences."*
  - *"Although it was seven years ago for us, it is still burning in our hearts because we haven't had answers."*
  - *"WHH shut down to us, they were more concerned about us taking legal action than actually wanting to learn from A's death."*
  - *"We've heard lots of people say they knew the hospital was an unsafe place and the culture was wrong. When we complained about the basic things, like the cleaning of condemned mattresses,* [senior nurse] *said she was surprised, because the CQC* [Care Quality Commission] *were due and everywhere had been painted. It was like, we've done the painting, and it's all ok; like the Queen's coming to visit so we've done a bit of decorating."*
  - *"People think that we are on a witch hunt for the surgeon, but we are not that sort of family. We understand that things go wrong, but we are having a problem because they could have seen it from a different view."*

Indicative behaviour: A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints

3.50 We heard about:

- A poor complaints process, with responses to complaints sometimes not being received, defensiveness and a "pick and choose" approach to what was covered in complaint responses:
  - *"If it's a small company, you can go to the boss to complain that this has been terrible … With something as big as the NHS, you're fighting a losing battle."*
  - *"I had made suggestions in my complaint, and I had made it clear how wonderful the people were that had helped me. My complaint wasn't about the fact that this was maybe an error or a faulty device, my complaint was about the lying and blaming me and covering it up. That's what's really upset me about it."*
  - *"We wrote a measured complaint after some time, we didn't do it in raw emotion, we waited, and I think it was quite clear what we wanted out of it in terms of an apology and to know that things were going to improve and not just ignored or brushed under the carpet … it took three attempts to send that letter in before someone replied to us and in the end it took me writing to the CEO of the hospital Trust, just to get a reaction and acknowledge that we'd written the complaint … they went on to investigate it … and it took another six months before we had our meeting."*

Indicative behaviour: A tendency for the Trust to fail to take responsibility for errors or to show accountability

3.51 We heard about:

- A failure by the Trust to undertake robust investigations or to involve families:
  - *"People are investigating things by looking at the notes and we're the ones who were with her, who could hear what she was saying and all the texts on her phone saying no one's listening to me, everyone's acting like it's normal to feel like this."*

- Delays in completing internal investigations, a defensive approach, and a reluctance to involve families, keep them informed of progress or report back to them, sometimes resulting in them fearing a cover-up:
  - *"It was literally like cloak and daggers, going round, trying to find out information and getting stuff from nurses who had put it by for us, who had photocopied things to try and give us the information we needed. We were getting no support from the management about anything at all."*
  - *"Every time at the hospital, it always seems like one person is covering up for the next; they are a team and they work together, but they shouldn't cover up when children are dying."*
  - *"Their attitude was 'we made a mistake, but it wasn't that bad, and it won't happen again'."*

- The ongoing concerns and experiences of women being consistently ignored and invalidated after the event:

- *"They did their investigation … I don't know whether it's ironic, but we got their response back, it was not good enough, I mean the response took over three months, but we got a response back the day before the Coroner's court, but it was very very short, it was almost like bullet points, and we were like this is not good enough, straight away. So then we did a timeline, we did every question possible and the potential answers and we sent it to them … so we are now waiting to see the response from that."*

- A failure to demonstrate that the Trust has learned from serious incidents:
  - *"I just want to put things right for mums and babies. I just want to see things get better. Without accountability you can't hold them to their promises and that's why we're here. I know people will promise you anything to get rid of you, but we really do need to get the accountability in order to get improvements – I don't want differences, I don't want changes, we want improvements."*
  - *"What I can't accept is that you refuse – you actively go out of your way to try and avoid learning from the situation, you actively try to cover it up, and that ultimately means it will happen again. That is something that I find unacceptable."*

Indicative behaviour: A failure to provide adequate follow-up support, including appropriate counselling

3.52 We heard about:

- Inconsistencies in the referral process to the Birth Afterthoughts service; when families were referred, they often found it unhelpful or even detrimental to their recovery:
  - *"That appointment was more hurtful than anything else. The lady was trying her best but she didn't have all the notes, some of the notes were in the wrong order. There were notes that contradicted each other … we just came out and cried."*
  - *"I asked for Birth Afterthoughts and was told that wasn't suitable because I had a complaint in process."*

- Poor and sporadic access to and quality of counselling for the mother, with non-existent provision for fathers; many families have resorted to sourcing counselling themselves:
  - *"There was no care, no support, it was very lonely."*
  - *"I just left there and thought this was the biggest waste of time ever. Because you don't really want to go back to that hospital anyway when something like that has recently happened, and to go there and they can't even get your name right or the baby's name right, or how far along you were in your pregnancy, it was insulting."*
  - *"It* [the follow-up] *was really, really bad. It was terrible. When they answered the phone, they didn't want to help, they didn't want to know anything about it."*
  - *"For my counselling after it, I put myself forward for the doctor … I didn't even really know I needed anything, and then I got myself in a really bad state one day and thought about harming myself and then I realised I needed help."*

- Failures of the bereavement service to provide an adequate and supportive response:
  - *"We asked to see the bereavement counsellor, and she refused to see us because we weren't having a funeral, she was like, well, there's nothing I can do for you."*

- *"I wanted to get some counselling, but the waiting times were months and months for those … I had a bereavement counsellor but because it was covid times, it was all over the phone and it was quite distanced and it was a very lonely time. I didn't really find the bereavement* [counselling] *terribly helpful … in the end it felt I was left to my own devices."*

3.53 Not being listened to, not being extended kindness and compassion, and feeling ignored or marginalised when accessing healthcare may leave patients who have uneventful care feeling insignificant and invisible. In those circumstances, it is not uncommon for patients to rationalise their responses as being the result of service pressures and to accept and normalise them.

3.54 However, when these responses occur after events that are traumatic, frightening or have a poor outcome, as was the case for families in our Investigation, there is an expectation that staff will do all they can to minimise any impact and will act with compassion and insight. When this does not happen, the impact is greater. We heard this in the accounts given by the women and their families, and saw it in their visible distress months and years after their experiences. They were left questioning why they were treated in such a manner and feeling diminished, powerless and even worthless, adding a layer of harm to what was already for many an almost unbearable event.

3.55 In common with other investigations, the trigger for regulatory scrutiny and the commissioning of this Independent Investigation came from individual families who had been failed by the Trust. It was their persistence and determination to get to the truth that has led us to where we are now. It is disappointing that families continue to have to do this to substitute for ineffective safety monitoring by trusts and regulators.

Theme 6: Being forced to live with an incomplete or inaccurate narrative

3.56 Many women were not party to the whole of their own or their baby's experience, due to being sedated, not being in the same room as their baby or simply being too unwell to remember parts of what happened. In the absence of full and frank information from Trust staff, this left a space that was filled by women and families trying to make sense of what had happened and how and why it had happened.

3.57 Being left with so many questions about events that they were unable to answer naturally led women and families to seek answers from the Trust. These answers were not always forthcoming, were only partial, or in some cases were misleading. We heard of internal investigations failing to get to grips with what had happened, so that no meaningful explanation could be provided. This led to families resorting to working through and trying to make sense of clinical notes in order to piece together what had happened, or to get answers to their questions. In doing so, they often found that how they had felt at the time and what they had been telling the doctors and midwives were not reflected in their notes, adding to their frustration and anxiety.

3.58 In addition, being blamed by individual doctors or midwives for aspects of events, or being made to feel to blame for what had happened to their baby and being unable to challenge hierarchical systems and individuals with professional knowledge, left our families living with "what ifs". This inevitably meant that they were forced to construct an uncertain or incomplete narrative about what had happened, due to the lack of facts, their sense of responsibility for events or simply the uncertainty with which they were left.

Indicative behaviour: Blaming women and families, or making them feel to blame, for what had happened to their baby

3.59 We heard about:

- Women and their partners being made to feel to blame and living with the guilt of believing that they were in some way responsible for the outcome or should have done more:
  - *"A member of staff said to me 'is there anything that you think you could have done better?', which stuck with me for months and months afterwards, I felt so guilty."*
  - *"As I'm sitting here talking about what other humans could have done more, I still also feel myself that I could have done more as his mother, and I'm sure his dad feels the same, but this is what you're left with."*
  - *"To cover it up, to cover herself rather than try to stop it happening again, by blaming mums, I think this is something that happens. I think this is an ingrained thing, and that does cause damage, psychological damage. I am still upset now talking about it, but my son is okay."*
  - *"The problems are ingrained, not listening to anyone and blaming the most vulnerable people at the most vulnerable time. They need to be doing the opposite of that. They need to be listening to the mums. They need to take accountability even if it's human error. I would forgive anyone for a mistake, but lying and blaming is unforgiveable."*

Indicative behaviour: Not giving women and their families answers or reasons for why things had gone wrong

3.60 We heard about:

- Families being left convinced that their baby's death or injury was the result of failures in care because of the lack of information and attention provided by the Trust in the days, weeks and months after the death:
  - *"My opinion will always be that F died because somebody didn't do their job properly; and that's fine if you work in Sainsbury's but when it comes to a family's life; it has affected me, my husband, our son … it's devastating and it can't be undone, it's what we just have to live with."*
  - *"What's caused the suffering, and what is dangerous, is the lies and the falsifying the notes and blaming me to cover up for the human error or the device, and that being seen, when you make a complaint, as acceptable. I think that covering up and that blaming is really dangerous because we do not know what really happened."*

3.61 The consequences for the families are profound. Living with a narrative that they know to be untrue or partially untrue, or never knowing for certain if things might have been different, has fractured their trust in healthcare professionals, often challenging previously held beliefs about who is trustworthy and who is not. Having these previous beliefs challenged, as well as feeling unable to construct a true explanation about a major event in their own lives – even when they may have been present – has undermined their confidence in their abilities, strengths and decision making.

3.62 We saw that this has often led to major changes in how families viewed themselves and others, and their ability to manage their lives. They were generally less trusting and confident in the ability of others to have their best interests at heart, even those closest to them. This additional harm has added to their grief, loss, physical disability or change in circumstances, with some families also experiencing major financial difficulties. In these circumstances, their ability to regain their capacity to cope has been severely hindered.

Illustrative Case U

Two weeks after her due date, U was booked in for an induction. Despite a sweep and two doses of Prostin, progress was slow, and U and her partner felt neglected as staff were busy with other patients. One midwife refused to carry out an internal examination of U that evening, even though one was overdue, and no examination took place before a second dose of Prostin was administered.

During the night, U woke in intense pain and experiencing contractions. As her contractions became more frequent and stronger, she asked again whether she would be examined but was made to feel like she was making a fuss. In the morning, U mentioned the pain she was experiencing and that her contractions were getting shorter. Then the contractions suddenly stopped and she experienced reduced fetal movement. The midwives said that her baby would be sleeping.

On the induction ward, U was monitored and there was still very little fetal activity. A midwife said she should stay on the trace for another ten minutes for a "sleep trace". The monitor started to sound an alarm, and within minutes an emergency caesarean section was performed and baby U was delivered covered in meconium and requiring resuscitation. She was cooled straight away and had several seizures. Fortunately, she did not sustain any long-term damage.

U and her partner were informed that there had been a meeting about the event, but they were denied any details. Subsequently, they requested the minutes of the meeting but were told that these could not be found. They believe there was an investigation but the outcome was not shared with them. They queried the care provided on the evening prior to baby U's delivery when the midwife refused to examine U, and the failure to properly monitor her to identify that the infant was in distress. However, they received no answers and no explanation of why the baby was born in such poor condition.

The couple indicated their intention to complain and asked to be put in touch with the Head of Midwifery; however, the hospital failed to contact them. Then, feeling that they had done all they could to obtain answers to their questions, they instructed a solicitor. The Trust called into question U's account of events because it did not correlate with what was recorded in her notes. The couple were told that their legal claim could not succeed because their baby had survived without lasting damage. They agreed to mediation at the request of the Trust. However, on the day before the mediation, the Trust submitted additional paperwork and refused to be bound by the mediation's outcome, leaving the couple without any determination and a hefty fee. They are left not knowing what happened and believing that the hospital is hiding something from them.

Many of the cases included all the above themes

3.63 Illustrative Case V is representative of many accounts we heard, in that it describes how one family experienced failures in care and poor behaviours of staff that cut across the range of themes we have identified. It is necessarily more detailed than the others in this chapter and, for that reason, all the more powerful.

Illustrative Case V

When V became pregnant, she was told that she was at high risk, so she was surprised that each time she attended for an appointment, she saw a different doctor. She experienced swelling in her face, feet and fingers, and breathlessness, headaches and tiredness. All of these symptoms and the extent to which she was struggling were dismissed as due to her weight.

"I felt like I was going to these appointments and was just being churned through a mill. I would sometimes sit for way past an hour past my slot time, to be measured and weighed and just told yes, just carry on, we'll see you in four weeks. And I thought, you've not asked anything about what went on since the last appointment; I was saying things like 'I'm really swollen', but they didn't listen, they didn't take on board the things I was pointing out … I was just told, no, you're just fat."

Near to her due date, V had an appointment with a new junior doctor, who told her that she had too much fluid, and that if she were to go into labour she was at risk of the fluid *"gushing out of her"*, possibly resulting in an accident to the umbilical cord. This alarmed her, and she worried that all she could do was ring for an ambulance if her waters broke.

By the time of her final consultant appointment, V was suffering from symphysis pubis dysfunction; her pelvis was extremely painful and she had difficulty walking. She told the consultant that she felt sure she would need a caesarean section, particularly given that her scans were showing her baby to be large. She was told that she should have no concerns about a natural birth and all would be fine.

"And again, I felt like, in that appointment, I was churned out, they didn't have any time for my questions. That was my very last appointment with a consultant, and I was just totally disregarded. I really don't even know why we bothered going, because everything that I was worried about, it was just 'you'll be fine, mother nature will take care of you'."

V's anxiety was compounded by her midwife, who told her that *"it was not midwife territory"* and *"they're not interested in having you under consultant care"*. She told V that she too had raised concerns with the consultant, which were dismissed.

At 41 weeks pregnant, V was very unwell. Feeling *"fobbed off"* by the hospital, she went to see her GP, who sent her straight there, giving her a letter to take with her stressing the urgency of the situation due to her evident pre-eclampsia.

"I got there, and it was just the same as usual; it was the same 'well, this is how it is at the end of your pregnancy, you're not going to feel your best'. And I thought, there's not feeling your best, and there's feeling horrendous. One of the things that I really want to be highlighted is that there were so many times throughout the pregnancy when I said I'm worried about this, I'm concerned about that, I'm not feeling great, but my notes just seem to say 'mother was happy'. And I wasn't happy."

The hospital consultant confirmed that V's baby needed to be delivered in light of her pre-eclampsia. However, there was no room for her that day, nor the next, which was a Friday, so she would have to come back on Monday because they did not induce women over the weekend. The consultant organised for her to have a sweep and she was told that, if that brought on labour, she should go straight back to the hospital because a woman in labour could not be turned away. Her labour began that weekend.

"I had to go with 'there's no room at the inn' and go home after the sweep, and I felt again that they were just not taking it seriously. I went home and I did go into labour

over the weekend. We went in on the Sunday morning, I think at a time that wasn't ideal, it was the changeover of the shift, and they actually said when we got there, 'oh, we've had such a long night'; and we were a bit apologetic. And I said, 'well I've had a long night too, we've not really had any sleep'. My contractions had started on and off and then really picked up in the early hours of Sunday morning, and they were like 'well, they're not that strong' and started to play it down immediately."

V was told by a midwife that she was not in labour because her contractions were mild and subsiding, and that she should go home and come back the next day, Monday, for her booked induction. The midwife asserted that, in her excitement to give birth, she was reading too much into the pains, which were not the real thing. V asked if she was going to be examined by the consultant, whom she had seen at the desk when she arrived and who had said she could stay if her cervix was dilated, but was told by the midwife that she did not need to be subjected to *"unnecessary poking and prodding"*. The midwife said: *"I can 100% guarantee that you're not dilated."*

"We were leaving, even though I was in pain, because we were not wanted there."

V went to bed. Later that day, she noticed that her abdomen had softened and dropped and there was no resistance or kicking back when she pressed it. She rang the hospital and explained that she hadn't felt her baby move for around six hours. The person on the telephone told her to come in and then hung up. On arrival, V, her partner and her mother were put in a room with other people. Looking back, she wonders whether it might have been better to place them in an empty room, given that she had told the hospital that her baby wasn't moving.

All the curtains were open as staff tried to find a heartbeat. Everyone was staring at them. When no heartbeat could be found, V became upset and the family were moved to another room for a scan. After what seemed like a long wait, a junior doctor arrived; the doctor wouldn't talk to them, look at them or give them any information, merely saying, *"well, give us a chance"* when they asked what was happening. Even though no heartbeat had been found, V was in a state of disbelief that something could be wrong.

"After a really long time, I'm guessing close to an hour, an obstetrician turned up and [they] *scanned me. Again, there was no conversation. And then* [they] *said, 'you have to be very brave, because your baby has passed away, there's no heartbeat, your baby has died'. Everyone was crying but I said to* [them] *straight away, 'how did this happen, I was here this morning and you said everything was fine and I should go home'. And then* [they] *left the room, and I didn't see* [them] *again for six years until I was in a courtroom with* [them]*."*

Having been told that there was no heartbeat, V was given a pessary to commence labour. She was told that as her cervix was already 5cm dilated, it would probably happen quite quickly.

"It's not really one of those things that you can measure because I know that people can go from zero to five centimetres in no time at all, but it plays on my mind that maybe if [the consultant] *had just examined me in the morning, I would have been enough dilated to have stayed. And even if the outcome had been the same, that I'd have been left in that room all day on a monitor and he still died, I'd have felt that I was in the right place. Instead, we have all these 'what if' questions, which now we just have to live with and it's difficult to move past that."*

V's labour was traumatic and began with a failure in communication that was most distressing for the family.

"When they came in, one of them said, 'calm down everyone, you're going to have a baby today' and they hadn't been told. Then she had a bit of her own meltdown because she felt so silly, and we ended up feeling sorry for her. It was such a mess. Sometimes, I think I don't know what difference it would have made, for her coming and saying sorry for your loss, let's help you, but at the same time, the two of them came in like a parade, like happy, happy, it was just awful."

V spent 18 hours trying to deliver her infant because the hospital did not initially agree to a caesarean section. At one point, she lost consciousness – a terrifying experience for her partner. Finally, a caesarean section was carried out to deliver the stillborn baby. The surgeon told them that the baby shouldn't have died, that he was a good size and healthy and they should take matters further.

"I had just delivered a stillborn baby and I was already being told, this isn't right, something has gone wrong here. But we knew it, we knew it anyway, because we'd been to all these appointments, but nothing was put in place."

Afterwards, V had to stay in hospital for a while. Being on the ward with no baby was particularly difficult, but it was during those few days that the couple experienced a growing awareness that things had gone wrong. The comments of one particular doctor stand out for them.

"[They] *said to us 'we can manage this in other pregnancies, we can give you a small dose of aspirin every single day and your pre-eclampsia will be managed; this won't happen to you again, and I'm sorry it happened to you this time'. And then* [they were] *swept out of the room so quickly, as if we shouldn't have been told that, because until then, pre-eclampsia just hadn't been mentioned."*

Then, when V had returned home, she was telephoned by her midwife; her recollection of what the midwife said is as follows:

"I shouldn't say this to you, but I think we're friends now, you need to get a lawyer … they're covering things up and I shouldn't tell you this and I don't really want to talk about it anymore."

The couple pursued a legal claim, but no fault in V's care could be proved – not least because of the emphasis placed on her clinical notes, which the couple believe do not give an accurate picture of her condition or care. They are left with the belief that the management of V's pregnancy was *"a mess from start to finish"*. They remain particularly upset that the hospital made an error regarding the gestation of their baby, whose post-mortem examination confirmed that he was far more advanced than had been recorded. Despite telling the hospital that her dates did not match theirs, V was left to go overdue, her baby *"fighting on for an extra two weeks"* before he died.

Over the last eight years, V and her partner have asked hundreds of questions about what went wrong and have still not had answers. They were told that nothing went wrong; it was one of those things. They have never received an apology.

Conclusions, including consequences and impact on wellbeing

3.64 The Panel has considered carefully the evidence provided through the family listening sessions, alongside the information obtained from reviewing clinical notes and other documentary sources. In doing so, it has identified a range of repercussions for women and their families. These families attribute the following consequences to the events they experienced and the actions of clinicians and other Trust staff:

- Not knowing if things might have been different; living with "what ifs"
- Feelings of guilt and responsibility for what happened
- Changes in personal beliefs about healthcare
- Mistrust of clinicians, institutions and the wider health system
- Feeling forced into a position where they sought legal advice to find out what had happened
- Loss of personal confidence
- Heightened emotions, including anger, rage and shame
- Self-blame for not raising concerns more forcefully or speaking up enough
- Panic attacks
- Not wanting more children or being frightened at the prospect of having another baby
- Needing to move away from the area or avoid being in proximity to the hospital
- Relationship difficulties, including some that have ended in separation, and difficulties with intimacy.

3.65 We would also like to highlight the additional guilt that many families have come to feel for not speaking up, when they have seen more recent cases come to light. We are absolutely clear that no family should feel that way: it is not up to families to correct the deficiencies of a Trust that has shown itself consistently incapable of learning.

3.66 Losing a baby or sustaining a life-changing injury during childbirth as a result of failures in clinical care has an emotional and psychological effect that most people would find hard to contemplate. However, the Panel is in no doubt that, on top of this, these women and their families experienced behaviours from clinical staff which failed to meet the standards required of them and rightly expected by the families.

3.67 We found that the impact on the wellbeing of women and their families was often compounded by the additional harm caused by the behaviours and attitudes of those responsible for communicating with and supporting them after the event. This included the doctors and midwives who had been directly involved in their care, as well as others who were acting on behalf of the Trust in a different capacity, such as those responsible for leading internal safety investigations or managing complaints.

3.68 This additional harm served only to worsen and magnify the families' sense of pain, anger and injustice and hinder their ability to come to terms with what had happened to them and begin to live their lives fully again. The Panel is in no doubt that this could have been avoided had the initial response of the Trust and its staff been open and compassionate, with a focus on including and supporting women and their families.

Illustrative Case W

W sustained a life-threatening surgical injury, either during a caesarean section or afterwards during a procedure to stem heavy bleeding. After her discharge from hospital, she met with her consultant. They told her that they fully expected to see her in a few months, because *"you've still got everything, you can still have a baby, we'll look after you"*. But the experience has left W terrified about becoming pregnant again. It appears that at no point was any explanation given that her continued bleeding had been due to surgical injury to her cervix and vagina.

"It just seemed that people would think that everything would be fine because I was alive and I would just move on and I shouldn't be sad or upset or mentally scarred from it, from a traumatic experience, and for me I was robbed from having my second baby. I've always wanted a second baby and I will never do that, ever, and no one appreciates that side to it."

3.69 In this chapter we have described the wider experiences of the families, setting out and providing evidence for the themes we have identified and the behaviours that are indicative of those themes. These experiences provide further evidence of care and treatment that fell short of what might reasonably be expected, and that in some cases contributed to the poor outcomes many families suffered.

3.70 In addition, we have made clear our finding that women and their families have suffered additional harm as a result of the behaviours and attitudes of the health professionals who were responsible for their care, as well as others at the Trust with whom they had interactions after the events. For some, this has had an impact on their wellbeing which continues to affect their lives today. It is the Panel's view that aspects of the families' experiences have been so damaging as to have had a profound and lasting effect on their health and wellbeing.

Chapter 4: What we have heard from staff and others

Alongside listening to families, the Investigation has conducted interviews with 112 current and former staff at East Kent Hospitals University NHS Foundation Trust (the Trust) and with others whose work brought them into contact with the Trust's maternity and neonatal services. This has been a key part of the Investigation. It is important to note that these interviews helped shape our findings as set out in Chapter 1 and that this chapter describes what we heard. This chapter should be read as performing that function, not as an indication of the Panel's own thinking and conclusions.

Introduction

4.1 Between October 2021 and June 2022, the Investigation Panel met with 90 different members of Trust staff, including midwives, neonatal nurses, obstetricians, neonatologists, paediatricians and other clinicians, as well as members of the Board, the Executive and other managers. The Panel met five of those people twice.

4.2 In addition, the Investigation interviewed 22 individuals who did not work at the Trust but whose role brought them into contact with the Trust in connection with the provision of maternity care, such as representatives from the Care Quality Commission (CQC), the Healthcare Safety Investigation Branch (HSIB), Clinical Commissioning Groups (CCGs) and NHS England/NHS Improvement (NHSE&I).

4.3 This chapter reflects what the Panel was told by those it interviewed. It does not contain the Panel's commentary or assessment of any of the information provided by staff and others except where explicitly stated, but it does focus on what the Panel heard about the problems and challenges facing the Trust. That is not to say that the Panel did not hear about positive aspects – the efforts made to improve the culture and service, the initiatives to support better performance and outcomes, and the commitment of the majority of staff to do their best for their patients.

4.4 In particular, the Panel was conscious that many interviewees understandably wished to put a positive light on subsequent improvements in services, but we found that this view was not generally borne out by other evidence.

History and structure

4.5 Many staff with whom the Panel met raised the fact that the Trust was previously three separate trusts: the Kent and Canterbury Hospital Trust, Thanet Healthcare Trust and South Kent Hospitals Trust. The three trusts merged in 1999 following a local review of services, "Tomorrow's Healthcare", and the resulting trust became one of the largest hospital trusts in the country at that time. The long-term outcome of the Tomorrow's Healthcare review on maternity

services was to focus obstetrics at Ashford's William Harvey Hospital (WHH) and Margate's Queen Elizabeth The Queen Mother Hospital (QEQM).

4.6 Each hospital had an obstetric unit. WHH had a Level 3 neonatal intensive care unit, which is suitable for all babies who do not require very specialised regional or national specialist care. QEQM had a Level 1 special care unit, suitable for low dependency care of babies born after 32 weeks of pregnancy. Dover and Canterbury hospitals operated standalone Midwifery-Led Units (MLUs) in the former obstetric units (later relocated alongside the obstetric units in WHH and QEQM).

What we heard from staff

4.7 The Tomorrow's Healthcare review was described by one clinician as *"a bruising period"* and by another as *"a very traumatic process, as it basically pitched all three Trusts against each other"*. The clinician told us:

> [It was a] *challenge to integrate the whole of the maternity services which were so divided before, and especially during, the Tomorrow's Healthcare consultations, and to bring some order to the whole Trust. It took years, not months, to bring understanding that they would have two units and it was no longer possible to have three.*

4.8 The Panel heard about the challenges that merging the trusts brought. One member of the medical leadership team said: *"Moving from three relatively small organisations to one large organisation meant there was a lot to do in terms of healing rivalries, managing the communities and to some extent the staff."* Although effort was put in to build an *"East Kent focus"* across the Trust, many people reported that the hospitals remained quite separate, and in 2014 a CQC inspection report noted that the Trust still behaved like three separate organisations.

4.9 The Panel was told that the Trust *"had never really coped with the merger"* and that *"the merger is highly relevant to what goes on in the Trust day-to-day"*:

> *They were supposed to be one team but in reality that wasn't the case. Even the guidelines were different for each site until recently.*

4.10 When the Trust became a Foundation Trust, the internal structure was relatively flat and involved clinical directorates; this, it was said, allowed people to participate in decision making. The application for foundation status resulted in Monitor* insisting on fewer management groups, which, the Panel heard, left senior staff (especially clinicians) feeling that they did not have a voice and were excluded from Trust business. The Trust moved the individual directorates into four (*"massive"*) divisions in 2011 as part of a reorganisation. The Women's Health directorate was rolled up in the Specialist Services division with renal, dermatology, cancer services and paediatrics – *"specialities that had nothing to do with each other, but that was the structure of the Trust at the time"*. The Panel heard:

- *"It felt like* [women's services] *were being put with other odds and ends – the elsewhere 'unfileable'."*
- *"… the voice of maternity services was diluted within that Division."*

* Monitor was an executive non-departmental public body of the Department of Health, responsible between 2004 and 2016 for ensuring that healthcare provision in NHS England was financially effective.

4.11 One Trust Board member commented that *"staff in maternity felt they were always the poor neighbour to cancer"*, and an obstetric consultant told the Panel that the Specialist Services division had far too wide a remit and resulted in people at divisional level taking their eyes off the ball in terms of maternity services. The Panel heard that the new director leads had little understanding of midwifery and maternity services, and *"the maternity unit was in disarray with few plans for the future"*.

4.12 In 2018, soon after the arrival of a new Chief Executive Officer (CEO), the Trust changed from directorates to clinically led care groups. This was intended as a move from a management-driven structure, in which clinicians supported managers, to one in which the clinicians delivering the services would be supported by their managers. There were initially seven care groups, but the Women's and Children's Health group was later split in two and there became eight. This was considered a positive development.

4.13 The Trust was described to the Panel as a *"challenged"* organisation typical of a cohort of trusts where there were significant performance and operational challenges, but where the underlying problem was really one of culture.

Poor staff morale

4.14 A member of staff who had been with the Trust for 20 years described the first ten years as *"generally good"*, but they resigned more recently due to a *"toxic culture"*. Working at the Trust during the reference period of the Investigation was said to be *"challenging"*.

4.15 One band 7 midwife[†] who had been at the Trust during the same period described the peaks and troughs: *"times when I felt positive and times when I felt rock bottom. It has always been that way at East Kent, good times and bad times."* When they were going through a trough, when morale was low, people might not work as well as a team or they might be short-tempered. Those were the times when this midwife felt that teamworking was not good.

4.16 In 2014, following the CQC report, the executive team was described as *"demoralised and not working as a team"*. In the year that followed:

> *An awful lot of work took place to try and engage and improve the morale of staff, trying to bring together management and clinical staff. That was probably the biggest problem the organisation had, that there was this disconnect between the hierarchy of management and clinicians.*

4.17 The Panel heard about a *"really bad period of time"* when there was a big change in managers and people didn't have the experience to manage correctly or appropriately. This resulted in lots of disciplinary issues, and it affected morale because people were nervous and they weren't *"nice"* to each other: *"It had a knock-on effect, like dropping a pebble in the water."* We were told:

> *Everybody wants to get it right and everybody wants to give quality care. Nobody wants to cause any harm to people. When it does go wrong it has a massive effect on people's wellbeing and morale. There was definitely a lack of understanding between divisional and Trust levels of management and what goes on on the shop floor. That lack of understanding would sometimes have a negative effect on things.*

[†] Band 7 is a senior grade of midwife or nurse, still generally with clinical responsibilities.

4.18 One director attributed the causes of staff disenchantment across all sites to the Foundation Trust status requiring financial savings and the close scrutiny under which the Trust operated. Decisions taken by the Trust to improve efficiency and clinical systems were aimed at improving patient safety and clinical services but resulted in staff earning less money. Some staff expressed that they were unhappy with the new arrangements.

4.19 A member of staff decided to leave the Trust because it was *"trying to do too many things in too many places"*, not only from a workforce perspective but also from a financial perspective. Their view was that the models of care that were operating were not sustainable, and the cultural difficulties persisted:

> *[S]ome people were trying to deliver services that were really hard for them to deliver, and consequently, their behaviours and interpersonal relationships struggled and were damaged by that.*

4.20 The Panel was told how perceived poor performance by people in senior positions negatively impacted staff morale, but that there had been more recent initiatives such as regular safety huddles that aimed to help develop and strengthen relationships between different disciplines and in all areas of maternity services.

4.21 One midwife, who had often raised concerns around consultant decision making, was told in relation to a poorly performing doctor that having *"someone was better than no-one"*. Those aspects were described as *"very challenging and demoralising"*.

4.22 This same point was echoed by a member of the medical team, who commented that, for the Trust, *"having bad clinicians is better than having no clinicians"*. They remembered a clinical member of the Trust Executive saying that a clinician who had been investigated by the General Medical Council (GMC) was *"just about good enough and that was all that could be expected at East Kent".* The message given was that mediocre was acceptable, which was a depressing standard for clinicians to aspire to.

4.23 A senior obstetrician told the Panel that the staff were fundamentally good people who were placed in an impossible position because of the pressures of the roles they were asked to perform.

4.24 A member of staff told the Panel that the Trust and maternity services had a bad reputation and that there was a bad news story every week, which had a profound impact on morale:

> *It was hard to watch the media reports and see the Trust criticised. Staff morale was low and there were shockwaves among the staff. It was difficult for pregnant women to come into the hospital having seen the media reports. They would ask if they would be safe delivering there … There was support, but the shockwaves that affected the shop floor weren't noticed.*

4.25 One midwife working at the Trust throughout the Covid-19 pandemic noted that morale seemed worse at the time because of bullying and the questioning of practice in a *"personal and aggressive way that wasn't justified".*

4.26 Another midwife, in commenting on the behaviour of senior midwives, told the Panel:

> *[S]enior midwives often came across as lazy, or they were just attending the ward to complete their hours.*

4.27 Band 7 midwives told the Panel that they were held accountable for what other midwives were doing, when there should have been a level of individual accountability (they were *"getting the blame from everywhere"*). The band 7 group of midwives also felt very demoralised due to the scrutiny of maternity services.

4.28 Concerns about accountability were raised by another midwife in connection with the lack of personal professional responsibility on the part of some members of the midwifery team. This was attributed to low morale and poor management:

> *There has to be some accountability. Since the loss of supervision, there are no consequences for people not acting correctly.*

Engagement and leadership

4.29 The biggest obstacle to implementing change – in particular the improvement plans in response to the 2014 CQC report and the Royal College of Obstetricians and Gynaecologists (RCOG) report in 2016 (see Chapter 1) – was the lack of staff engagement with the process. The Trust was described as reactive and not *"terribly forward-looking"* in changing the culture around staff engagement.

4.30 One Board and Executive member, commenting on the change to a managerially led divisional structure in 2011, told the Panel:

> *It would be unfair to say that was responsible for poor medical engagement because the poor medical engagement was there already, but it didn't help.*

4.31 The Trust had poor medical engagement, the obstetrics and gynaecology department was described as *"dysfunctional"*, and poor behaviour and leadership by consultants adversely impacted patient care and safety. However, the Panel was told that, since 2018, there has been a change of emphasis within the Trust, with more clinicians prepared to step into clinical lead roles.

4.32 Another Board and Executive member found the Trust a very despondent place for all staff. Consultant engagement scores were very low and the culture came across as very negative. There was a historical lack of clinical leadership and of clinicians feeling accountable for what they did. The same Board and Executive member identified several dangers around the way in which clinical effort was focused, including the divisional structure and the need to turn the Trust from a managerial approach to a clinically led culture. This was described as a *"colossal"* piece of work, which lasted from 2018 well into 2019 and required the appointment of new clinical leaders, particularly in maternity services.

4.33 The Panel was told that consultants did not engage in clinical audit or clinical guideline development because there was no time written into their job plans for it. For the same reason, we were told, areas where one would expect consultants to lead – the development of clinical guidelines, conducting maternal death and perinatal investigations, and leading on perinatal meetings – were all led by midwives.

4.34 A lot of time was spent on incidents and complaints, with governance midwives being recruited to manage these alongside the consultant with responsibility for risk management and clinical governance. There was a lack of engagement from obstetricians on clinical governance and updating guidelines, *"leaving* [the consultant] *to do a lot of the work"*.

4.35 One consultant noted a difficulty in getting clinicians at QEQM to be part of an investigation into a neonatal incident, and told the Panel that this remains a challenge. The Panel heard that there was a greater focus on midwifery than on obstetrics, and that there was an expectation that engagement in serious incidents was the responsibility of midwifery rather than obstetrics.

4.36 The Panel heard that Women's and Children's Health, as part of the Specialist Services division, had two and a half days a year devoted to learning and considering incidents, complaints and feedback, including positive news. However, the Panel also heard that doctors never attended the meetings; only nurses and healthcare professionals attended (although this began to change later).

4.37 The Panel was told that there were *"about three"* cultural change programmes at the Trust that failed because of a lack of direction and leadership, and that the Trust paid lip service to cultural change but this was not sufficient. There was not enough commitment or engagement from leaders of the organisation.

4.38 Professor James Walker, the Clinical Director of Maternity Investigation at HSIB, commented:

> *They don't really have consultant supervision to try and support the service. Now whether that is because they haven't enough, or they don't have enough people interested or whatever, I don't know, but it took us a long time to get the obstetricians involved* [with HSIB investigations]*. Even now, we get the lead obstetrician there or the lead paediatrician comes in – I am not sure how much our messages are getting down into the shop floor. In other hospitals we present back, and we've got consultants, students, registrars, and student midwives in the room, and that is where these hospitals really take ownership of problems. It's interesting because people will then talk about the cases and the obstetricians and midwives will then realise the problems the others have, and that helps to move forward for solutions.*

Staff behaviour and bullying

Relationships between professions

4.39 A senior clinician with a regulatory and oversight organisation told the Panel that East Kent maternity services had the worst culture they had seen in their long experience of working in hospitals with inappropriate cultures, and a *"terrible culture between the medics and the midwives"*. Staff were not supportive or encouraging to each other and there was *"a bullying culture"*; *"freedom to speak up at the Trust was not good"*. They said:

> *People's standards weren't what they should have been, and they didn't know what good looked like.*

4.40 The relationship between midwives and doctors was described by one senior midwife as *"cordial"*, and concern about difficulties with working relationships at the Trust featured prominently during staff interviews and was an issue raised across different levels of seniority.

4.41 The Chief Executive of the Nursing and Midwifery Council (NMC), Andrea Sutcliffe, told the Panel that *"the relationship between midwives and obstetricians is absolutely critical"*.

4.42 Contrasting views were expressed about teamworking. Some said that teamworking between obstetricians and midwives had always been good. Nevertheless, the Panel was

repeatedly told of poor teamwork, particularly between different professions. The senior consultant obstetricians were described by one senior manager as *"extraordinarily challenging in their behaviours, lack of communication and teamwork"*:

> *Their behaviour was appalling, and they had no respect for their colleagues. Consultants did and do still refer to midwifery staff as "lazy fucking cunts".‡ They take no responsibility for their actions and blame colleagues for any challenges and failings … such a rancorous, hostile environment creates a service ripe for error, risk and lapses in safety.*

4.43 A senior member of the Executive noted the *"dysfunctional relationships within specialities"* and that, within maternity services, there were issues with obstetricians and midwives working together. A senior manager observed that *"doctors and midwives sat apart in meetings … and clearly did not respect one another"*.

4.44 Doctors were said to have been overpowering in a lot of situations and women's voices were discounted as a result. It took one midwife a very long time to feel confident enough to speak up to doctors because they came across as quite intimidating. The same midwife felt that the situation later improved, although women were still not always empowered by doctors. This point was echoed by another midwife to whom the Panel spoke. They described ineffective communication and discussions that were *"quite hierarchical … Ultimately, decisions come from the top, rather than because staff communicate well and listen to each other."*

4.45 A senior midwife spoke about the fact that many of the consultants working at QEQM are longstanding members of staff and have a more *"traditional"* model of working when they are on call overnight, and that because there are a few layers between midwives and the consultant (mostly filled by junior doctors), midwives can find it hard to reach a consultant at times. In contrast, the obstetric team had a greater opportunity for contact with consultants.

4.46 The Panel heard that there were set patterns for doing things and that it was difficult to introduce new ideas from elsewhere. A midwife at QEQM who had worked at the Trust for over 20 years told the Panel that they felt like *"an outsider"* for quite a few years. Students who came through the unit would be the trained midwives of the future; similarly, trainee doctors would often return as consultants once they had completed their training. The team was considered to be *"like a family"* and their strengths and weaknesses were well known.

4.47 The dynamics of the team affected decision making; this was recognised as *"not a safe way to practise"*. There was no multi-disciplinary team learning and there was very much a *"divide between disciplines"*. The Panel was told that the obstetricians had *"huddles"*, but these were a *"tick box exercise with no real value".* One midwife commented that the relationship with the obstetricians could be challenging and it had a big impact on how midwives felt about their work. Some of the consultants were very unhappy about being questioned and would become stubborn and unwilling to back down. Another midwife mentioned that junior doctors felt *"bullied"* by the midwives, and the relationship with the obstetricians wasn't very good.

4.48 A midwife who had been with the Trust for a lengthy period told the Panel that the lead clinician for obstetrics faced *"massive challenges"* with relatively little support, that there were some *"big egos"* among the obstetric consultants, and that to try to bring about change with these strong personalities present was very challenging. They also said that poor communication was a significant theme and spoke about how everyone knew that it would be a difficult day if a particular clinician was on duty.

‡ The Panel deprecates the use of language that is disrespectful to other staff and demeaning to women; it is included here only to underline the extreme lack of respect and professionalism among some Trust staff.

4.49 Some consultant obstetricians were described as *"a bit dictatorial",* and, while a lot of the team had gone on the "Human Factors" course to try to improve things, there was a cultural expectation of hierarchy. The hierarchy disempowered staff from speaking up and the Panel heard that it was hard to voice opinions without them being taken the wrong way.

4.50 A midwife said:

- *"… the culture just continued. A lot of work with human factors was done but it never really seemed to translate into the management team."*
- *"Years ago, the matrons used to go round and talked to all the staff first thing in the morning when they came on duty. They used to go and speak to the women to see if they've got any problems. A lot of complaints could also be addressed at that level before they got bigger. The management team now go to their office and don't speak to anyone."*

4.51 One midwife commented that the Trust seemed to have forgotten the Human Factors principles in the past few years and that professional challenge was perceived as criticism. A consultant told the Panel: *"The Trust thinks if you send someone on a three-day training course in human factors, that their personality will change forever but that's not going to happen."* Another clinician expressed having limited confidence in the behaviour and competence of certain obstetricians.

4.52 A midwife spoke of the *"fear of speaking up"*. Instead of consulting staff and discussing how issues could be improved, staff were told what to do and viewed as *"negative"* if they proposed any alternatives:

> *Staff feel they don't have a voice, that nothing will change and that if they don't agree with instructions from above, they will be ostracised. Staff are desperate to get on with everybody at work which means that they say and do things that they don't agree with. It hinders their ability to speak up when things aren't as they should be.*

4.53 The Panel heard examples of this behaviour, such as a staff member feeling as though they weren't very good if they asked for a short break after ten hours of work instead of carrying on like the rest of the team, or a midwife admitting that they didn't feel confident suturing a woman and facing a response like *"she's been a midwife for years. What's her problem?"*

4.54 The Panel was told of an occasion when a midwife had sought to explain to a consultant the adverse impact of the consultant's late arrival on the operation of the clinic and associated services, in response to which the consultant wagged a finger in the midwife's face and said: *"I am a consultant, and you can't tell me what to do."* The midwife was astounded that colleagues could speak and act in this way, but this kind of behaviour was described as *"relentless".*

4.55 The Panel heard about conflict over patient management plans and midwives *"bracing"* themselves to discuss these cases. There were suggestions of pressure put on midwives to accept women into the low-risk pathway when they had not been risk assessed or they were outside the guidelines, and consultants challenging any resistance to this approach.

4.56 One member of staff told the Panel that many families had complained about staff arguing among themselves in front of women over whether to call for support and assistance from a more senior clinician, including in life-threatening situations.

4.57 Another midwife commented that, in the past, although members of the multi-disciplinary team were supposedly working towards the same goal, it felt as though they were on *"parallel tracks"* rather than on the same path. However, they thought that this was less the case more recently. The introduction of a preventive measure for rhesus disease was cited as an example of good collaborative working between midwives and obstetricians. The Panel was told that, in the recent past, *"it was definitely not a case of them and us"* and that things had improved, but there was still some way to go. The Panel was told that the change process had been aided by new staff thinking differently, having more enthusiasm and providing a lead for others to follow. A more recently appointed obstetrician had been particularly interested in leading on multi-disciplinary working.

4.58 The Panel heard contrasting views about multi-disciplinary working. On the one hand, we were told that the relationship between multi-disciplinary teams was positive; relationships with the neonatal team had *"always been good"* and anaesthetists were *"a great support to the labour ward"*. One senior member of staff suggested that the relationship between neonatology and obstetrics had always been good at QEQM, with communication between the teams if there were problems. The Panel was told of the recent appointment of obstetricians who had trained at East Kent maternity services and knew the units.

4.59 However, the Panel also heard numerous contrary accounts. It was said that there had always been friction between anaesthetists and other specialties: on one occasion a *"massive argument"* took place between an anaesthetist and a doctor in the middle of the corridor on the labour ward. We heard accounts of problems between midwives, obstetricians and neonatologists; neonatal provision at QEQM was not as *"supportive, available or accessible"* as it was at WHH. The obstetricians were described as *"challenging"* but nothing was done to address challenging behaviour.

4.60 The Panel heard that one perinatal meeting ended with a dreadful conversation and arguments with a senior midwife, who became very upset and went on sick leave. The issue was never addressed. We were also told that there were ongoing issues with communication between paediatricians and maternity services on the Kingsgate Ward; midwives were not listened to and were not taken seriously when concerns were raised. Paediatricians were also said to be slow to attend.

Challenging poor consultant behaviour

4.61 The Panel heard from a number of people about poor consultant behaviour and the difficulties in challenging consultants and addressing their behaviour. It was felt that the poor behaviour of consultants was dealt with very differently compared with the poor behaviour of midwives.

4.62 The Trust was said to have done little to change the poor working culture; instead, it tolerated bad behaviour, especially in relation to those who had been with the Trust for a long time or held a senior position. In 2019, a formal complaint was made about bullying at WHH; at that time, one consultant was known for making midwives cry in front of others, often at handovers. However, the Panel heard that nothing really happened when bad behaviour was reported. Some staff did not have faith in the Trust to make improvements.

4.63 Staff observed that the consultants who had worked there longer had a louder voice than the newer consultants, who struggled to find their way. When efforts were made to tackle poor behaviour, people backed away from the situation, or didn't report it in the first place. Consultants' poor behaviour was dismissed as *"just the way they were"*. Staff reported being

heckled, shouted at and having things thrown at them: *"it was accepted and allowed to happen, that was the way we worked"*.

4.64 The Panel heard that staff were not empowered to challenge consultants' bad behaviour. The Panel heard instances of extremely poor behaviour from consultant obstetricians; one became rude and very personal with another member of staff who had tried to generate discussion in a large meeting around the findings of the Morecambe Bay report. No one intervened, although it became evident afterwards that there were people in the room who recognised that the behaviour had been unacceptable. This incident was one of the issues that prompted the Medical Director to invite the RCOG to conduct a review.

4.65 The Panel was told about clinical and behavioural concerns raised by one consultant about another, which they thought would be investigated by the Trust. The only feedback provided was that there was a communication issue and there would be training:

- *"After this there was reluctance for people to raise issues or make comments if they were asked further because of the way the process was done."*
- *"If people get away with bad behaviour, they're going to keep doing it."*

4.66 Some midwives told the Panel that when they raised issues with their line manager, they would not hear about the outcome. The Panel heard that midwives often talked to each other about raising issues but questioned whether anything really changed. The person involved might be told off and improve for a few weeks, but then they would slip back into old habits. Behaviour was also explained away as *"it's the way they are"*.

4.67 The lead CCG for maternity services pointed out that Medical Directors generally lacked the tools to be able to handle intransigent consultants. As an example, in 2020, there was a discussion with the Trust's new Chief Medical Officer about an anonymous survey to identify problem consultants (whom people did not feel able to challenge and with whom they could not escalate issues). Although the problem consultants were known, no one was willing to raise a concern formally. The CCG also noticed a difference in the way in which nurses and doctors were treated in connection with serious incidents – nurses would potentially be disciplined, while doctors were merely asked to reflect (see "Culture of blame and handling complaints", paragraphs 4.154–4.168).

Midwifery culture

4.68 The Panel heard about a lack of professional respect for midwives from the MLU and the community, and that their professional judgement was disregarded and dismissed in front of women.

4.69 The Panel was informed that there were several "freedom to speak up" issues raised from the maternity department at WHH. The issues related to bullying and behaviour. The Panel heard from one midwife that *"once that individual had the impact of their behaviour pointed out, they reflected and modified it. It just needed someone to point it out to them. There haven't been any further concerns raised about the individuals' behaviour."* However, other midwives told us that bullying persisted and remained prevalent. There were also issues raised around rostering and equipment.

4.70 The Panel heard that, since 2012, the Trust had had a Medical Director for Governance and Patient Safety and two band 7 nurses as Freedom to Speak Up Guardians, although the latter had not had protected time to fulfil these roles. Only recently had the Trust appointed its

first full-time Freedom to Speak Up Guardian. A predominant theme at patient safety speak-ups was behaviour – not so much bullying as poor leadership and a reluctance or lack of skills to actively listen to what staff were saying. Poor behaviours existed *"at all levels of the organisation from top to bottom"* and the Panel heard that it was *"challenging when it is senior people who are bullying"*.

4.71 The Panel heard that there was discussion within the Trust on whether there was enough documented information to take people through a disciplinary process. However, although the Trust received a lot of information, staff were rarely prepared to put it in writing. We were told: *"The Trust sometimes moves the problem around but actually it's about six months later and there are reports from the other site around the same issue."*

4.72 The origin of different cliques of maternity staff was said to have dated back to the closure of the Canterbury site, when staff were moved to WHH and QEQM: *"In both hospitals, there were two circles of core staff that had been at William Harvey/QEQM and then the Canterbury staff. They didn't get on well together."*

4.73 A midwife who had worked at various sites and in various roles across the Trust told the Panel that the staff working at WHH had a reputation for being outspoken, and that allegations of bullying – in particular, more senior nurses treating junior staff with little respect – had circled the site for many years and had not been dealt with effectively. QEQM was considered to be friendlier, with less staff turnover and better working relationships, and new staff found it easier to settle in; it was suggested that this might be due to QEQM being a quieter site.

4.74 Staff told the Panel that *"senior midwives"* at WHH had a tendency to form *"cliques"* and that this could come across as threatening to more junior members of staff. They also told us that support workers had raised complaints about being treated unfairly compared with other groups of employees within the maternity unit. They indicated that, while there had been an improvement latterly at WHH in the way in which staff communicated with each other and mothers, it remained a concern. The Panel also heard that management *"cover themselves"* so that action would not be taken if the friend of a band 7 midwife did something wrong. One midwife was told expressly not to enter details of an incident on Datix (patient safety incident reporting software) as the band 7 midwife involved *"just forgot"* to take the required action.

4.75 One midwife described difficulties with the coordinator culture at WHH, with coordinators not listening to other team members or doing things in a set way. They were described as *"unhelpful and not hands-on"*, and they did not have the confidence of certain members of staff.

4.76 The Panel was told about midwives shouting and screaming at each other. A band 7 midwife spoke about witnessing a loud argument between a unit coordinator and a ward clerk, which prompted the band 7 midwife to close the doors around the ward to prevent women and families from hearing the argument. Afterwards, the band 7 midwife felt *"terrified by the way the coordinator spoke to* [them] *about having done this"*.

4.77 The Panel heard that a supervisory session for midwives was carried out at WHH and one of the questions asked was *"what is a good day for you"*. The response from one midwife was *"getting to the car, across the car park, at the end of the day without bursting into tears"*.

4.78 The Panel heard that student midwives did not feel valued by more senior staff members. Many student midwives did not feel welcomed and heard more senior members of the midwifery team gossiping about them. Another member of staff observed *"quite sharp questioning"* at WHH during handovers, which left staff feeling uncomfortable and feeling that they were being

judged rather than supported. The handover was described as a *"blood bath"*, with one member of staff telling the Panel that it was *"terrifying as* [a] *student"* and reporting being told off for showing a baby to the grandparents in the corridor, or for using someone else's cup. The band 7 midwives were described as *"quite fierce"*:

> *As someone who was quite new to the profession, you would second guess yourself quite often to make sure you weren't using someone's cup or sitting in someone's seat.*

4.79 The culture of the Trust was also described as follows:

> [There was] *favouritism and some people are not treated fairly within midwifery … there were* [senior midwives] *put in place who were bullies and they reported people who perhaps shouldn't have been and others perhaps who shouldn't be in the job.*

4.80 More than one midwife identified challenges with internal recruitment: namely, that promotions were predictable and the same people would always be promoted. People with friends higher up in the maternity unit were said to get jobs before they had even been interviewed. Regarding senior management culture, we were told:

> *[I]f you're friends with someone, you'll get the job. It has been the case for quite a while that preferred candidates are coached for job interviews.*

4.81 One midwife said that they did not apply for positions as they knew they would not be chosen. Another staff member had withdrawn from an application as their face didn't fit:

> *At East Kent, if your face fits, you'll get the job.*

Bullying

4.82 The Panel was told that there were large numbers of staff who complained of bullying, harassment or discrimination. A member of the HR team commented on the high levels of bullying and harassment:

> *There were other issues but that was the most troubling because of the duty of care to the workforce and their perception of what it was like to work in that environment.*

The same person told us that nobody got to grips with the situation or wanted to tackle it.

4.83 A member of the Executive told the Panel that the problem of bullying was *"well distributed"* across the organisation, and that it was not any worse in maternity than elsewhere. However, the Panel also heard:

> *[P]eople outside maternity would probably not have been aware of the bullying culture within midwifery and* [the] *difficulty with performance of obstetricians. There was a cloud of secrecy as staff members were involved in the disciplinary processes. It wasn't openly discussed. They had to deal with individuals confidentially and professionally.*

4.84 The Trust was said to be occupied with firefighting visible issues, such as the difficulties with the Accident and Emergency department (A&E), but did not address the underlying problem of the culture of the organisation, including bullying, harassment and discrimination. One midwife commented that the focus was on the little things to make it look good from the outside.

4.85 While complaints of bullying were often made by midwives, it should be noted that staff also spoke of bullying behaviours towards consultants and among members of the Executive. One consultant told the Panel that they were bullied by a senior midwife in the special care baby unit and by senior nurses. The Panel further heard of poor behaviours of non-executive directors at the Trust Quality and Safety Committee: *"The behaviour of the non-executive directors was appalling, rude, bullying. It was shameful."* Sessions with registrars had been introduced to enable junior doctors to report concerns; these were then fed back to consultants to determine what needed to be done.

4.86 A CCG staff member told the Panel that, through quality visits, they had picked up on *"quite unpleasant"* bullying. One senior member of Trust staff described maternity services as *"a vipers' nest"*, and another expressed the belief that the deaths of some babies could have been prevented had there not been a bullying culture within maternity services.

4.87 A midwife told the Panel that staff were not given any individual or constructive feedback to improve the results of the staff surveys. Band 7 midwives had occasional study days, annual supervisory reviews and either irregular appraisals or no appraisals at all. However, nothing was mentioned to identify that any improvement was needed in this area and the Panel heard that issues of bullying had not been raised as part of the appraisal process. In 2010, approximately 80% of staff had no appraisal at all.

4.88 The bullying culture at WHH was described as *"horrible"* and *"sickening"* and as persisting indefinitely. Between 2010 and 2012, an anonymous complaint was made to the Chief Nurse by junior midwives at WHH stating that the band 7 midwives were bullying them, forming cliques, excluding the junior midwives and creating a hostile "in or out" group dynamic. No one was named in the complaint. The Head of Midwifery wrote to all midwives across the Trust, urging them to speak to the Head of Midwifery directly. The Panel heard that one midwife left the Trust because of bullying.

4.89 The Panel heard that repeated concerns were raised about some staff members' behaviour, but no action was taken in response. The Panel also heard that, in some cases, allegations of racial abuse were made against individuals, but there was no resolution and there was no structured way of dealing with allegations. Bullying and harassment policies required that an opportunity be provided for people to speak to each other in an informal way, to try to encourage them to understand the other person's position. However, the inability of certain staff to communicate respectfully with each other was such an issue that they could not safely work on the same shift.

4.90 One midwife commented that bullying was a mindset. They told the Panel:

> *[I]f people bully you, you're part of that relationship … there were people that I dreaded to work with, and I knew they would be short or cross … but I just had to carry on doing the work … you have to focus on the people that you're caring for – sometimes, the management or whatever is happening in our sort of profession may be harrowing – there's no staff, it's difficult, there's … problems between managers and things that you have to really put into the background and try and focus on the care.*

4.91 In 2014, an internal investigation into bullying began, carried out jointly by the then Head of Midwifery and the HR department. As a result of information obtained from the investigation, the Head of Midwifery was sufficiently concerned to recommend that the unit at WHH should be closed because of the risk to women.

4.92 The bullying was described as occurring more at WHH, where *"there were a lot of cliques"*, and where, *"as a junior midwife, you would hand over and you'd be berated … and put down. I remember … one time saying this lady's been in second stage for two hours and the band 7 said, 'she'll end up in ITU and it'll all be due to you'."* The environment was described as *"toxic"*, and it was commented that *"Labour Ward and Post-Natal are high risk and high pressured enough without feeling scared to hand over"*. Cliques were prevalent in management and on the shop floor within midwifery. The Panel heard that, if a friendship group of midwives was on the same shift, the most difficult cases were delegated and shorter breaks given to the midwives outside the group. The Panel was told: *"It would depend on what mood the co-ordinators or some of the midwives were in on that day as to what you got … If your face fitted you did really well."* The existence of cliques was also an issue at QEQM, where one junior midwife noted that the culture in maternity services was *"hostile at times"*.

4.93 The Panel heard that the repercussion of making a complaint at WHH was to be given extra work. One midwife described feeling unable to tell the truth around the time of the 2014/15 investigation because, if they did, they would be bullied themself. The midwife felt that they had no choice but to give a character reference to a band 7 midwife accused of bullying, although, really, they were *"dying to tell the truth".*

4.94 The Panel was told that a number of anonymous letters were sent prior to the 2014/15 investigation but that the response from leadership at the time was that they would not do anything about it *"if no one is brave enough to put their name on these letters"*. Another senior midwife told the Panel that there was no recognition of, insight into or acknowledgement of the issue of bullying from obstetricians or midwives, and that people in senior positions did not respond appropriately to the situation.

4.95 A midwife at QEQM described a culture of *"playing the bullying card"*, and *"if you say something that I don't like then I will accuse you of bullying me"*. In their view, this tactic put a halt to managing challenging situations, while attempts to introduce positive change were met with the response that *"you are picking on me"*.

4.96 In 2015, a collective grievance was raised by staff about the manner in which the 2014 internal investigation into bullying had been conducted. However, the grievance about the investigation process accepted the existence of serious bullying and dysfunctional behaviour within maternity services at WHH. The grievance also referred to the fact that:

> *An absence of senior support for staff at this present time has exacerbated an already difficult situation, as a result of which we believe there is a significant risk to our health and wellbeing, the patients we care for and the service as a whole.*

4.97 The Panel was told that the Royal College of Midwives (RCM) represented some of the midwives who were subject to the investigation into bullying and that the RCM assisted with lodging a collective grievance.

4.98 A representative of the RCM told the Panel that the RCM had known before the collective grievance that there were challenging issues around midwifery leadership in the Trust at both WHH and QEQM. There were two big units operating without sufficient overall strategic leadership or strong management on either site. Cultural issues of bullying, harassment and poor staff engagement had been identified by RCM members, as well as being raised with the CQC.

4.99 The Head of Midwifery in 2014/15 told the Panel that they regretted going to the RCM for support with whistleblowing because the RCM advised them to resign and move on; if not, the RCM said that they would be unemployable in a senior position, and they should protect themself. They told the Panel that it was really hard making the decision as they did not want to leave women vulnerable. However, they had been told by the RCM that whistleblowing was not in the public interest and they had to think of their career.

4.100 The Panel heard from Robert Eames, who worked as Associate Director of HR between 2014 and 2015, that *"*[the Head of Midwifery] *wasn't part of the problem. I think* [they] *had a good go at trying to fix the cultural piece and the behaviours, but the team lashed out at* [them]*."*

4.101 A number of midwives told the Panel that 2014/15 was a very difficult and strange time in midwifery. One midwife thought that the bullying stopped when certain midwives were suspended. However, the Panel also heard that some obstetricians and some neonatologists did not think the correct midwives were suspended. Other midwives told us that the bullying persisted after 2016.

4.102 Some staff did not perceive the behaviours as bullying; the band 7 midwives were *"good at their jobs; they were just a bit fierce and a bit scary. If you had a problem, you could take one aside and talk to them … they were strong, dominant women, commanding a unit."* A midwife at WHH considered that band 7 midwives were often a target for accusations of bullying, because the nature of the role meant that they often had to tell staff to do things differently.

Lack of diversity and racial discrimination

4.103 The Panel was told that the Trust had been rated one of the worst in the country for workplace diversity and attitudes towards cultural difference. The QEQM midwifery unit was described by one member of staff as being *"often seen as a white-led midwifery unit"* that would benefit from having more people from different cultural backgrounds.

4.104 Complaints of discrimination were sometimes based on race. A member of the Executive recognised racial inequality in East Kent and the existence of racial tensions, which probably contributed to bullying in parts of the Trust. One midwife from an ethnic minority background had been to HR three times; however, on each occasion the complaint was reduced to an overreaction. On one occasion, a midwife was discriminated against when a coordinator, at a woman's request, would not permit the woman to be looked after *"by anybody except an 'English' midwife".* Concerns were also raised about management making offensive comments or jokes connected to race; however, these concerns were minimised and put down to staff just trying to be humorous. The Panel heard more than once that instances of personally offensive behaviour by consultants and midwives were not treated seriously.

4.105 Concern was expressed that the Trust's attitude and lack of diversity were having an impact on patients as well as on staff. It was said that, at WHH, women who could not speak English or who were from different ethnic backgrounds were treated differently, as though they were at fault.

4.106 However, contrasting views were also expressed to the Panel. One senior member of staff from an ethnic minority background described not only being made to feel welcome but being positively favoured due to their heritage. Another member of staff told the Panel that they had not experienced any prejudice as a person from an ethnic minority background and felt happy when called to work at QEQM.

Consultant rotas and availability

4.107 Consultants identified challenges arising from the on-call rota. Prior to 2020, consultants would arrive around 8am and stay until 5pm or 6pm and then be on call from home. They covered other duties including gynaecology as well, limiting their presence on the labour ward.

4.108 One midwife told the Panel that the process for escalating a clinical issue was very clearly to the Senior House Officer (SHO; a junior doctor), then to the registrar, and then to the consultant, in that order:

> *I didn't escalate directly to the consultant because that wasn't the culture … the issue was that consultants were at home in the night and so it was difficult to call them about a pathological CTG* [cardiotocograph; a trace of fetal heart rate] *if the registrar was busy with a case in theatre.*

4.109 One consultant told the Panel that they escalated issues around lack of consultant availability, but that the process of trying to get these resolved took a long time because of the way in which consultants were treated (or needed to be treated). There was a lack of support provided to the junior doctors, and the Panel heard that *"East Kent did not feel like a consultant-led service".*

4.110 A midwife told the Panel that, in 2016, after the RCOG report had been submitted, the consultants at WHH made a noticeable effort to be more visible and accessible while on call.

4.111 A junior doctor recalled that *"consultants would point-blank refuse to come into the hospital after hours and would put other staff under intense pressure as a result"*.

4.112 The Panel was told about one occasion when a woman who was 35 weeks pregnant and thought her waters had broken attended QEQM. The woman needed a speculum examination; however, the SHO hadn't been trained on how to do it. Although the consultant was called, they did not attend and the SHO sought advice from YouTube on how to do the procedure.

4.113 There was a reluctance among junior doctors and midwives to raise the issue – people did not want to complain about a consultant or be named as the person who had brought up the issue. A Trust Board member supported this view and told the Panel that it was very hard for their clinical leaders to call out bad behaviour in a way that was effective.

4.114 However, the Panel was also told by an obstetric consultant that, more recently, adverse publicity had resulted in consultants either being contacted more frequently, perhaps in circumstances where trainees could do what was necessary, or themselves being too cautious.

The separate operation of the WHH and QEQM sites

4.115 The Panel was told by a number of staff that, although the merger of the three different trusts to create the East Kent Trust occurred over 20 years ago, the Trust continued to operate as if there were three separate hospitals that ran independently of each other.

4.116 The Panel heard that staff in the Trust had never come to terms with the merger:

> *Ashford is still taking it hard, and Canterbury doesn't understand why they aren't the centre of the world. It is deep rooted.*

4.117 More than one member of staff spoke about the Canterbury-centred nature of the Trust, which was an issue that needed addressing:

> [The Trust] *was run like three completely separate units, and nobody had really tried to merge it in any way. Canterbury was full of the great and the good consultant-wise, and they sort of looked down at Margate and Ashford and everybody knew that as well. The inter relationships were really difficult.*

4.118 The Panel heard that there was no cross-site teamworking or shared learning. The sites *"always ran distinctly, even down to different working policies"*.

4.119 There was also a perceived inequality and an "us and them" culture between the two sites at Ashford (WHH) and Margate (QEQM). One member of staff told the Panel that, although QEQM was quite big, *"it always felt like it was a bit of an afterthought"*.

4.120 One member of the Executive commented:

> *[P]eople working in Margate don't feel massively connected on a day-to-day basis with what's happening in the William Harvey maternity and neonatal service. This should not be underestimated. It's not an excuse for people not engaging and not following national guidance but it is a factor that cannot be ignored … There is an element of clinical isolation at Margate whereby you don't get an opportunity to see how things are done elsewhere and there isn't much interchange … However, you can also flip this round, and Margate has been able to find their own solutions to problems, and they are committed to their population who they live with and understand (whereas at William Harvey the atmosphere is not quite so embedded in the locale as Margate). When this works well it can be very powerful and a force of great good. But by the same token when it's not quite right you can get quite a long way from what is best practice.*

4.121 One experienced midwife told the Panel that there had always been a very different working pattern at the two sites, and this impacted on the midwives and on patient care. At QEQM, the consultants were not on the labour ward after handover; this also had an impact on the junior doctors, on their teaching and on the support available. Further, at WHH, regular ward rounds were conducted with the obstetricians; however, this was not the case at QEQM. Some staff at QEQM did not do ward rounds at all, although one midwife suggested that this had subsequently improved.

4.122 Another difference relates to the treatment of families following the loss of a baby. We heard that, for a number of years, the consultants at WHH have been speaking with families at around 6 to 8 weeks following the loss of a baby of 12 weeks' or more gestation, so that the family could understand what happened and to discuss how the family would be looked after in their next pregnancy. However, the Panel heard that the doctors at QEQM have resisted this practice.

Training

4.123 A member of the Executive spoke of their concern that an organisational development programme was not introduced when the Trust was going through restructuring; instead, the restructure focused on moving people without developing them.

4.124 A senior clinician recognised that there were challenges in gaining experience and competence in neonatal intubation and in maintaining neonatal resuscitation skills as a general paediatrician at QEQM. Each consultant performed intubation of extreme premature babies approximately once a year, and there were not many other intubations during the year. This posed a risk of consultants gradually becoming deskilled over time, and there was a need to ensure that all staff were up to date with neonatal life support training.

4.125 The Panel was told that a simulation training programme to teach resuscitation techniques was introduced following the inquest into the death of baby Harry Richford. Consultants across the whole team participated in the simulation and the Panel was told there was a neonatal simulation held jointly with midwifery every other week.

4.126 The Panel also heard that there had been a robust in-house teaching programme for neonatology and paediatrics for some time. Other basic skills taught include airway skills on mannequins, resuscitation, non-labour emergencies in neonates and communication with midwives.

4.127 The Panel heard that, more recently, staff grade doctors who came from abroad, or trainees without experience working in the UK, were trained and rotated to the neonatal unit at WHH for experience; this also applied to non-trainee grades who lacked confidence in their skills.

4.128 Many midwives spoke about a lack of support during their training or when they first started in their roles and a lack of mentorship. One midwife who was appointed into a coordinator role had to teach themself the leadership skills needed to maintain a safe service:

> *[S]ome band 5 midwives don't have professional resilience because they've not been taught how to develop it. It's a big jump from being a student to becoming a band 5 midwife.*

Organisational issues

Culture of denial and resistance to change

4.129 The Panel heard about the *"sense of optimism"* in the Trust as it achieved Foundation Trust status in 2009. The Dr Foster Hospital Guide named the Trust as Overall Trust of the Year and Foundation Trust of the Year in England in 2010; however, this appeared to be a double-edged sword. One member of staff said that the Dr Foster recognition was:

> *… a bad thing and a major error. Complacency started to come in … There were things the Board believed that were not true … [P]eople had got into the wrong frame of mind. It was great to get awards if you were doing well, but not if it gave false assurance, and things were melting down behind the scenes.*

4.130 One consultant felt that senior managers became arrogant as a result of the 2010 award and *"shot down other people's suggestions for further improvement as a result"*. A senior member of the management team described the Trust as:

> *… riding on the Dr Foster's award and felt itself to be quite above everything else … the Dr Foster's award was held up to every criticism.*

4.131 Many staff, and others, spoke about a culture of denial at the Trust and a resistance to change. The Panel was told that, following the 2014 CQC inspection and report (which resulted in the imposition of Quality Special Measures), the reaction of the Trust was one of real defensiveness.

4.132 A member of the Executive who joined the Trust after the CQC report commented that the Board was *"potentially in denial about the organisation"*, which served to reinforce the disconnect between the Board and the wards. One manager told the Panel:

> *[T]he organisation was utterly floored and did not recognise the report. People were traumatised.*

4.133 There was quite a strong feeling from Board members that the Trust was a victim, that *"everyone was against them"*, and that *"things weren't as bad as this"*. Another senior manager commented:

> *[T]he Trust board were in complete denial and were shocked, angry and hurt. They disagreed with just about every point in the report.*

4.134 The Trust went through the CQC reports:

- The Trust came up with *"hundreds of challenges to the report, including grammatical/spelling issues … rather than getting to the essence of the report or discussing what to do".*
- *"It was not for nothing that the Trust was rated inadequate, yet they responded by sending back comments about commas and semi-colons, losing sight of the problem."*

4.135 We heard that the Trust did not use its staff surveys to identify issues, and that there were some very bad staff surveys that fed into the CQC report. The staff survey results in 2014 gave an indication of bullying; however, these results were not a one-off and bullying had been a common theme in previous surveys. We heard that *"the trust central teams were in denial"* and it seemed that they were not *"systematically reviewing anything on a regular basis"*.

4.136 Interviewees confirmed that staff survey results at the Trust were never very good. A member of the HR team told the Panel that, whenever they tried to discuss the results, *"they weren't necessarily what people wanted to see and hear. We were told there were lots of reasons why the results were invalid."* They told us that there was no desire on the part of the Board or the executives to think about the survey results and what they were telling the Trust:

> *This desire to give a rosy view was unhelpful … it was unhelpful to patients too because it doesn't provide a full picture of what is really going on in an organisation and the potential risks and issues.*

4.137 In 2014/15, the then new Head of Midwifery identified cultural issues within maternity services; they described their reaction to East Kent maternity services to the Panel as being *"the next Morecambe Bay"*. One senior midwife told the Panel that staff were really shocked by this as they did not see the similarity: *"things were being said that were very untrue"*. The Panel also heard that East Kent was *"equal to or worse than Morecambe Bay"*, but:

> *[T]here was no recognition, insight or acknowledgment from the obstetricians or the midwives into any of the issues identified in the 2014* [CQC] *report.*

4.138 One clinician told the Panel that they did not recognise some of the issues that were highlighted in either the CQC or the RCOG report. A senior midwife remembered the RCOG report being dismissed by a senior consultant obstetrician as a *"load of rubbish"*. The midwife commented to the Panel that Trust obstetricians did not like the light being shone on them in that way.

4.139 Another clinician couldn't recall the RCOG report being widely discussed, and they were not made aware of the report's key findings or recommendations. Similarly, a junior doctor told the Panel that the report was not formally discussed with junior doctors. Another consultant told

the Panel that they believed the issue raised by the RCOG report around consultant availability was limited to just two consultants, one of whom left the Trust.

4.140 In 2018, the Trust's maternity services were rated by the CQC as "Requires Improvement", although reference was made to the introduction of multi-disciplinary training as a step in the right direction. We heard that the Board took reassurance from that, notwithstanding the lack of effective audit and quality assurance systems that was identified by the CQC.

4.141 Professor Walker, the Clinical Director of Maternity Investigation at HSIB, spoke of the initial defensiveness of the Trust in 2018 and of a lack of opportunity to engage with staff outside a small number of senior Trust staff. There was a meeting in the summer of 2019 between HSIB and members of the Trust's Executive, at which there was a lot of aggression and pushback by the Trust. Professor Walker told those present in the meeting: *"[L]ook, you've got a major problem at this hospital, which is going to escalate, and you'll hit the press by the end of 2019."*

4.142 Another HSIB officer told the Panel: *"There was denial in the Trust about the enormity of the underlying problems."*

4.143 The relationship with HSIB was described by a member of the Board and Executive as difficult. So too was the transition from a process whereby the Trust conducted investigations itself, with the benefit of having a relationship with the family involved, to outsourcing the process to HSIB. They commented that the HSIB process felt very impersonal, and people were defensive.

4.144 This defensiveness was echoed by another member of the Board, who described being *"blind-sided"* by HSIB's serious concerns in about 2019 that East Kent maternity services were at the top of the list for total body cooling (therapeutic hypothermia) and feeling disappointed that the Trust had not engaged appropriately with HSIB on the issue. There was an internal report to the Board in December 2019 addressing HSIB's concerns and citing improvements in certain areas (such as staff recognition of clinical deterioration or changes in the escalation process), although no evidence was provided and *"frankly the Board was not assured that what they were doing was enough"*.

4.145 A non-clinical member of the Board felt that the relationship with HSIB was not proactive and detected a reluctance within the Trust's clinical team to accept what HSIB was saying.

4.146 The Panel heard from Nick Hulme, a Trust Governor, that, even as recently as 2020, at Council of Governors meetings it was regularly highlighted that it was *"not fair"* that East Kent scored lower down the lists of trusts, given the large size of the Trust and that it had *"a lot of comorbidities"*. Mr Hulme told the Panel that governors were told to *"ignore the press"* because they had *"an agenda"*. Mr Hulme also told the Panel that he had been actively dissuaded from speaking to the Panel by a member of the Board, who told him that he *"would not add value"*.

4.147 Mr Hulme also told the Panel about an attitude within the Trust of *"well, as long as we're not bottom, that's alright"*. There was no ambition to be anything other than *"bang average"*, and the focus was on *"get to good"*. The Panel also heard from a Board member of a *"culture of failure for five or six years"*, with the Board being described in around 2017/18 as *"very fragile and brittle"*:

> *There were few people left in the Trust who knew what success looked like or who had experienced working in an organisation that was functioning effectively. It wouldn't be straightforward to change that.*

4.148 The Panel heard of clinical leads who were resistant to change and reluctant to look outside the organisation or to be open to other ways of working. One manager was used to organisations seeking fresh eyes on incidents or complaints, but this was always resisted at the Trust.

4.149 The Panel was told that concerns about maternity services were raised with the executive team by the divisional management and by other functions within the Trust, such as clinical governance and patient safety, legal and HR, but nothing happened.

4.150 The Panel heard that the practice of the Trust was to discourage the reporting of screening issues to Public Health England, despite it being national policy to do so, and that a screening coordinator was reprimanded for involving Public Health England in a serious incident and was told not to report issues externally. The Panel heard that the culture in the past was to keep things in-house, but that this had improved more recently.

4.151 One consultant midwife sometimes found East Kent maternity services slow to adopt new national recommendations, for example about identifying women at risk of restricted fetal growth. They told the Panel that they would approach the governance team, maternity leadership and the obstetricians about making the recommended changes, but those approached would often produce counterarguments relating to equipment or resources for why the recommendations could not be implemented.

4.152 A member of staff who had rejoined the Trust in 2019 recognised positive changes that had occurred and noted that morale and staffing had improved. However, there was still a reluctance within the Trust to adopt new research and guidelines.

4.153 The Panel was told that, even in 2020, obstetricians and paediatricians had a focus on process rather than on outcomes. That included some of the work of the Birthing Excellence: Success Through Teamwork (BESTT) programme:

> *For example, they would try to decide whether a day or a day and a half of training per month was needed, instead of identifying the outcomes they needed to achieve and then basing the training requirement on those.*

Culture of blame and handling complaints

4.154 The Panel heard from a number of people about a "blame culture" when things went wrong:

- *"Feedback was almost like a blame game where someone was at fault and had done something wrong, rather than giving feedback on how to improve when something happens."*
- *"Raising complaints at the William Harvey was difficult as individual staff would feel blamed for mistakes."*
- *"Ashford* [WHH] *is odd and the culture there is weird. They are less likely to support each other, and more likely to blame."*
- *"Staff are less supported now by senior management than they have ever been, and there is a culture of blame and recrimination."*
- *"There was often feedback, but it was not given in as supportive a manner as it could have been … You were only called to see your supervisor if you had done something wrong … I am open to scrutiny if there are lessons to be learnt but that doesn't mean you're a bad midwife or that you did it on purpose."*

- *"*[Consultants] *take no responsibility for their actions and blame colleagues for any challenges and failings."*
- *"One particular paediatrician would often blame obstetricians for any deaths or serious incidents that arose."*
- *"Historically there was a lot of jumping to conclusions and finger-pointing, whereas* [more recently] *there's recognition that things aren't black and white – that they can be complex, and you shouldn't jump to conclusions."*

4.155 A midwife told the Panel of an incident when they were called before an obstetrician after a baby had become grey and floppy in recovery, and the obstetrician seemingly accused the midwife of doing something wrong (*"that baby was screaming and fine in theatre, what happened?"*). There was a similar account from another midwife where there was a poor outcome:

> *[T]he consultant stormed onto the ward the next day and demanded to know what I had done to produce this outcome.*

4.156 A band 7 midwife told the Panel of the *"punitive approach"* to dealing with issues:

> *[T]here's a lot of fear among staff about making mistakes and being told off, and this hinders their ability to learn.*

4.157 The same member of staff told the Panel that there was *"no celebration"* of anything that was done well, and communication was not transparent. When a learning opportunity was identified, it felt like a punishment; the approach at the Trust's maternity services was *"not healthy"*.

4.158 The Panel heard from a senior midwife about the difference in the treatment of midwives and doctors. Whenever there was a root cause analysis investigation, there were often outcomes for midwives such as referrals for supervision or reflection, or formal HR processes. However, for doctors, there would simply be an informal conversation:

> *This was why the midwives felt that there was a blame culture and that things were inequitable.*

4.159 A separate senior midwife made the same point and described how issues raised with doctors wouldn't go any further and there wasn't any challenge to difficult obstetricians, whereas with midwives the outcomes were very structured, with a pathway and supervision.

4.160 We heard that a lot of disciplinary action was taken and that, at one disciplinary hearing, the Chair said: *"I don't know why this has got this far. How did it get to this?"* When a midwife was referred to the NMC, the case manager came back and said: *"I've looked at everything and I don't know why she was referred."* We were told:

> *There was a knee-jerk reaction to punish people and it created a very unpleasant environment.*

4.161 Others commented that, when things went wrong, there was no opportunity to debrief; the response was reactive rather than proactive. The Panel was told of a culture of blaming junior staff or locum doctors for whatever problems occurred within the Trust.

4.162 The Panel heard that some issues could escalate quite quickly, and that staff seemed to act on rumours rather than facts. A midwife could quickly be on an action plan after raising a

simple issue that they were not sure about, when *"*[it] *didn't need to go that far".* The Panel was told that midwives were hindered by fear: they worried about what people thought and said about them, and about things being done in the background that they were not aware of.

4.163 The Panel was told about a focus on documentation, and that this could distract from giving actual care, noticing when things deviated from the norm, or recognising when issues needed to be escalated. The Panel heard that midwives were sometimes too scared to press the emergency buzzer in case they were wrong, or to tell a more senior staff member on duty that they were unsure about a situation. This fear related to delivery suite coordinators and obstetricians as well as band 6 and 7 midwives.

4.164 There were approximately five to ten complaints each month about maternity services, mainly about communication and relationships. They covered:

> *… things like the fact that people didn't feel involved in the decisions that were being made and hadn't been provided with sufficient information.*

4.165 We heard that a high proportion of complaints about maternity services concerned the midwives' attitude towards and communication with younger women, who felt that things weren't always explained well or that they weren't listened to, helped with breastfeeding or given information about their baby. Other common themes reported to the Panel included pain relief and whether or not a caesarean section should have taken place.

4.166 A senior midwife commented that inappropriate staff behaviour was the most prevalent *"human factor"* at the Trust, and that it was not limited to midwives; complaints were also made against healthcare assistants, obstetricians and ultrasound staff. They commented that *"complaints as a result of poor behaviour impacted staff across the board"*.

4.167 The Panel was told that the obstetrics and gynaecology department had a "fix it" clinic every other Friday morning, where a consultant and specialist nurse would meet with women who were unhappy with their treatment and care. There was a six-month waiting list for the clinic, but the women *"had the opportunity to get stuff off their chest and try to sort something out".*

4.168 The Panel was told that Trust staff had later come to see the importance of standing back and thinking about what the family's needs were in situations where complaints were made, and the need for staff to take time to talk things through with the family, to listen to them, to understand what was important to them and how they were feeling, and then to respond to that, rather than assuming that they knew what was important.

External factors or problems as the staff saw them

Facilities and infrastructure

4.169 Infrastructure was cited as an issue for many services in the Trust. One member of the Board and the executive team talked about the estate:

> [It is] *profoundly challenging – it is difficult to attract clinicians and to provide good modern services.*

4.170 Another Board member commented:

> *The maternity estate is tired, poor, and needs replacing and totally modernising. But it's not just maternity – the entire estate needs this.*

4.171 Some members of staff talked about QEQM as *"falling apart"* and not *"fit for use"*. The Panel heard about the challenges presented by the size of the rooms and the lack of resuscitation trolleys on the ward.

4.172 We heard that theatre access was identified as a problem at QEQM: there is only a single theatre in the labour ward and, if there were a second emergency, it could take up to 30 minutes to organise and start operating in the main theatre.

4.173 One midwife referred to the *"struggle with the footprint of both the acute labour wards"*. The MLUs were new, but the majority of women were giving birth in environments that were not fit for purpose. Another senior midwife described the dated estate as a *"big problem"*.

4.174 A member of staff who worked in the MLU at WHH commented on the difficulty presented by having the MLU on a different floor of the hospital from the labour and postnatal wards:

> *The team felt disjointed … The perception was that you didn't matter. It was difficult to keep the woman at the centre when you're juggling politics between two areas.*

4.175 One consultant commented:

> [A] *lot of the labour beds have only 30% of space recommended by national guidance. This meant that if a baby was born in poor condition, midwives would have to run down the corridor to consultants as there was no space to treat the baby by the bedside.*

4.176 The Panel heard that WHH would struggle to meet guidance recommendations that each labour bed should have a bath available.

4.177 We heard that there was only one toilet for staff across the whole unit at WHH, so if someone was working on the Folkestone Ward (which provided care for antenatal and postnatal admissions), they had to tell the other midwives that they were leaving the ward to go to the toilet. One midwife told the Panel: *"I feel like we're not well looked after as midwives."*

4.178 The Panel heard that requests for a second obstetric theatre at WHH were declined because maternity services did not generate as much money as other departments.

4.179 The Panel was told by many interviewees that one of the problems at QEQM was that the resuscitation trolleys were outside the delivery rooms, and there were several cases where a baby was taken out of the room but their mother would hear things going on in the corridor that related to their baby, which was very distressing. The response of the Trust was that it couldn't do anything about it because, in its view, it was the nature of the Trust estate.

4.180 The Panel also heard from Mr Hulme, a Trust Governor, who commented:

> *[Y]es, the estate is in a mess and absolutely needs to be improved; they are awful but … it is not impossible to do really good care just because the buildings are rubbish.*

Geography

4.181 Some people who spoke to the Panel mentioned the challenges presented by East Kent's geography:

- *"The geographical location of the hospitals on two different sites is also a difficulty, as staffing levels and service quality need to be maintained across both sites."*
- *"You can't change the geography of the organisation. The challenge is how to ensure the right support is in there, given the geography."*

4.182 A director observed:

> *[O]ne of the challenges for East Kent staff is that there are few alternative employment opportunities. A nurse working in Margate would have to commute eighty miles, e.g., to Medway* [and back]*, if they wanted to work at another NHS trust. Professionals who train at Canterbury Christchurch University, e.g., radiographers and nurses, gain their practical experience in the Trust and then* [are] *likely* [to] *come to work for the organisation too … staff tended to be inward-looking in their view as a result.*

4.183 The Panel also heard comments that it is difficult to build strong organisational connections and shared values across separate sites. Some staff expressed doubt as to whether the Trust would be viable over the long term with two or three sites.

4.184 An experienced consultant told the Panel that the geography made the Trust difficult to work at:

> *[W]hen an incident does occur, managers become torn between multiple sites and must choose carefully where they spend their time.*

4.185 The Panel was told by an experienced midwife of occasions when the labour ward at QEQM was closed due to safety reasons, requiring attendance at other sites. As the nearest labour ward is 30 miles away and women are often reluctant to travel to other sites, unplanned home births could result. Women were not routinely told that there was a risk of the labour ward being full before they entered the hospital or that being transferred to a different trust was a possibility. This was particularly a problem at Thanet, where many people do not have their own transport and therefore there was little possibility of reaching another trust in time to give birth safely.

4.186 A member of the Board and Executive described how the maternity case mix at the Trust changed between 2007 and 2015:

> *[T]here was more complexity, higher teenage pregnancies, higher than usual problems with smoking, obesity, and diabetes – all the social determinants of health. East Kent has both affluent areas and also a lot of deprived areas, particularly coastal areas. From a midwifery point of view there was a lot of complexity that people were managing. The Trust was tracking c-section* [caesarean section] *rates and intervention rates and they were tracking slightly higher than the national norm.*

Staffing

4.187 A number of people to whom the Panel spoke commented on the difficulty of recruiting staff to the Trust, particularly at Margate:

- *"QEQM was always a difficult site to recruit to, on the extreme southeast of the country and a coastal community."*
- *"Margate is the furthest place from London where people want to go and settle, and finding staff is not easy."*

- *"One thing about the geography was that it was almost impossible to recruit staff to go to Margate, so the only staff they had were people who lived there, and they had been there a very long time. If you don't get any turnover, then that brings about an issue."*
- *"The biggest issue was staffing. Just prior to 2009 there was a large investment (almost £4M) into nursing and midwifery because the staffing levels were not safe. However, recruitment was a challenge given the geography of East Kent (coastal areas at one end of the country), and there was difficulty in recruiting both midwives and obstetricians, and the Trust was more reliant than it wanted to be on locums."*

4.188 One senior consultant described QEQM's middle grade medical staffing situation in 2012 as *"dire".* However, we heard that, by the end of 2013, QEQM had a full set of middle grades and there was active recruitment of staff from abroad.

4.189 The picture presented to the Panel in some interviews was that, up to 2015/16, there were quite a few experienced middle grade doctors who had been at the Trust for a long time; and that from 2015/16 to 2019, there were a lot of rota gaps and there was a time when more than 50% of the rota was covered by locum doctors. Some consultant obstetricians told us that they were always worried when working with someone they had not met before and that they gave careful consideration to whether locums could be left unsupervised. These issues were escalated to the divisional Medical Director, but it was not felt that they were taken seriously enough by the Trust. We were told:

> *It was difficult to maintain quality with locums. This is not a problem unique to East Kent but the thing that set them apart was the scale of it – 40-50% of the shifts … Trying to secure locums at short notice was an endless task.*

4.190 A senior midwife described how the CQC's intervention in 2014 and the adverse publicity facing the Trust caused difficulties in recruiting staff. They described the workforce as stable and structured prior to 2016, but after this there was a need to use significant numbers of locum doctors, which had a negative impact. The quality of some of the locums was described as *"troubling"* but it was *"a case of having that locum or nobody"*.

4.191 We heard that the Trust was spending about £17 million per annum in 2018 on locum doctors and agency staff, which was, according to one Board member, *"bad for patient safety and continuity"*. The Panel heard that there were constant challenges in keeping staff up to date.

4.192 The Trust was described by a regulator as *"not a Trust that attracts quality staff from elsewhere"*, and a midwife told the Panel that trainees did not want to come to East Kent as it is too far out of London.

4.193 The Panel was told that a benchmarking exercise within midwifery in 2020 had established that numbers of staff within the Trust's midwifery unit were too low. A review of resources in the same period had established a need for specialists in mental health and heart monitoring, more core midwives, an additional community midwife, a Deputy Director of Midwifery, and two senior band 7 nurses to focus on patient experience and digitisation.

Leadership

4.194 The Panel was told that, following the achievement of Foundation Trust status in 2009, the period from then until 2014 was one of relative stability, and that at Board level things felt strong. However, one Board and Executive member reflected that staff morale was adversely affected by the impact of 5–6% efficiency savings year on year; the Board failed to recognise

this development, even though the signs were there in the staff survey results, which showed that stress and bullying increased during this period.

4.195 A non-executive director told the Panel that the Trust was *"too large, complex and diverse for the ability of the executive team"*:

> *It was just out of their league. It was just too big. The span and complexity was too large for them … They weren't even firefighting. They were just on the ropes being punched the whole time.*

4.196 It was said that individuals were doing the best they could; however, the system was letting them down. The lack of senior leadership training and senior leadership models was an issue. Also, we were told that the problems in maternity were:

> *… symptomatic of an organisation that is outwith the competence of the executive team.*

4.197 One director during the period described the Board as:

> *… very dysfunctional; it was not united. They did not work well together, and they were very separate … The chairman and the chief exec were pretty much not talking to each other.*

4.198 It was commented that the quality of non-executive directors on the Board was variable and that they did not always provide the right kind of challenge. One member of staff described the non-executive directors as *"weak"*:

> *[T]hey didn't know what they were doing and didn't have enough challenge. They didn't know the data. Your non-execs are there to hold the executive to account in the right way and I didn't think that was happening enough.*

4.199 The Panel heard about *"really awful reporting to the board"*:

> *There was no challenge or testing at executive level, and that's partly what got them into the mess that they got into … Nobody really knew what the truth was about a problem.*

4.200 A non-executive director with experience of both public and private sector boards commented that the Trust was just going through the motions.

4.201 The Panel also heard about communication breakdown between non-executive directors and the Executive Board. One non-executive director first became aware of issues in maternity services the day before a news story was about to break on the BBC website. On another occasion, the same person first learned of an issue after seeing the front page of a newspaper. It transpired that the Executive had known about this for a month but had not thought it appropriate to tell the non-executive directors.

4.202 Senior management were described as lacking people skills. One member of the Executive was described as a *"threatening"* presence throughout the Trust; the Panel heard that *"staff did not feel supported by* [them]*"*. Another member of the Trust Executive was described as *"overwhelmed"*, with a tendency to talk at people rather than engaging fully.

4.203 The Panel was told of a toxic culture and unhealthy tension between managers and clinicians, who had different priorities. The managers were quite wary of powerful clinicians:

> *[I]t led to a really unhealthy tension where people just tiptoed around the issues.*

4.204 Of the culture, it was said:

> *[T]hey're* [senior managers] *really frightened of these people* [consultants].

Changes at Board and senior management level

4.205 After the 2014 CQC report, the Trust lost its Chair, the Chief Executive, one of the joint Chief Operating Officers, the Director of Nursing and the Director of Finance. This heralded the start of a long period of instability at Board and senior management level which had:

> *…* [a] *tremendous impact … Everything got put on hold because key people were not in post.*

4.206 Since 2014, there have been three Chief Executives of the Trust, four Chairs of the Board, three Chief Nurses and four Heads of Midwifery (referred to since 2018 as Directors of Midwifery). A number of members of Trust staff identified that the level of turnover in key senior positions had had a detrimental impact on the effectiveness of the Board and Executive during this period. It was also said to comprise a disproportionate amount of the Council of Governors' work.

4.207 One member of the Board and Executive described the Chief Executive post as *"undoable"* and a case of *"how long is the next one going to last"*. One Head of Midwifery was asked by a senior colleague on taking up their post, *"how long are you going to stay?"*.

4.208 The result of so many changes within the management structure was that *"people didn't have much confidence in the management team".*

4.209 The Panel was told how tough it was to maintain momentum while losing people and continually having to develop new relationships; of the damaging impact of the constant changes of senior leaders; and how initiatives were regularly implemented and then abandoned with the next change of leader.

4.210 The Panel was told that the departure of the Chief Executive in 2017 was *"catastrophic"* and that *"the visible loss of leadership had major consequences for the Trust"*: *"conflict and difficult relationships"* abounded and remained a problem for two years.

4.211 One senior midwife described how, every time someone new came in, the journey would start again, with new leaders wanting to know everything that had happened and changing priorities. It was a case of *"that's not important, this is now important"*. The BESTT Maternity Transformation Programme that was launched in 2017 was cited as an example of a programme that had been owned by the staff but was now *"shelved"* and *"just another example of not seeing something through"*.

4.212 Another senior midwife said:

> *[T]he goalposts were being moved quite a lot because there were new Heads of Midwifery coming in.*

4.213 And another member of staff said, in reference to the six different Heads of Midwifery throughout the period of the Investigation:

> [A] *new incumbent would bring new ideas and then things would change again with the next person. It felt as though we were always trying to catch up.*

4.214 The Panel heard that, both in the immediate aftermath of the 2014 CQC report and since, there had been a high turnover of non-executive directors, with some leaving because they had come to the end of their tenure but others leaving due to frustration or because the pressure of reputational issues was too much. Some non-executive directors chose to move on before the end of their term because they did not want to be associated with what was happening at the Trust.

4.215 We heard about the dangers of "hero leaders" who were expected to single-handedly reverse the fortunes of an organisation, only to be quickly and repeatedly replaced when they inevitably failed. We also heard of the need for a strong leadership team with a long-term strategic vision beyond the next two to three years.

4.216 Commenting on a whole series of changes of leadership, Professor Ted Baker, former Chief Inspector of Hospitals at the CQC, observed that stability and support from external parts of the system such as NHSE&I and the CCGs are required in order to turn a trust round from special measures:

> *If you look at East Kent … there has been a whole series of changes of leadership and none of the leaders have stayed very long. That kind of chopping and changing leadership and people who go in to lead an organisation like that and have a two-year horizon in terms of what they want to achieve, are never going to drive the change you want. There's a history in some of these trusts that don't make progress, that when we find real problems – put them in special measures – the leadership changes and a new hero leader is brought in, whoever they may be, and they are going to sort it out. And two years later they have failed, and they move on quietly and someone else comes in. The misconception is: one, it's not one person, it has to be a team; two, it's not a hero leader, it's someone who is thoughtful and who is going to drive cultural change; and three, they need support, however good they are, from the external part of the system – NHSE&I, CCGs or ICSs* [integrated care systems] *now. They need to support them because taking a trust that is in special measures, that is inadequate and has really serious issues and turning it into a really good trust, is a huge job and a formidable challenge. It's not one person's job, and it's not something anyone can achieve easily.*

4.217 Professor Walker, who had significant experience of investigating maternity incidents at the Trust with HSIB, offered this insight:

> *There were continued problems and with continued themes, which in fact have continued to this day … A lot of big hitters come into East Kent to try and solve a problem, and in fact they make the problems worse because they obligate the Trust to spend a lot of money and time building structure, while not necessarily solving the problem on the shop floor. And so, the same problems on the shop floor, lack of support, lack of escalation, are still going on … The appointment of a CTG midwife or a lead person in this, or having a committee in that, doesn't solve these problems … A lot of the oversight groups spend their time trying to be reassured by what's going on, rather than finding out whether something is improving. They want people to say, "we've got this committee, we're looking at that, this is our report, this was our graph", and everyone nods and says, "well, that's really good" and "let's move on" without looking to see whether things have changed … What East Kent told us is that although there was leadership there, they weren't in touch with what was going on … and they tended to believe what they were told.*

4.218 The Panel was also told of a lack of stability within key clinical roles and that members of the Executive did not act as a single cohesive team providing a tier of support below the Chief

Executive. The size of the Trust, the portfolios of those working there and the expectations were said to be huge and potentially unworkable.

4.219 One experienced midwife told the Panel that they saw the situation deteriorate around 2015/16:

> *[T]here seemed to be a flurry of appointments made of people who had very little experience and it appeared almost as if they were trying to eradicate all previous managers and senior people from the team … They were appointing people with no background experience and their lack of experience was reflected in what was happening on the shop floor unfortunately.*

4.220 The Panel heard:

> *[T]he long history of reports of deep cultural issues in East Kent maternity services was related to instability in the leadership team. Other contributory factors were the fact that the two sites worked separately rather than together as one trust, and the large geographical spread of the trust. In 2018 there was more stability in the leadership, and it felt as though a shift in culture led to people working well together … staff took more ownership of what was happening. There were obstetrics and midwifery leads for all pieces of work and if the focus of a project was on one site, then the other site had shadow leads for obstetrics and midwifery.*

Clinical leadership

4.221 The Panel heard that doctors were not engaged in the management of the Trust, and a senior member of the Executive spoke of the difficulty in attracting good leaders as well as in having a body of consultants who were unwilling to be led.

4.222 Another member of the Executive highlighted several dangers related to the way in which the clinical effort was focused at East Kent maternity services – there was a historical lack of clinical leadership and *"it was much more controlling and quite negative"*:

> *There is a culture of politically aware bureaucrats versus clinicians who don't have the leadership skills.*

4.223 The Panel was told of a reluctance on the part of staff within obstetrics to take on leadership roles, and that the midwives and obstetricians held their meetings in silos with very few multi-disciplinary meetings. One midwife described a Clinical Director within the obstetric team as like a *"lone ranger"*.

4.224 The Panel was told that consultants' views were not included in decision making, and without good clinical leadership in women's services, it was hard to get voices heard. It was noted that clinicians did not feel accountable for what they did, which led to consultants not being there when they were supposed to be.

4.225 One consultant told the Panel that they had told the RCOG that three colleagues should be sacked because *"they didn't have the same work ethic and responsibility"*.

4.226 Leadership within midwifery was described at times as resistant to challenge and favouring the status quo, which was a source of frustration. The Panel heard from senior midwives that there was a perception that the views of midwives were blocked and not

escalated appropriately due to *"gatekeeping"*. It was frustrating that midwifery did not have a voice at Board level.

4.227 The Panel heard positive comments about the leadership of midwifery more recently, with improvement in effective leadership, visibility and openness to challenge.

Financial Special Measures

4.228 The Panel heard that, immediately after exiting CQC special measures, and perhaps as a result of spending on the improvements required, the Trust was placed in Financial Special Measures by Monitor.

4.229 A Board member described the impact of being placed in Financial Special Measures in 2017 as like coming out of Quality Special Measures on a Tuesday and going into Financial Special Measures on a Wednesday. A number of Board and Executive members told the Panel that going straight into Financial Special Measures was not helpful. One said:

> *The organisation came out of special measures, and the next day they went into financial special measures, which was massively unhelpful and not necessary. It gave the organisation no time to take its breath … This didn't directly lead to the problems within maternity services, but it is part of the context and the people who would have been doing work on maternity services were responding to financial special measures and all of the effort that required. Had the organisation been given time to breathe it may be that there would have been more focus on maternity issues.*

4.230 The Panel was told about the significant impact that Financial Special Measures had on the transformation and improvement agenda, and on innovation; the Trust became very financially focused and operationally led. One member of the Board and Executive described the organisation as *"controlling"* and stated that, because of the problems with the finances and the buildings:

> *[P]eople couldn't see a way out. It felt very negative. Staff were not utterly disengaged but they were very despondent.*

4.231 A member of the Board and Executive made the following points:

- The Trust has been in deficit since at least 2016 and the deficit target has been missed every year since 2017.
- The Trust has been aiming to make 4–5% efficiency savings each year (£30 million) and has sought to do this in a way that does not affect clinical services, for example by making structural changes that produce a saving on VAT.
- However, there have also been some cost efficiencies in clinical areas.

Governance

4.232 Members of the Executive spoke of the disconnect between ward and Board and of communication issues. One told the Panel:

> *It didn't help to have a disparate multi-site Trust. It didn't help that there were issues with medical engagement and a lot of turnover in the Board. It didn't help to have a bunch of people who, when the divisional structure came in, got put into roles without any development. One of the recurring themes in CQC inspections around the country is the*

> *middleman, through whom nothing filters down or goes back up. Where organisations work well, the communication is great from ward to Board and Board to ward. It comes back to the multi-site structure – people need to walk around to see what's going on. It is not enough to be in an office and do it by video link.*

4.233 One member of the Board and Executive was aware, even before they joined the Trust, of the fact that the views of management were not shared by the staff. Another described sitting aghast as they listened to feedback provided by ward colleagues and feeling like they were not part of the same organisation. The executive team did not listen enough to what people were saying, and they did not talk to those on the ground. One senior executive observed:

> [There was a] *significantly different view between the board and the staff about the purpose of the organisation.*

4.234 One clinician felt that certain sites were underrepresented within the Trust's governance structure, with QEQM being under greater pressure because of recruitment issues and a lack of capacity for staff to participate in governance. Well-staffed sites, by comparison, had more time to focus on non-clinical issues.

4.235 The Panel was told by a Board member that the governance structures within the Trust were not sufficiently robust to allow assurance from ward to Board, and that the Board did not give consideration to this issue or to what it could do differently. Another member of the Board described the governance arrangements in 2018 as:

> *… like being in a car, when you move the gear lever, and nothing happens. The governance from board to trust and from ward to board had broken down and needed to be fixed.*

4.236 Consistent with this observation, the Trust was described by regulators as an organisation that did not actively look for problems and issues to solve; rather, it waited for them to be pointed out. They suggested that the Trust needed to be problem sensing rather than comfort seeking in its approach.

4.237 A senior midwife told the Panel that maintaining compliance, receiving feedback and implementing lessons learned were some of the key priorities that were not always addressed. It appeared to them that sometimes the Trust was waiting for an incident to happen, rather than utilising the vast amount of patient safety incident data available to predict incidents.

4.238 A senior manager described governance within maternity services as:

> *… frightening, but they had normalised it and couldn't see there were issues … The leadership within maternity did not mix at all. Staff days and learning within the nursing teams was not embedded. It was very narrow in the way that it operated and didn't invite people in.*

4.239 A senior manager told the Panel that the Board *"tended to deny there were problems and suppress discussions"*. After the 2014 CQC report, Board committees were split so that the Quality and Safety Committee included nursing and medical staff but did not include divisional directors; this impacted the quality of the conversation and the decision making.

4.240 The Panel was told that the Executive had difficulty accepting the findings of the initial CQC review and *"spent about six months quibbling over what was in the report"*. It was said at the time of the report that *"there was nothing of significance coming out of women's services"*.

One senior member of staff thought the Trust did not understand how much time was needed to take the actions forward.

4.241 Former Board members told the Panel that, between 2016 and 2018, maternity services featured very little in Board discussions and should have had a higher priority. The priority issues for the Trust in 2018 were described by a member of the Board as: safety, governance and finance – *"the core business of a hospital"* – but with specific focus on A&E (which was the worst in the country); cancer services (which were the fifth worst); and the response to treatment time (the Trust had the second longest waiting list in the country). It was accepted that maternity services did not consistently appear in governance sessions and that issues became diluted; their significance was not recognised as they were reported up through the chain and repeatedly summarised.

4.242 The Panel was told that the Board was looking for patterns and themes, but the mechanisms were not in place to identify them. It was recognised that clinical governance required improvement because the Trust did not have information flowing up and down the organisation between the point of care and the Board.

4.243 In terms of the Trust's recognition of the wider significance of individual events, Professor Walker told the Panel:

> *They didn't link* [two maternal deaths] *together … They just saw them both as really unusual things that happened out of the blue …* [HSIB] *tried to get across, yes there is a reason for it. It's the systemic failure … These were all, what used to be termed under old parlance, "latent errors" – errors waiting* [to happen] *… It was almost like a journey of realisation for them that these things were repeated in the same way. The problem they tended to do was they blamed individuals. They blamed the locum, for instance, for the problems, instead of saying, "well, the locum only has a limitation in their ability and knowledge of the hospital". What supervision or assessment did you make of that individual? Or did they just turn up on the night of their on call, without any orientation or anything like that? … The Trust had to think about the systems approach and the preparation and making sure everything is in the right place. So that took quite a long time, really, for them to be convinced of that. Initially they kept on seeing them all as one-off events.*

4.244 A Board and Executive member commented that the information flow seemed to be there but noted that the relative performance of the Trust was not known by the Board and that they were not aware that it was *"the worst performing"* trust in the country. They also told the Panel that the Board was concerned about whether it had sufficient information, which led to overcompensation by diving too much into the detail on issues, rather than standing back to understand what the information was telling them.

4.245 One Board member was aware before joining the Trust that it was one of the – if not the – *"most challenged trusts in the United Kingdom"*:

> *My initial impression was that there was a very severe problem with governance throughout the trust, throughout the three hospitals, and that was split into two groups. There was a structural problem and there was a deep-seated cultural problem. The structural problem was that the Board only met every two months, and this is a Board with five hospital sites with some of the most challenging performances in the country and quite clearly that was nowhere near enough … But there appeared to be no recognition of what was needed*

> *for a Board. There was no ownership of* [Board] *papers. The papers were often late. To be honest with you on closer questioning they could be inaccurate. They could be incomplete.*

4.246 A different Board and Executive member expressed the belief that there remained issues around serious incident reporting and the level of visibility the system provided. They told the Panel that they became aware of baby Harry Richford's death only when they saw the first draft of the root cause analysis report in March 2018 and read it *"with mounting horror"*. They told the Panel:

> *[O]ne of the reasons it was so difficult was that obstetrics is largely a well-specialty. They were dealing with people who were well, and it can take time to pick up where things were not quite right. If activity or behaviour starts to become normalised, it needs someone to forcibly point it out, and that was part of the problem.*

4.247 The Harry Richford case was not formally considered by the Board until late 2019, prior to the inquest into his death. In response to the inquest, the Panel was told that different workstreams were set up, including a prevention of future deaths workstream, to which the action plan relating to what happened in Harry's case was added. The neonatal resuscitation process was reviewed, as was the 21-point Prevention of Future Deaths report and the 2016 RCOG report (which included the issue of consultant presence on the labour ward).

4.248 Mr Hulme, a Trust Governor, was struck by the fact that there was no external benchmarking of serious incidents; the only information provided was the number and type of serious incidents. He found it was very difficult to unpick whether the Trust was improving over time or not. There was no focus on repeated serious incidents. Mr Hulme said:

> *That does not show a learning organisation if you're not tracking the number of times that a serious incident has happened … Apparently there was no way … of looking at SIs* [serious incidents] *adjusted for comorbidities, for the size of the Trust and see whether, as a trust, we're not just resting on our laurels and assuming that we've always got to have 50 SIs per quarter, and that's just what it is.*

4.249 It was suggested that the Trust invest in a different methodology for looking at serious incidents, but *"that did not land well"* and an invitation to consider alternatives at a different trust was never taken up.

4.250 The Panel heard of concerns from midwives about how the organisation learned. Although HSIB reports were emailed, they were often not looked at or read. Although there had been improvements with the current risk team, there was no strong pathway for feeding back the learning from incidents. One midwife spoke of new guidelines being introduced in response to incidents but no one explaining why:

> *Staff aren't involved in improvement plans and yet they know what went wrong. They know how it could be fixed but they weren't invited to comment.*

4.251 One member of staff described the Trust's learning from incidents as *"formulaic"*, a *"pray and spray"* approach with *"fingers being crossed, and a policy updated"*.

4.252 There was criticism of the divisional structure, which created an extra tier of management. The structure of the divisions was described to the Panel as follows:

> *Each* [division] *was led by a divisional director. They had a doctor as a clinical lead as well, and the relationships almost without exception, between the doctor and the manager,*

were not good … The divisional directors and doctors just didn't understand about working together.

4.253 An experienced midwife recalled when a divisional leader came to a supervisors' meeting and said: *"I'll be perfectly honest with you, I don't actually know what you do."* A senior midwife told the Panel the same thing: that the appointed divisional leaders had very little understanding of maternity services and the difficulties midwives face.

4.254 Another senior midwife reported that a divisional leader did not assist the midwifery team in implementing new recommendations following the public consultation on maternity services in 2011, and that the *"potential for improvement had been lost"*.

4.255 The Panel heard similar comments from Board members and managers:

- *"[O]ne of the challenges that East Kent has had with its divisional structure and then its care group structure, is that a lot of responsibility has been delegated to those divisions/groups but the Trust has not always had the process in place to provide central oversight of their effectiveness."*
- *"There was this centralised but non-integrated board approach, and then below them they had what they called autonomous divisions and these divisions genuinely believed that they didn't have any accountability, so this wasn't just maternity. There were issues with each of the divisions."*

4.256 Midwives informed the Panel of concerns around clinical governance and said that they had written to divisional management to highlight that there was only one midwife within governance, while the number of reportable incidents in maternity services was higher than in many other specialties. They told the Panel that the governance role was much too big for just one person, that complaints were not dealt with well, and that there was a lot of pushback from consultants.

4.257 Senior midwives told the Panel that governance had not been an integral part of maternity services and that it had not been a golden thread running through the division, as it should have been. They indicated that, because governance was performed for the whole of the specialist division (of which maternity services were just a part), the ownership of governance was not felt strongly within maternity services; there were a lot of gaps and not a lot of reporting. The Panel heard that Women's and Children's Health *"didn't have a fair place at the table"*. More recently, the placement of governance within maternity services was an improvement.

4.258 The same point was made by a director:

[T]he golden thread lacked breadth and depth. It was obvious that there was no way that a good or a bad point would be taken from the top and worked down through the trust and spread across so that there could be learning or replication of good practice. The Women's and Children's Division was the same as the others, urgent care was the same, it wasn't specifically a maternity issue.

4.259 Maternity services were described as more insular than other services within the Trust, and the reporting culture was not as strong or as open as it was in other services. One midwife commented that debriefing and governance were not things that East Kent maternity services did very well. One anaesthetist commented that obstetricians and midwives often had to be requested for the debriefing process; for some, the debriefing was not very important and could

wait. A difference in approach between midwives and doctors was also noted, with midwives reporting more incidents and very little incident reporting from doctors.

4.260 One Executive member expressed concern about risk-rating issues with Datix; however, the Board was not receptive to the suggestion that the Head of Midwifery should report directly to the Board as an additional route of escalation. The Board was also dismissive of introducing a non-executive director for women's health to whom people could speak if they weren't being heard. It was therefore felt that there were issues incapable of resolution or of being escalated upwards.

4.261 A midwife told the Panel that one of the barriers to reporting was the time needed to complete the details required in Datix, and that if someone were an hour late leaving their shift then it would be quite likely that they wouldn't report an incident, even though it should be recorded. It was also said that it remained common not to escalate issues through reporting, including through Datix reports.

4.262 The Panel was also told that governance was compromised by recruitment problems and constantly changing leadership.

Response to the Royal College of Obstetricians and Gynaecologists report

4.263 The RCOG review was commissioned in 2015 because of concerns about the culture of maternity services, clinical standards and quality, particularly at QEQM. A senior manager told the Panel that they knew there were issues: *"[W]e needed something brutal to help them to change."*

4.264 A senior representative of the CCGs at the time told the Panel that the momentum for bringing in the RCOG came internally from the Medical Director within the Trust, who felt that it would be more credible to the obstetricians, particularly in QEQM, if they heard from their own professional group.

4.265 A senior midwife told us that the description of the behaviour of obstetricians within the RCOG report was accurate and said that the response to the report was not appropriate and that obstetricians did not engage with it. An Executive member similarly described the themes in the report as accurate and recalled a meeting being called with the whole executive team because the feeling was that the report was not being accepted:

> *The report's findings never resulted in an organisational approach to tackling the problem … Efforts to improve the O&G* [obstetrics and gynaecology] *service were confounded by poor and unstable midwifery leadership and disengaged clinicians.*

4.266 The Executive was asked to help get consultants to engage with the report. The Panel was told by a Board member that the main focus of the Board in relation to maternity services and its response to the 2016 RCOG report was the implementation of the BESTT programme in 2017 (which was described by one midwife as simply *"papering over cracks"*) and Human Factors training. Although the programme was considered a response to the RCOG report, it was built around the national agenda with specific areas of focus, and those involved in developing the BESTT programme were not provided with a copy of the RCOG report as it was considered *"outside of the scope of the project"*. RCOG recommendations were incorporated into a later phase of the BESTT programme in 2020 following the Harry Richford inquest.

4.267 The Panel was told that the RCOG report was never shared with the Trust Quality and Safety Committee, and that programmes such as the BESTT programme:

> *… seemed to indicate that matters were improving but it only involved recently appointed obstetricians and not the long-standing recidivists who were not going to change.*

4.268 Other Board and Executive members told the Panel that the response to the RCOG report was merged into one improvement plan together with the actions in response to the CQC report and the Local Supervising Authority (LSA). They told us that, with hindsight, this might have meant that there was insufficient focus on maternity and neonatal services. The improvement plan was signed off by the Executive, scrutinised by the Improvement Board, and reviewed monthly by the CCGs (with respect to maternity services and obstetrics). However, it was felt that maternity services were never given any financial support and had to work within existing budgets. One Executive member considered the action plans in response to the RCOG report to be more a "tick box" exercise compared with the response to the CQC investigation. People only began taking it seriously with the triangulation of other reports.

4.269 Nobody in the Trust had been able to produce evidence of how the RCOG recommendations had been implemented and completed, and there had been no action plan endorsed at Board level to rectify the situation.

4.270 The response to the RCOG report was described by one non-executive director as follows:

> *At that point, the hairs were going up on the back of my neck really quickly now. I'm just thinking, "oh my word".*

4.271 The culture of the obstetrics and gynaecology service was put on the risk register by the governance and patient safety team, in response to what they believed was contained within the RCOG report, although the Panel heard that they were not permitted to read the report and were later asked to remove the obstetrics and gynaecology service from the risk register.

4.272 A consultant who was involved in a review of the RCOG report in 2019 found that the action plan drawn up in response was incomplete and that fewer than 25% of the actions were robust and signed off. The consultant did not know why this was the case and could only speculate that either it was not considered important or there was no time to carry out the work properly.

4.273 A Board and Executive member spoke about how they had more recently sought to identify the actions taken by the Trust in response to the RCOG report but could not find a comprehensive response, or evidence for decisions that had been taken, or evidence of the monitoring of those decisions. They suggested that, because of this failure, the absence of a central repository for recording information and the numerous changes of personnel, a lot of the work done at the time the RCOG report was provided had been lost. They told the Panel that it was not until five years after the RCOG report that there was an action plan in place to cover the recommendations it made.

4.274 The Panel heard that the RCOG had no further involvement after the report had been written. It was believed that the Trust did not contact the RCOG after 2016.

4.275 Despite the RCOG report having been provided in early 2016 and containing a number of complaints about consultants failing to respond to requests for assistance from junior colleagues, the Panel was told that the report was not provided to the GMC until 2020, some four years later. The Panel was also told that the GMC decided, following review, that the complaints did not require "fitness to practise" proceedings.

4.276 In addition, the Panel was told that the RCOG report was not provided to the CQC until it was presented as part of information supplied prior to the May 2018 inspection.

4.277 Following the RCOG report, it was recognised by a member of the Board and Executive that it was significant that the Chief Nurse at the CCGs had written to the Trust to say that they were concerned about the quality of the serious incident investigations.

Risk management

4.278 The Panel was told that part of the risk management strategy around 2012 involved making divisions responsible for their risks:

> *This gave management teams a broader range of responsibility, though clinicians saw risk as remaining the responsibility of trust management.*

4.279 One midwife felt that people within the Trust didn't understand risk when the midwife joined in 2013, although this improved subsequently because the governance and risk obstetrician and midwife brought risk to the fore.

4.280 The Panel heard that there was one risk register for QEQM and another for WHH, and that issues on the risk registers did not necessarily come to the attention of the Risk Management Committee. The Panel heard that there was a monthly risk group meeting that lasted two hours. Corporate risks were reviewed at each meeting. Each care group had a risk register, but, depending on how many risks were on the register for each care group, it wasn't always possible to review every risk without extra time being allocated. Some maternity issues raised at the risk group – such as reading CTGs and resourcing – *"did not get the air time they needed to provide assurance for the board"*. However, there was acknowledgement from the Board about the importance of managing risk.

4.281 The risk register was sometimes updated to reflect the barriers to making changes, but it was *"underutilised and a bit hidden*. *It was all a bit of a mystery."* One senior member of staff thought that the care groups did not understand what the risk register was for, how it could be used or how it could help. The Panel heard that some staff were unfamiliar with the risk register or completely unaware of it.

4.282 A number of safety management concerns were identified to the Panel, including:

- A lack of progress with the CQC recommendations
- The risk register being frequently out of date
- Out-of-date policy documents
- An insufficient budget
- A lack of action relating to the quality improvement programme.

4.283 One member of staff was shocked by the things band 7 midwives at WHH had to say about patient safety, such as *"what's that got to do with us?"*, and that one patient safety lead was not open to challenge.

4.284 The Panel heard that perinatal morbidity and mortality meetings had always taken place at the Trust and provided an opportunity for reflection and learning. The meetings were Trust-wide until around 2006/07, when they became local. We heard that QEQM had monthly meetings to discuss patients and that these meetings were attended by middle grade doctors,

neonatology consultants, midwives and obstetricians. The obstetricians also held their own discussions that did not necessarily involve paediatricians.

4.285 Staff perceived the discussions at these meetings differently. Some considered the meetings at QEQM to be open, with challenges to practice on both sides. However, others spoke of clashes between members of staff, with one particular paediatrician often blaming obstetricians for any deaths or serious incidents.

4.286 The Panel was told that handovers (between off-going shifts and on-coming shifts) were identified as an area of risk, as were delays in communication and issues with communication between disciplines. A consultant expressed frustration at the absence at either site of a multi-disciplinary team for high-risk pregnancies.

4.287 One staff member who had experience of working in another trust commented on the communication issues in East Kent maternity services. Their experience elsewhere was that communication was open and transparent and staff were kept in the loop about investigations and learning from them; however, it was not like that at East Kent maternity services, where the staff member knew only what happened during their shift and was not kept informed about the wider picture.

4.288 One midwife told the Panel that, although there were systems in place for midwives to learn from adverse outcomes (risk meetings and perinatal meetings), in reality they did not go to them. However, midwives had statutory study days, and these were well attended.

4.289 A consultant told the Panel that there had been improvement more recently:

> *Historically there was a lot of jumping to conclusions and finger-pointing, whereas now, there's recognition that things aren't black and white – that they can be complex, and you shouldn't jump to conclusions … Before, people were told what to do rather than why things should be done. They came up with "quick reflex action points", rather than reflecting and agreeing a collaborative approach about how to address the issue … Some changes didn't work as they were just reflex responses at the time. For example, following a case of uterine rupture during induction, one action was that all inductions should have 3 hourly CTGs in the lead-up to labour. However, in this case, there were lots of signs that other things were going on with the woman, such as poor pain control. The introduction of 3-hourly CTGs was more like a tick box exercise instead of doing holistic risk assessment continuously during the woman's induction and labour. In high risk cases of induction of labour, pain or uterine activity should immediately trigger the application of the CTG to monitor foetal wellbeing. By doing 3-hourly CTGs on everyone, they are taking their eye off the ball, instead of risk assessing the woman holistically every time they look at her. They need to unravel things and reflect on what the thought process was behind the action. They need to risk assess each woman.*

Regulators and commissioners

4.290 A large number of organisations have been involved in supervision and regulation of NHS services: the GMC, the RCM, the RCOG, the NMC, the LSA, the CQC, HSIB, NHSE&I, CCGs and the Local Maternity System/Local Maternity and Neonatal System (LMS/LMNS). The Panel heard about the potential for confusion that this has caused, as well as the inability of the supervisory and regulatory bodies to bring about significant change over prolonged periods. We were told:

> *It isn't always helpful for individuals to have to deal with different organisations and the landscape is so confusing when you have a complaint about something significant that happened in your life. It is very difficult to pursue that.*

4.291 Members of the Board and Executive described a very challenging relationship between the Trust and its regulators and commissioners. One told us that a decision had been taken by the Trust to *"fight the regulators"*, although this was a fight that could not be won and was a waste of resource and energy. The Panel was told separately that the Trust had considered taking legal action in response to the 2014 CQC report.

4.292 One member of staff expressed the following perception:

> *[T]he priorities of the regulators might not always be aligned with what is best for the patients. The regulators have their own set of challenges. They are balancing the politics and the requirements that are placed on them, along with the need to regulate organisations.*

4.293 Managers within the Trust talked about how it was impossible to meet all of the regulators' expectations, but they said that nobody discussed whether this situation should be exposed:

> [It] *might not be the regulators' intention that they are not aligned, but they don't get to hear the things that they need to hear. People don't always get rewarded by being honest.*

Clinical Commissioning Groups

4.294 A member of the Trust's Board and Executive commented that the four CCGs there had been in Kent all did things differently, making it hard to respond. The relationships were difficult:

> *[T]hey weren't all pulling in the same direction, and they were very focussed around money.*

4.295 The Panel was told that, from the very beginning of the work of the CCGs (April 2013), the CCGs raised and escalated significant concerns about the Trust to NHS England (NHSE). Maternity cases were raised as an issue at every Quality and Compliance Steering Group, from the very first one in 2013, and within the CCGs' written escalatory reports to NHSE every single month. However:

- The CCGs' professional challenge *"was met with anger and defensiveness by the Trust, always, no matter whether it was a financial challenge or clinical challenge"*.
- *"[Y]ou took a deep breath to have the conversations before you picked up the phone or you met with them."*

4.296 A then newly appointed member of the Executive told the Panel of their astonishment at the level of antagonism in the room when attending their first Quality Surveillance Meeting with the CCGs.

4.297 The CCGs were escalating issues long before the CQC report in 2014; however, they found it difficult to gain recognition of their concerns. It was suggested to the Panel that the very people to whom the CCGs were escalating their concerns, particularly around maternity services, were the individuals who had previously commissioned those services. This meant that they didn't have fresh eyes, nor the same sense of the need for action. We were told:

[W]e were escalating to people who had obviously done the same role as us, and had worked with the provider, and accepted that practice … accepted that that was safe and hadn't escalated it, and now we were coming in saying that the same thing wasn't acceptable, so it was quite difficult politically to manage that situation … we weren't getting anywhere through repeated escalation … the lady who led the bomb-shell CQC inspection … was instrumental in getting everybody on the same page.

4.298 Another CCG officer told the Panel that the key issue in 2013 was trying to get people to believe the CCGs' concerns. They couldn't be sure whether the problems at the Trust had been there for some time but had not been picked up (and the CCGs were able to identify them because they had the benefit of fresh eyes), or whether there had been a rapid deterioration just before the CCGs took over commissioning. They commented:

[S]ome days you almost felt like you were going mad because … it just felt like people would not listen … we continually raised concerns at meetings like the Quality Surveillance Group.

4.299 The Panel was told that *"getting everyone on the same page"* was crucial because, prior to the CQC inspection and report in 2014, some people were saying that the Trust wasn't as bad as the CCGs were saying, and it was crucial for the commissioning of recovery plans for there to be a common understanding. We were told:

[T]he Trust thought they were exemplars of best practice and there was a real arrogance back in 2013 … they would say it in public meetings, "we are the best acute trust in the country, we are innovative, we are clinically excellent, we are the safest place to be" … they would narrate it … over and over to try and make it become fact … you then had NHSE saying, "yeah we haven't really got any specific issue" … and then you had us … shouting, "… they're not financially stable, their leadership is falling apart … they're not a cohesive leadership team … they're not safe from a clinical and patient safety perspective … there are many gaps, and then they've got big cultural issues, huge cultural issues around their geographical base".

4.300 However, the Panel was told that, even after the 2014 CQC report was published, there was no acceptance at Board level that it was accurate until there were major changes at Executive level in the Trust. The appointments of new members of the Executive contributed to a more collaborative relationship.

4.301 We heard that one of the things that the CCGs identified from the start in 2013 was that the Trust had a very high turnover of senior leaders in midwifery and lacked a Board lead for paediatrics. The Board lead for midwifery (the Chief Nurse) didn't have midwifery experience. The CCGs tried to work on these issues with NHSE.

4.302 Another Trust-wide issue that the CCGs identified through maternity services was the Trust's approach to serious incidents and learning: how it learned from incidents, near misses and when things went wrong. The Trust's approach was described to us as very tokenistic and it did not use nationally recognised practice or national templates. The CCGs had a battle with the Trust over everything surrounding this issue; the Trust did not identify learning, root causes or relevant systemic contributory factors. There was also evidence of a blame culture that focused much more on midwifery than on obstetrics, and there was an expectation that engagement in serious incidents was more the responsibility of midwifery than obstetrics. However, we also heard that the CCGs believed that, although early reports were not very good

and poor recommendations were made, progress was made later and the quality of reports started to improve.

4.303 A senior member of staff from the East Kent CCGs in 2018 told the Panel that their wider concerns about the Trust were in connection with:

- A large number of Never Events (safety incidents defined nationally as those that should never occur)
- A lack of learning from incidents and a failure to implement actions identified
- Cultural aspects such as a lack of challenge around serious incidents
- Long waits in A&E and poor-quality care
- Failures to follow up patients
- Concerns around medication doses
- Safeguarding and issues around security
- Infection control
- Poor communication with GPs
- A lack of proper processes for the supervision of staff
- Poor Friends and Family Test (patient experience) results
- Concern about the ability of the Trust to sustain a safe Intensive Therapy Unit service.

4.304 The Panel heard that there were also overarching issues around leadership and the ability of leadership to get to grips with the concerns, culture (particularly in relation to staff not feeling able to challenge) and learning (much of what was happening had occurred previously and there was a failure to learn and to implement actions to prevent the same mistakes from happening again).

4.305 A senior member of the CCG told the Panel that the CCG was concerned, as a commissioner, that the Board wasn't as informed as it could have been on some of the quality issues; there was awareness at committee level, but not once issues were escalated to Board level. This did seem to improve a bit as time went on; this appeared to be partly as a result of changes in leadership. There was also a worry about the number of issues that the leadership team was dealing with and its ability to get a grip on all the concerns: for example, the Medical Director, who had to contend with a challenged organisation across three sites, was also the Director of Infection Prevention and Control, and the CCGs had significant concerns about infection control.

4.306 The Panel was told that, at the end of 2019, the CCGs reported that the Board's oversight of maternity services had been poor, but that the situation had started to change; however, there was more external scrutiny happening at this time, so this may have been a factor in the improvement. The new Chief Nurse and a new Head of Governance, both of whom started around June 2019, seemed to make concerns more visible. Within maternity services there was an increase in serious incident reporting, which the CCGs believed was evidence of an improved safety culture (people were more willing to report incidents), there were better systems and training around CTG monitoring, and there were better induction processes for locum doctors. These actions, together with the work of the new Director of Midwifery, provided the CCG with assurance that things were progressing.

4.307 The CCGs raised concerns about leadership (including leadership capacity) with the Trust through discussions with the Medical Director and the Chief Nurse, in system oversight meetings and in the Quality Surveillance Group (QSG).

4.308 CCG officers observed that WHH was hampered by recruitment difficulties and that the midwives and consultants were committed to doing their best for the women using maternity services (*"they're good people, they've got good intentions"*), but the system did not support them – the scale of the challenges at the Trust was so big, and the churn in leadership didn't help. The CCGs' view was that there was also a tendency to seek to resolve problems by appointing new leaders and, when they failed, to see those leaders as the problem rather than the underlying issues.

Care Quality Commission

4.309 The Panel heard:

> *[T]he relationship with CQC and the Trust was absolutely dreadful.*

4.310 The 2014 CQC report identified a significant difference between the Board's perception of how well the Trust was doing and what the CQC found on the ground, including the frustration of staff who described bullying behaviours and a fear of speaking out about things that were problematic. A senior CQC staff member who met with the Panel spoke of the importance of the freedom to speak up as part of a strong, positive safety culture that needed to be embraced more.

4.311 A senior CQC staff member also commented that maternity services and the Trust in general had been stuck at "Requires Improvement" since 2014/15 and that the basic underpinning drivers of quality were not being addressed sufficiently to move the Trust forward to what would be regarded as "Good". It was suggested that this was partly due to the failure to develop a model of care for the large geographical area of East Kent, which is relatively remote from major population centres, and the absence of a long-term strategic plan.

4.312 We heard that, following the CQC report in 2014, the Trust Chief Executive had monthly meetings with Monitor that focused on Trust finances, the performance of A&E and the improvement plan. An Improvement Director was appointed.

4.313 There was a CQC inspection of children's and young people's services at the end of 2018. This raised significant concerns, and the Trust was rated "Inadequate" overall. The CQC issued a Section 64 letter (under the Health and Social Care Act 2008, this requires trusts to provide specific documents and information) as the information provided by the Trust didn't answer the CQC's questions. The CQC was not assured and issued urgent conditions.

Healthcare Safety Investigation Branch

4.314 The first HSIB maternity investigation involving the Trust was in April 2018. We were told:

> *The Trust was quickly branded an outlier as its referral rates were markedly higher than the trusts in the rest of the region.*

4.315 We heard that HSIB had difficulties with its day-to-day operational relationship with the Trust. These included issues such as information requests, staff attending for interview, staff giving their consent to attend for interview and difficulty in getting support with this from the Trust's senior leadership team. The Panel heard that the HSIB team had a *"very difficult reception from East Kent"*, despite its efforts to build good relationships: *"engaging with the governance team at East Kent would be difficult"*. This contrasted with other trusts. Consequently, HSIB investigations were delayed because the relationship wasn't good from the outset. However, an HSIB investigator said that, when they were able to engage with more junior staff, these staff were open and honest.

4.316 In 2018, engagement between HSIB and the Trust included preliminary recommendations from an HSIB review of ten ongoing HSIB investigations, visits to the Trust in October and November (including a presentation on HSIB's work) and a round-table meeting with the Trust in December. The meeting in December identified emerging patient safety themes, including neonatal resuscitation, documentation processes and escalation during care; these were followed up in a letter to the Trust. However, it was clear that the Trust *"did not want to engage with HSIB at all"*.

4.317 The Panel heard that obstetricians did not attend any meetings with HSIB, although they were invited to do so. One HSIB investigator's assessment was that the obstetricians didn't want to engage in such discussions, rather than that they were excluded from doing so:

> *In 2018, obstetricians didn't see incidents – especially those involving midwifery – as anything to do with them.*

4.318 The Panel was told by officers within HSIB that, by the end of 2018 (following seven or eight months of input), HSIB was identifying themes associated with maternity incidents and it had concerns about East Kent maternity services. Its concerns included: failures of escalation; unsupported junior staff; problems with locum doctors and a lack of proper supervision and assessment; the level of neonatal deaths at QEQM; neonatal resuscitation; CTG interpretation; triage, management of reduced fetal movement and ultrasonography; and the home birth and midwifery-led care environment, including fetal monitoring. We heard that HSIB was confident that it had identified the right themes:

> *[B]ut* [HSIB] *knew that they weren't being received very well at the Trust. The Trust was irritated with HSIB. It was as though the Trust thought that HSIB wasn't a regulator and what right did it have to be in the organisation, doing investigations and asking questions? East Kent wouldn't engage. By contrast, in other trusts, HSIB were being received openly, with a view to having a fresh set of eyes on the challenges.*

4.319 There were several recurring themes in the cases that HSIB saw:

- **Escalation:** Recognising women and babies who were deteriorating, reporting this to more senior staff, and those more senior staff responding appropriately; there were also frequent problems with locum staff and how they were recruited.
- **Triage:** Particularly in relation to documentation. At times there was no record that calls from patients were made, who was taking the calls or what advice was being given to patients.
- **Neonatal resuscitation:** Concerns around the geography of the work (e.g. the location of resuscitation trolleys) and the impact on families (rather than concerns about the particular skills of individuals). There was no resuscitation trolley in A&E.

4.320 These issues kept appearing, which indicated to HSIB that sustained change was not happening in response to issues being raised. As time passed, HSIB formed the view that these were longstanding issues. HSIB had three main concerns with East Kent maternity services:

- A high number of referrals in comparison with other trusts – the numbers dropped after the first year and the Trust saw this as an improvement, but when HSIB triangulated this with other information, it was clear that cases just weren't being referred
- Recurring themes – indicating that lessons were not being learned
- Patient safety concerns.

4.321 By early 2019, there was still no improvement in the Trust's engagement with HSIB, so matters were escalated to HSIB's senior maternity team and the CQC. The Panel heard:

> *[N]o changes were being made at East Kent. The Trust had still not returned HSIB's initial roundtable letter, and the same patient safety themes were continuing to harm patients.*

4.322 There was a meeting between HSIB and the Trust's senior leadership team, including clinical leadership, in June 2019; the meeting was described as *"very difficult"*. By this time, the HSIB team had *"grave concerns".* The HSIB team were not made to feel welcome by the Trust (they were kept waiting for 45 minutes in a corridor) and were greeted in an *"incredibly aggressive"* manner by the Trust representatives, with one commenting that *"I don't know why you are here"* and that HSIB's recommendations were *"not needed"*.

4.323 There was a *"heated discussion"* about one of the maternal death cases. There was denial in the Trust about the enormity of the underlying problems and HSIB was not seeing evidence that actions were being taken to change things. An HSIB investigator noted: *"It felt like the issues were being given lip service."*

4.324 As a reflection of the level of concern within HSIB about the performance of East Kent maternity services, a letter was issued to the Trust CEO in August 2019 by Sandy Lewis, Associate Director of the Maternity Programme at HSIB. This was considered a highly unusual step. The letter stated:

> *Given the gravity of the concerns raised and the lack of response to the issues raised, I consider that there may be a serious continuing risk to safety within your Trust.*

4.325 The Panel heard that the Trust's referral rate was 50% higher than that of other trusts with which HSIB was engaged at that time and HSIB was concerned about the recurrence of issues about which it had already made recommendations. HSIB thought that Trust staff *"weren't hearing them when they made recommendations"*.

4.326 HSIB set up quarterly meetings with the Trust from October 2019 for the purpose of monitoring improvements. At these meetings, overviews of national figures were provided together with common investigation themes. An HSIB investigator said:

> *Sadly, these meetings once again highlighted that the patient safety themes at East Kent were not changing.*

4.327 The approach to maternal and neonatal safety was described as *"tick-box"*: for example, following the introduction of safety huddles, poor escalation issues continued to arise, and the Trust's reaction was that it had *"already implemented a solution, so nothing more could be done to improve the situation"*. However, several Trust staff stressed in their interviews with HSIB that the safety huddles were ineffective, as they were developed by senior leadership who did not understand experiences on the shop floor.

4.328 The Panel was told that the Trust also struggled with having a safe space where people could discuss concerns.

4.329 HSIB's clinical oversight concerns revolved around the lack of engagement between midwives and obstetricians and junior staff:

> *The two professional groups don't function as one team. They are separate. There are, of course, individuals who work well together. The result of this is that the two groups don't*

provide effective safety for one another and mothers and babies. The communication between teams often leads to confrontation rather than reasoned discussion. They don't respect one another or have the confidence to challenge one another in a helpful and respectful way.

4.330 In addition, a senior HSIB investigator commented:

The Trust board saw patient safety issues as problems with individual staff, rather than as part of their role to improve systems and learning. Patient harm was seen as the shortcoming of staff on the shop floor. There seems to be a great disconnect between the senior team and general staff.

4.331 An HSIB investigator told the Panel that there was a strong culture of *"pushing things under the carpet"* and not listening to staff who raised concerns. We were also told of a striking disconnect between staff on the ground and the management team.

4.332 The investigator also commented that staff were not good at identifying their own problems. They stated that *"when they do look back they don't seem to be able to see what is glaringly obvious to others"*, and that the Trust had not maintained *"good, open, communicative"* relationships with families who had had bad outcomes, but that more recently this had improved.

4.333 Reflecting on how investigation reports were communicated to the staff who were required to implement them, a midwife cited the example of HSIB reports; the reports were available in hard copy, on a shared drive and circulated by email, but it was demanding for staff to absorb this information while delivering their roles, and quite a challenge to become aware of all the recommendations. It was difficult for staff to understand the detail and significance of the information without making further enquiries, and there was so much going on that information was not always properly digested. In general, recommendations were not conveyed simply and there were no bite-sized chunks of information for staff to digest.

4.334 While the number of referrals from East Kent maternity services had begun to decline and HSIB's relationship with the Trust to improve, Professor Walker explained that HSIB was still seeing *"some of the same problems coming through, particularly about support and staffing, their midwife led care services etc".*

4.335 The Panel heard that the Trust's 72 hour reports were *"very poor"*; they didn't go into detail and HSIB provided training to help improve the quality. However, the reports remained poor. Initially, the Trust would not share these reports with HSIB. The Trust challenged why HSIB would need them and said that *"they aren't there to help you with your investigation".*

4.336 HSIB still saw cases where women presented with symptoms that appeared to be an infection but were sent home without being seen by a senior person, only to return in a more serious state. Professor Walker commented that *"it is about proper assessment, risk assessment, escalation, and things like that … but to be fair the numbers* [became] *less than they were".*

4.337 The most prominent HSIB themes in 2018/19 were guidance, escalation, fetal monitoring, documentation and birth environments. The themes in 2019/20 were guidance, escalation, fetal monitoring, staffing and general clinical oversight.

4.338 Professor Walker told the Panel that, in the early years of HSIB (2018/19), it didn't know how to talk to other organisations. For example, HSIB was contacted by the CQC, which

enquired whether HSIB shared the CQC's concerns about the neonatal and paediatric services at the Trust. HSIB didn't know what information it was able to share and was anxious to maintain its independence. However, HSIB recognised that it had a duty to escalate concerns and found a way to do so without sharing case-specific facts.

Nursing and Midwifery Council

4.339 The Panel was told by Andrea Sutcliffe, the NMC's Chief Executive, that the NMC's involvement in either an individual case or a cluster of cases was dependent on the referrals that came through, which might be determined by lots of local factors. She told the Panel that, while many referrals might indicate a problem, it could be just as problematic if people weren't making referrals, because they weren't recognising problems and dealing with them. She added that, given the relatively small number of fitness to practise referrals made to the NMC, it was difficult to identify organisations with recurring problems. Referrals were affected by the leadership of organisations, and she thought that one of the issues with East Kent was the high turnover of Chief Nurses throughout the period.

4.340 Ms Sutcliffe told the Panel that the NMC received some referrals around maternity incidents at East Kent: *"[I]t was very much on an individual basis, and our analysis shows that quite a lot of these referrals were coming through from families."* In the case of baby Harry Richford, the family referral included four midwives and the NMC opened cases on a further three midwives as a consequence of that family referral. No referral was made by the Trust. Ms Sutcliffe commented:

> *Perhaps we should regard the referral of a practitioner to a regulator by a family as failure of the system. If something has gone wrong, the organisation itself should be dealing with that and doing so in a way that gives confidence to the family that the issues are being addressed appropriately and if there are issues that are to do with fitness to practise of an individual, they should be confident that that individual will get that referral. Whereas what often happens is that we get referrals from families when they've already been let down locally and so we're all compounding loss and distress as a consequence of that.*

4.341 Ms Sutcliffe told the Panel that:

> *If people are scared of the regulator then they're not going to speak up when they should. They're not going to engage with our processes in a meaningful way when they should. One of the things we've been absolutely clear about is making sure that we are improving the fairness of those processes, looking at the context of what is happening and making sure that is fully and properly taken into account.*

4.342 Ms Sutcliffe stressed the importance of regulators such as the NMC, GMC and CQC working together with trust organisations, to collaborate and share information, and to identify the indicators that might show that there is a problem. She told the Panel that the NMC set up its Employer Liaison Service in 2016 to feed back information to trusts, and to provide insight and support as well as helping in some of the training that they might need.

4.343 While continuing to stress the difficulties for a regulator of individuals to identify systemic issues (red flags) based on individual referrals, and the difficulties in taking action, Ms Sutcliffe told the Panel:

> *[I]t is probably fair to say that all of us, and the NMC is in and amongst that, could undoubtedly have done better in joining the dots earlier … If I look back and think "what would we want to do differently now" we would want to have better collaboration.*

General Medical Council

4.344 A senior GMC interviewee confirmed to the Panel that its focus is on the fitness of individual clinicians to practise. However, it receives significant and comprehensive feedback from approximately 60,000 trainees each year, and there had been no mention within that feedback of any issues with maternity services at the Trust. The fitness to practise data did not point to there being an issue either.

4.345 The Panel was told that the GMC gains information from its outreach function and the meetings with the Responsible Officer (RO) and Medical Director at trusts; these have been taking place since 2011/12. There are regular meetings to support ROs with fitness to practise issues and revalidation issues. As part of this work, the GMC has sought to address clinical leadership, which, it acknowledges, can be a difficult area for doctors.

4.346 There are other sources of information, such as revalidation data and surveys of trainee doctors (national training survey data). The GMC established an internal mechanism called the Patient Safety Intelligence Forum that gathers information on organisations and can lead to action such as talking to other organisations, or to instigating enhanced monitoring within the GMC's education functions.

4.347 We were told that the Trust was regarded within the GMC as a concern in general terms from around 2015, but not maternity services at that time. The longstanding challenges at East Kent were with recruitment and retention, the geography of the sites, and the use of locum doctors. However, the specific concerns about obstetrics and gynaecology were more recent. One GMC interviewee thought that they were not raised until early 2020, when the RO told the GMC about the CQC's and HSIB's involvement.

4.348 We were told by GMC staff that the fitness to practise data have not been informative because they involve such a small number of referrals. Making better use of the data would depend on linking them with other sources, and the GMC told us that it had put a lot of effort into working more closely with other regulators in terms of data sharing. The interviewee also made the point that the GMC is aware that teamworking issues can have a significant impact on patient care.

4.349 The Panel heard that information sharing has been challenging for the GMC, and is constrained by its precise legal powers.

4.350 The Panel also heard of the difficulties in dealing with behavioural issues among doctors, as follows:

> [Within] *healthcare regulation and oversight there are a myriad of organisations, and it can lack clarity as to who is doing what, and who is responsible for what … it can be quite confusing, I think it is confusing for patients, and it can be confusing even amongst regulators – who precisely is doing what, and who is responsible for what?* [The GMC is] *responsible for individual doctors in terms of their fitness to practise and their revalidation etc., but where you are talking about lower-level behavioural issues, or cultural issues, or attitudinal issues that are not ideal, but you are not going to strike someone off, that can be a little bit tricky as to who is responsible for dealing with that.*

Local Supervising Authority

4.351 The Panel heard that when the first Morecambe Bay recommendations were starting to be known, the LSA Midwifery Officer (LSAMO) began a gap analysis against the emerging findings.

This continued throughout the year and included the need to make sure that supervision was clear and complemented the clinical governance processes of trusts.

4.352 The first audit of the Trust carried out by the LSAMO was in 2012, and yearly thereafter. The Panel was told that the findings and recommendations of each audit were as follows:

- **2012:** The recommendations made by the LSA included better engagement with feedback from women (the Trust was not particularly strong on this at the time), ensuring one-to-one care in labour, and ensuring that meetings were held with individual midwives on an annual basis.
- **2013:** The LSA revised the supervisory audit to make it more specific to the standards and rules. The LSA also sought evidence prior to the audit – moving from a reassurance model to an assurance model. In looking at compliance with Birthrate Plus,[§] and at learning from incidents, there was a theme around disjointed supervision and clinical governance.
- **2014:** There was improved interface between governance and the supervisors of midwives, but there was still a need for more evidence. The LSAMO arranged an away day for the supervisors of midwives that was facilitated by the Trust and was centred on leadership and working towards improvements as a group. Around this time there was a lack of transparency within supervision generally (not limited to East Kent maternity services) and it was difficult to get people to say who had a problem and where the problem was. It was also a challenge to embed openness and transparency, and to share problems and issues so that improvements could be implemented and midwives could be supported in practice – this was what the teamwork was designed to address.
- **2015:** The audit showed that there was improved governance and that the Trust had a clear policy around governance – supervisors were reviewing all serious incidents. They still needed a little more evidence around this, but the situation was starting to improve. The LSA escalated to the lead CCG the need for a much clearer link between supervision and incidents; this escalation became part of the CQC action plan.
- **2016:** This was the final audit. The Trust was partially meeting most of the standards, but there was still work to be done to ensure that every midwife had an annual review and there were still some issues around making sure that governance was strengthened.

4.353 The Panel was informed that, in 2017, when the LSA ceased supervision, the action plan was handed over to the Trust; the final recommendations and action plan were also shared with the lead CCG.

4.354 The LSAMO told the Panel that they also provided education for supervisors of midwives and held monthly meetings so that good practice from the LSA's audits could be shared. Representatives of service users attended the meetings to provide information about the experiences of women who had used maternity services; this feedback looked positive for the Trust. However, the Panel heard that the supervisors of midwives would always comment about the birth environment, which was a longstanding issue for East Kent maternity services.

4.355 In the LSA's view, governance was also an issue. During this period, the Trust failed to achieve Clinical Negligence Scheme for Trusts (CNST) Level 3 (the best level of rating of risk management in a trust). Governance is at the core of a safe service, and a governance review

[§] A tool to estimate the desirable level of midwifery staffing, taking into account the size and complexity of a maternity service.

had recently been completed by the Maternity Improvement Advisor (MIA), although this could have happened earlier, had it been possible to put feet on the ground.

4.356 The Panel was also informed that a challenge of the LSAMO role was that they supervised a team of people within a trust but they had no formal management control, and the midwives only reported to the LSAMO through the statutory process. Other challenges included the length of time that investigations took and the fact that, although the outcome of any supervision investigation was shared with the trust involved, there was no reciprocal sharing of investigations by that trust, which would have provided greater context.

NHS England/NHS Improvement

4.357 A Trust Board and Executive member told the Panel that the Trust did not receive a great deal of support from NHSE&I.

4.358 Another member of the Trust Board and Executive told the Panel:

> *[T]rying to get the commissioners and NHSE&I to understand, as part of the clinical strategy, that the Trust could not continue to do loads of things in three places was a really long road.*

4.359 We heard from a member of staff of a regulator that, as late as 2018/19, the safety structures within NHSE and NHSI (at that time two separate organisations) did not see the Trust as being a problem.

4.360 The remainder of this section of the chapter (to paragraph 4.385) records the observations of NHSE&I representatives, including an account of actions undertaken by NHSE and NHSI.

4.361 NHSE was alerted by HSIB about the lack of senior engagement in 2019. In response, an intelligence-sharing call was convened with NHS Resolution (NHSR), the CQC, HSIB and the CCGs, which identified the following issues:

- NHSR raised concerns about the Trust being an outlier for claims.
- The Richford family were concerned that the Trust wasn't meeting the requirements of NHSR and CNST. A whistle-blower had also raised concerns about adherence to CNST requirements.
- The CQC expressed frustration about the lack of information coming back to them.
- HSIB raised concerns about the number of cases being higher than the national average and about the "scattergun" nature of the response from the Trust, particularly in relation to the Harry Richford case. There was no evidence of lessons being learned and there were issues with the way in which the Trust was managing the relationship with the family.
- NHSE had concerns about reports from HSIB.
- The CCGs had concerns about how difficult it was to get information from the Trust, CTG monitoring, the multiple action plans, changes in Heads of Midwifery, and the Board not being sufficiently focused on maternity services. The lack of Board to ward oversight and the lack of escalation to the Trust Quality and Safety Committee and the Board were continuous themes.

4.362 A single-item Quality Surveillance Meeting was subsequently held on 10 December 2019 at WHH. HSIB, the CCGs, the CQC, members of the Trust Executive and clinicians from

maternity and paediatrics services attended. HSIB presented its concerns and there was a long presentation from the Trust. We were told by a senior NHSE&I representative that:

> *The trust seemed slightly defensive, as though they were trying to pretend there wasn't a problem. It also felt as though they were trying to do so much that they couldn't see the wood for the trees. They seemed to have difficulty honing-in on the issues highlighted by HSIB and on the cases and the learning from them.*

4.363 After the meeting, there was further discussion among the partners. A senior NHSE&I representative told the Panel:

> *They were concerned about the pace of change, given the long history of problems in the Trust. For example, there had been a lack of action following the RCOG report of 2015. There was a lack of assurance about the changes that were needed. They felt concerned about relationships in the leadership, particularly in relation to the medical director and clinical director roles. HSIB indicated that the head of midwifery had engaged well with them but that she was probably the only one. There was no senior involvement in oversight.*

4.364 There was a concern about reporting lines between the Director of Midwifery and the Chief Nurse:

> *There seemed to be a direct relationship between the director of midwifery and the chief executive, but where was the voice of nursing in that?*

4.365 There were also concerns about whether the Trust was sufficiently focused on the issues that arose from the cases discussed at the meeting, such as escalation, CTG monitoring and fetal distress. It needed to step back and refocus on the key issues. The inquest into the death of baby Harry Richford was due in January 2020 and, as NHSE&I did not feel assured that the Trust had learned from the case, which had happened several years earlier, NHSE&I put some measures in place.

4.366 NHSE&I instigated the Maternity Safety Support Programme (MSSP) and arranged support from the regional team for the Trust Medical Director, the Chief Nurse and the Head of Midwifery to help them with the governance challenges. Actions and events included the following:

- The inquest took place in January 2020.
- The independent review of maternity services was announced in February.
- NHSR sought to recoup funding it had provided for CNST.
- The CQC did an unannounced inspection and produced findings.
- There was a joint relationship visit with the CQC.
- The Chief Midwifery Officer for NHSE&I and the Regional Chief Midwife visited the Trust at the end of January.
- There were meetings with the executive team.
- Additional external support was provided to the Trust, in the form of a former Head of Midwifery, a paediatrician, a neonatologist and an obstetrician.

4.367 A QSG review meeting was held in February 2020; by that stage, the Trust was *"feeling under siege"*. There was also increasing press attention. NHSE&I set up weekly East Kent huddles involving the GMC, the NMC, Health Education England, NHSI, the CQC and HSIB to share intelligence, help coordinate the number of requests being made of the Trust and allow the

Trust to remain focused on improvement. It specifically asked for an overarching plan that would bring together in one place responses to the RCOG report, work on coroners' cases, the BESTT programme and other relevant issues. It also requested a review of the medical workload, especially in relation to the balance between obstetrics and gynaecology. The Trust was working on an improvement model, but maternity services were just one of the Trust's challenges. It was also dealing with the pandemic and several other issues that had escalated.

4.368 The Panel heard from NHSE&I that trusts are often defensive under such circumstances, but that East Kent was particularly so. NHSE&I could see the lack of openness around the cases, and the Panel was told that the Board did not seem to be fully aware of the concerns about maternity services. The Trust wasn't open with stakeholders and providers either. We were told:

> *It felt like that at all levels. There was a lack of openness with families, through to lack of openness with stakeholders such as the CCG. It felt as though they didn't always get the information they should have done from the Trust.*

4.369 The Panel was told that the Trust didn't identify problems partly because it didn't know about them and partly because it didn't want to declare them. For example, the Harry Richford case caught the Executive off guard, until it reached escalation point in October 2019. The Panel heard that:

> *Initially, when support was offered to the Trust, they were reluctant to accept it and it was as though they were trying to prove that there wasn't a problem. There was an acceptance issue. The region had to check regularly that the support was being used continuously.*

4.370 In relation to dealing with inappropriate clinician behaviour, NHSE&I supported action in various ways:

> *The new medical director was doing a good job and making an impact, but this was* [their] *first medical director role and* [they] *needed their help with it. One of the planks of the maternity safety support programme was to help with the relationship issues between midwives and obstetricians.*

4.371 We heard that NHSE&I also provided support to paediatrics. NHSE&I split the paediatric and maternity leadership to enable maternity services to have enough bandwidth to deal with their issues.

4.372 Throughout 2020, NHSE&I was concerned about how the Board was obtaining assurance about the experience of families and patients. It also had concerns about the governance of the organisation and some of the approaches to governance during the pandemic. NHSE&I's view was that the Trust had made some improvements, but the pace of change and oversight by non-executive directors were still concerns. Improvement directors were assigned to the organisation, to help with coordination of the various improvement activities, and Board advisers were provided. NHSE&I requested a rapid governance and leadership review of the organisation, which was done in the autumn. A regional director had fortnightly meetings with the organisation to provide enhanced oversight and to keep traction on the improvement programmes.

4.373 In response to these measures, NHSE&I began to see some improvement in maternity and infection prevention and control issues. The Trust became more open, and we were told that the Medical Director began to contact the regional NHSE&I if there were any issues. The Trust became more receptive to help and support when things went wrong. However, NHSE&I remained concerned about the pace of change. For example, there was a case of maternal

death on New Year's Eve in 2020, and although the Trust reported it immediately, it didn't think that there were any issues of concern. Yet a few days later, NHSE&I received a letter from HSIB that identified several issues of concern:

> *It seemed that depth of understanding and the ability to identify issues hadn't embedded yet. They had made a few steps forward, but it was not enough, and the pace of change remained a significant concern.*

4.374 NHSE&I was concerned about the effectiveness of Board scrutiny, particularly via the Trust Quality and Safety Committee. Ward to Board escalation wasn't really happening:

> *On paper, the governance structure looked fit for purpose but under the surface, there were issues with people's understanding of the governance system and escalation. There was no common approach to safety across the organisation and there were issues around clarity of roles – especially between clinical roles at executive level.*

4.375 The lack of escalation of these issues was attributed by NHSE&I to an ineffective governance mechanism and a lack of openness, which was apparent in incident reports. The culture of openness and learning had not fully embedded in the Trust and a fear of blame partly accounted for that, although NHSE&I had not seen any actual evidence of this.

4.376 In relation to governance structures and escalation in the Trust, there was concern about the strength of Board papers and the depth of information that went to Board committees:

> *Things might have been reported but may not have been in enough depth for oversight and scrutiny.*

4.377 There was also concern about non-executive directors' scrutiny of papers in the Trust:

> *They asked lots of questions but that might have made it difficult to be open when things went wrong.*

4.378 The Trust had gone through a restructure of care groups and NHSE&I had concerns about the strength of leadership in the maternity care group and concerns about what the different committees did:

> *There were a lot of sub-groups in maternity and* [we] *questioned their effectiveness as an eye into the organisation. Also, the fact that the same people were on different groups didn't necessarily make for a robust process.*

4.379 A maternity improvement group was set up; NHSE&I told us it had made sure that it included someone from the CCGs and two representatives from NHSE&I to help them gain assurance and to act as critical friends.

4.380 NHSE&I had several concerns about nursing and midwifery in the Trust, including about nursing leadership on matters such as safeguarding and the Trust's ability to make progress on some of the issues in nursing and midwifery. NHSE&I was also concerned about:

> *… the relationship with the director of midwifery and where the executive clinical nursing role fed into that.*

4.381 Based on many interactions with the Trust, there was a concern about some of the responses of the nursing leadership and its presence in the organisation. NHSE&I provided

support to the leadership, particularly to the Head of Midwifery. The NMC conducted a review to check if nurses and midwives were being referred from East Kent maternity services, and the CQC expressed concerns about midwives.

4.382 One thing that was heard from staff was the following point:

> *[D]espite the challenges, everybody was coming to work every day to do a really good job. There was something about how you balance what are really difficult stories for women, for their families, really difficult incidents, some of them quite historical, with the ability to celebrate the small success and incremental change. It didn't feel as though the Trust had that balance quite right. There was also a need to ensure that staff were briefed in order to support them with tricky conversations or queries from women who may be concerned at the quality of care from adverse media coverage.*

4.383 The role of the NHSE&I Regional Chief Midwife for the South East was created in April 2020 to offer informal support to the Trust's Head of Midwifery on an ad hoc basis, mainly through the MSSP and meetings with the MIA on a weekly basis. The MIA relationship was key – they were there to support the Head of Midwifery, be a critical friend, and help them develop and work through the improvement plans.

4.384 The MSSP first went into the Trust as an action arising from the "Single Item" QSG in December 2019. A team went in to carry out a diagnostic assessment and the midwife lead for that team, along with an obstetrician, provided a report. There was also ongoing feedback and support. However, the pandemic hit and the MIA who carried out the diagnostic assessment was called back to their own organisation. Another MIA was sourced, commencing work in April 2020.

4.385 The feedback to the Regional Chief Midwife about the Trust at that time was that there was improvement although the pace was slow. The principal output from the "Single Item" QSG concerned consultant cover; in response, the Trust was introducing 24-hour support at WHH and improving how cover was provided at QEQM. There was also work around CTG monitoring, and around the aggregated action plan (linking to the Trust's Improvement Director).

Improvement initiatives and programmes

4.386 The Panel was told of improvements beginning in 2018 through the BESTT programme, including strengthened governance (midwife governance leads), the appointment of bereavement midwives, improved fetal monitoring, an improved dashboard, and the achievement of 100% one-to-one care.

4.387 Referring to the BESTT programme, the Panel was told:

> *[S]taff really engaged in it and were keen to be part of the change. By 2018, there were improvements in recruitment. People wanted to work at the trust and at interview, applicants were citing BESTT as a reason why they wanted to work in the trust's maternity services. They noted a big improvement in the trust's reputation on the recruitment front, and students who had trained elsewhere wanted to work there. There were significant improvements in staff survey results and staff felt more supported in engaging in improvement activities.*

4.388 Professor Walker from HSIB told the Panel that one of the problems for trusts is the multiplicity of recommendations that have originated from all over the place, and some of the recommendations disagree with each other:

> *They're getting big hammers coming in and there are too many cooks … The problem is that I'm not sure that their structures and their management structures are in place to encompass that and help the staff achieve that. I'm not sure if some of the changes they've brought in are achieving it … I wasn't convinced that they were on the right track. There're lots of people doing things and committees doing things and people with oversight of things, but I'm not sure that the people on the ground floor are being encouraged to say, "yes you are good, you can be better, let's see how we can do this" … I don't think the solutions are difficult. I think they're just fundamental and at grassroots level, like "let's build this up, let's build the teams, let's build their confidence, let's build the team working, the support". It's really from the bottom up that you want it, not from the top down.*

4.389 An experienced midwife told the Panel:

> *You have to ask yourself, why is it that despite feedback after incidents, complaints, legal claims, despite the robust training programmes that you have in place, do behaviours not change? Why are we still seeing the same themes coming up, not just in one Trust but across the country?*

4.390 The Panel was told by Professor Walker of his reaction to the focus on specific hospital trusts:

> *We've got to stop mentioning hospital names … this is a maternity problem and we've got to take ownership of it throughout the maternity system. That doesn't mean every hospital is bad, but … I think every hospital has got problems and I think we should be looking at that in a global way … But I think we need to rethink how we disseminate information, and particularly how we train and implement change.*

This chapter has explained that, alongside listening to families, the Investigation has conducted interviews with 112 current and former staff at the Trust and with others whose work brought them into contact with the Trust's maternity and neonatal services; and that this was a key part of the Investigation. We would like to thank everyone who was interviewed for their willingness to share their experience with the Panel for the purpose of this Investigation.

It is important to note that these interviews helped shape our findings as set out in Chapter 1 and that this chapter describes what we heard. This chapter should be read as performing that function, not as an indication of the Panel's own thinking or conclusions.

Chapter 5: How the Trust acted and the engagement of regulators

This chapter gives an account of how East Kent Hospitals University NHS Foundation Trust (the Trust) considered maternity and neonatal services and engaged with regulators and others. It draws upon documents and other information that the Investigation has received from the Trust and from organisations and individuals with whom it has engaged.

We refer throughout to the Board of Directors as "the Trust Board" or "the Board".

This chapter sets out how the Trust conducted itself as reflected in its own documents. Nothing included in this chapter should be taken as expressing the Investigation's own findings, except where explicitly stated: its findings are set out in Chapter 1 of this Report.

How the Trust managed maternity and neonatal services

5.1 The Board of the newly constituted East Kent Hospitals University NHS Foundation Trust met for the first time on 2 March 2009. This was the day it received its authorisation as a Foundation Trust.

5.2 As a Foundation Trust, the Trust enjoyed greater freedoms than a non-Foundation Trust, including more financial autonomy. The Trust's Chair and Chief Executive, in their foreword to the 2008/09 Annual Report, said:

> *[W]e now have much greater involvement in our decision-making from local people, including patients and staff, through a new 32-strong Council of Governors, mostly elected by a membership that now exceeds 13,000. Being granted Foundation Trust status is recognition of the standards that have been achieved by the organisation through the expertise, hard work and dedication of our staff. We are now awarded greater freedom to govern ourselves in a way that is responsive and flexible to the changing needs of the people we serve, while continuing to ensure that healthcare is provided in a safe, effective and efficient manner.*[1]

5.3 The Trust Board met for a second time on 27 March 2009. In neither of these inaugural meetings did the Board agenda include consideration of maternity or neonatal services, nor have we seen any reference to them in the papers circulated for those meetings. It is clear from the Annual Report that the Trust was focusing its attention on national priorities, which at that time included waiting times, coronary heart disease and cancer, but not maternity services.

5.4 From the material seen by the Investigation, the first substantive reference to maternity services at the Trust was at the Board meeting on 28 August 2009. At that meeting, the Deputy Director of Nursing introduced a Serious Untoward Incident (SUI) report. Particular reference was made to the changes in reporting maternity cases to the Strategic Executive Information System (StEIS), which is supposed to capture all serious incidents; this had resulted in an

increase in the number of maternity cases on the system. As a result, it had been agreed with the Eastern and Coastal Kent Primary Care Trust (PCT) that from July 2009 only cases where concerns with practice had been raised would be recorded on StEIS. The meeting also noted that neonatal deaths were being monitored by the Trust's Audit Committee and that no formal report was required by the Board.

Internal review and report, 2010

5.5 The first indication of awareness of concerns about maternity services within the Trust came at the Board meeting on 24 September 2010, where the Medical Director gave an overview of a recent SUI within maternity. They reported that the Trust's internal monitoring process had highlighted an increase between April and August 2010 in the number of babies showing symptoms of hypoxic ischaemic encephalopathy (HIE), a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain. They reported that an internal investigation involving a review of medical notes had commenced to establish the facts, and a formal report of findings would be brought to the Board in October 2010. They added that the PCT would be involved throughout the investigation and external midwifery support was also being sought. The Medical Director went on to report that external midwifery support had immediately been put in place at the William Harvey Hospital in Ashford (WHH) due to a concern regarding a potential decrease in skill mix at this unit, which would unfortunately have an adverse effect on other units. This was intended to be a temporary measure and would be reviewed once the internal investigation had ended. Monitor and the Care Quality Commission (CQC) had also been informed.

5.6 At its meeting on 27 October 2010, the Trust Board received a confidential interim report. The report stated that *"during Q1 a higher than expected term admission rate to NICU/SCBU* [neonatal intensive care unit/special care baby unit] *was noted and discussed at the perinatal mortality and morbidity meeting in July. No themes or common factors were identified."* It went on to state that *"concern was raised about midwifery staffing levels at WHH and a 'risk alert' was circulated to midwifery staff"*, and that:

> *… a decision was made to enhance midwifery levels at WHH pending the outcome of an internal review and to do so to close the Buckland Hospital* [Dover] *birthing unit to births to increase staffing levels at WHH. This was communicated as a SUI and both CQC and Monitor informed.*

5.7 The interim report also stated that it *"does not enable any final conclusions as to the standard of care offered at this stage although a number of trends have emerged which largely reflect recognized risk factors for HIE"*. These were that *"46% of babies were born 'through' meconium stained liquor; 53% of mothers were either overweight or obese; 26% of babies showed signs of growth restriction (birth weight < 10th centile)"* and that *"to date 'no suboptimal' or 'minor suboptimal' care has been recorded in over 85% of cases"*.

5.8 The 2010 internal review examined the antepartum management of 91 babies who had an unexplained admission to the NICU or SCBU within the Trust between January and September 2010. In 40% of the cases reviewed, the review highlighted the presence of suboptimal care, and in a third of those cases the suboptimal care was considered possibly, probably or likely to have been a relevant factor in the outcome. Of the 91 babies reviewed, there were 16 perinatal deaths, and significant or major suboptimal care was noted in 4 of those cases. Six babies were identified as likely to have what the review describes as *"long-term handicap"*, and significant suboptimal care was identified in three of those cases.

5.9 More broadly, the review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of shortage of oxygen. The report identified a number of themes, many of which are recurring issues in the reports, inspections and findings that took place between 2010 and 2020.

5.10 The report noted areas of commendable practice, including the prompt and effective response to potential or actual obstetric emergency situations.

5.11 In summarising its findings, the report addressed staffing issues and recommended an urgent review of midwifery staffing at the WHH site. It noted that midwives faced *"the challenge of caring for more than one high risk labouring woman at any one time"*, and that *"an informal poll of trusts in the South Thames region has revealed that staffing/patient ratios in EKHUFT* [the Trust] *are amongst the lowest in the region"*.

5.12 The report also noted that, where the review team identified areas of suboptimal practice, the staff involved received a letter advising them to address that area of their practice, which was copied to their supervisor. While there was a robust arrangement in place within the midwifery profession to learn from incidents and address areas of practice, the report noted that *"arrangements for medical staff are less robust and this will be reviewed"*.

5.13 The report included recommendations such as reminding staff to practise within guidelines, improving diagnosis of labour in low-risk settings, improving standards in fetal monitoring, reviewing clinical guidance and resuscitation arrangements where meconium is present, reviewing the process by which medical staff of all grades learn from adverse events, and reviewing the process of escalating concerns about the progress of labour to more senior staff on call.

5.14 The Medical Director introduced the final report of the neonatal admissions review at the Board meeting on 22 December 2010. They highlighted that there were concerns about midwifery and obstetric management and that *"midwifery staffing levels may limit the provision of safe care across obstetric birthing sites in East Kent"*. It should be noted that at this point in time there were four geographically separate maternity units: WHH, the Queen Elizabeth The Queen Mother Hospital at Margate (QEQM), Canterbury and Dover. This is what was deemed unsustainable, hence the relocation of the two standalone Midwifery-Led Units (MLUs) to be located alongside the obstetric units at WHH and QEQM. In response to a question from a non-executive director raising concerns about 40% of cases having suboptimal care, the Medical Director stated that *"this represented 1.9% of total births"* and that the Trust had not been identified as an outlier in national perinatal statistics.

5.15 The Trust Board was asked to note the recommendation that one standalone MLU remain closed until May 2011 while an urgent review of minimum midwifery staffing levels was carried out. An action plan resulting from this review would be presented to the Board.

5.16 The Assistant Head of Midwifery and the Clinical Director for Women's Health presented the action plan at the Trust Board meeting on 28 January 2011. The Clinical Director for Women's Health emphasised that *"the Trust was operating a safe staff to patient ratio"*. The Board formally noted the action plan.

Report to Monitor and review of maternity services

5.17 Monitor was responsible between 2004 and 2016 (when it became part of NHS Improvement (NHSI)) for authorising, monitoring and regulating NHS Foundation Trusts.

In January 2011, Monitor received an update on the maternity serious incident report described above. This stated that, in response to the findings of the report, the Trust was implementing changes to midwifery and obstetric practice. The Trust also recognised potential concerns with activity and midwifery staffing levels at the high-risk obstetric units.

5.18 The report to Monitor noted that, in view of these concerns, the Trust was carrying out further analysis of midwifery staffing levels at WHH and had embarked upon a review of maternity services across East Kent with the PCT, to be completed by May 2011. Until the outcome of this review was known, the Board had agreed to the closure to births of the MLU in Canterbury, while maintaining daytime services. The Board had also agreed to the reopening to births of the MLU in Dover, which had been closed in September 2010. The Trust maintained that these restrictions enabled the maintenance of enhanced midwifery staffing levels at the high-risk obstetric unit at WHH.

5.19 At the Trust Board meeting on 28 January 2011, the Medical Director reported that they had recently met with staff from the PCT who were carrying out the review of midwifery staffing levels. They referred to the need to inform the local authority's Health Overview and Scrutiny Committee of progress.

5.20 There was no further discussion of maternity services at the Trust Board until 24 June 2011, when a review of the configuration of maternity services was discussed. The review stated that it was the Trust's ambition to *"provide 1:1 midwifery care in active labour corresponding to a midwife to birth ratio of 1:28 at all birth units in line with 'Safer Childbirth' recommendations"*.[2] The average ratio at WHH was 1:40, while at QEQM it was 1:35.

5.21 The options for consultation were discussed at the Board's meeting on 26 August 2011, where the recommendation was made to the Trust Board that:

> *[T]he most sustainable option would be to maintain all services except births and step-down postnatal care at both Dover and Canterbury. This will enable a midwife to birth ratio at Queen Elizabeth the Queen Mother hospital (QEQM) and WHH of 1:28 and will enable the QEQM co-located Midwifery Led Unit (MLU) to be opened.*

This was recorded on the leaflet circulated for consultation as *"Stop births at Dover and Canterbury centres but retain midwife-led antenatal care, day clinics and postnatal support. Open the new midwife-led service at Margate. Increase staffing levels to provide one-to-one care for all mothers."* The Board agreed and consultation commenced on 14 October 2011.

5.22 After consultation, the preferred option was discussed and agreed at the Trust Board meeting on 27 April 2012. In discussion, the Assistant Head of Midwifery stressed that current services were not unsafe. They said that the driver behind the review was to ensure that services were equitable across the Trust, with all women receiving one-to-one care during labour. The Board agreed to the implementation of the preferred option. Although the issue of equitable provision across the Trust was reasonable and clearly dominated the Trust's response, it overlooked the accumulating evidence that there was more to the safety issues than that – in particular, the longstanding cultural problems subsequently described.

5.23 The Trust Board returned to the issue of maternity services on 26 October 2012, when they were featured in its regular "Patient Story" item. This focused on a positive story within maternity services at WHH: 24-hour visiting for patients and more male toilets. It was noted that the Trust had successfully recruited all the midwives who had completed their training at WHH.

5.24 There was no further reference to maternity services until the Trust Board meeting on 30 January 2014, when (under the "Questions from the Public" item) a Trust Governor referred to the Clinical Quality and Patient Safety Report (a Board paper) and the increase in incidents reported to be related to staffing levels. The Governor referred in particular to the Singleton Unit, an MLU at WHH which was fully staffed but reported 18 incidents related to staffing levels. The Chief Nurse agreed to find out the detail behind these incidents and to contact the Governor outside of the Board meeting.

5.25 The Trust Board returned to this theme at its meeting on 28 February 2014, when (again in the "Questions from the Public" item) it was reported that the trend of an increase in staffing incidents recorded had continued since January; this was due to a combination of sickness levels and maternity leave. The recruitment of 14 midwives was under way and the Trust was working through Human Resources (HR) to understand and address the underlying causes of the sickness levels.

5.26 The Canterbury and Coastal Clinical Commissioning Group (CCG) noted at its March 2014 Quality Performance Meeting that it was concerned about maternity services at the Trust. The CQC visited the Trust in the same month and rated it "Inadequate", with maternity services rated as "Requires Improvement", although the CQC report was not published until 13 August 2014.

5.27 In April 2014, the Local Supervising Authority (LSA),* then a designated function of NHS England (NHSE), commissioned a maternal death review, with a panel of clinicians responsible for the care of women during pregnancy and childbirth. The review considered six maternal deaths that occurred in Kent and Medway during the year from April 2012 to March 2013, *"in order to determine whether learning from these tragedies could help improve the future delivery of care"*.[3]

5.28 Quality Surveillance Groups (QSGs) were established by the NHS Commissioning Board (the predecessor to NHSE) in 2013. The intention was for local QSGs to be engaged in surveillance of quality at a local level, with the help of those closest to the detail and most aware of concerns. The members considered information and intelligence but also took coordinated action to mitigate quality failure. The meetings were chaired by the NHS Commissioning Board Area Director, Nursing Director and Medical Director.

Care Quality Commission report, 2014

5.29 The CQC published its findings on 13 August 2014. The overall rating for the Trust was "Inadequate", with findings that it was inadequate in providing safe care and being well led, and that it required improvement to deliver effective and responsive services. Some of the key findings from the CQC were the following:

- There was a concerning divide between senior management and frontline staff.
- The governance assurance process and the papers received by the Board did not reflect the CQC's findings on the ground.
- The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years, reflecting behaviours such as bullying and harassment (staff engagement was among the worst 20% when compared with other similar trusts).

* LSAs were accountable to the Nursing and Midwifery Council (NMC), though their midwifery officers were employed elsewhere, latterly by NHSE. LSAs were responsible for producing supervisory audits of maternity services to ensure the provision of safe and high-quality midwifery care. They ceased to perform this function in 2017.

- Staff had contacted the CQC directly on numerous occasions prior to, during and since their inspections to raise serious concerns about the care being delivered and the culture of the organisation.
- Patient safety incidents were not always identified and reported, and staff use of the incident reporting system varied considerably across the Trust.
- The CQC saw limited evidence of how clinical audit was used to provide and improve patient care and saw examples of where audits had not been undertaken effectively and provided false assurance.
- The CQC found examples of poorly maintained buildings and equipment, and in some cases equipment that was not adequately maintained and was out of date and unsafe.

5.30 Maternity services were given the rating "Requires Improvement".

5.31 The findings of the 2014 CQC report identified a significant difference between the Board's perception of how well the Trust was doing and the experiences of the staff, who described bullying behaviours and a fear of speaking out about things that were problematic. In response to the report, the reaction of the Trust was one of real defensiveness and disbelief.

5.32 The improvement plan for the CQC (which embedded maternity services within it) was reported and discussed at Board level. However, the Board rarely dived into the detail of maternity and neonatal services, and its response was more about monitoring progress against the overall improvement plan (of which maternity and neonatal services were just a part).

5.33 There was a clear disconnect between ward and Board and a perception among midwives that their views were blocked and not escalated appropriately due to "gatekeeping". Governance structures within the Trust were not sufficiently robust to allow ward to Board assurance, and the Trust was not willing or able to actively look for problems and issues to solve, but rather waited for them to be pointed out. The Trust needed to be problem sensing rather than comfort seeking in its approach.

5.34 Maternity services featured very little in Board discussions, despite the concerns that had been raised. Maternity services also did not feature consistently within governance sessions, and there was rarely detailed discussion about maternity and neonatal services at Board level. Issues became diluted, and their significance was not recognised as they were reported up through the chain and repeatedly summarised.

5.35 It remains a concern that a number of themes identified in the 2014 CQC report and in reviews since then have appeared during this Investigation. By way of example:

- At the time of the CQC's initial investigations, staff commented that they were still unable to raise concerns due to the culture at the Trust. The Investigation has heard repeatedly that there was little or insufficient response when concerns were raised by staff.
- Policies were reported as being out of date long after the CQC's initial inspection.
- Lack of support with training has been an ongoing issue (for example, staff being told off for asking questions), and some departments have only recently been requested to participate in formalised training.
- Bullying and harassment remain a significant concern of staff, with some stating that they continue to be negatively impacted as a result of raising a complaint. The suppression of dissent or complaints appears to be an ongoing issue.

- The CQC report identified staffing as an issue across all three sites (Ashford, Margate and Canterbury).

Follow-up to Care Quality Commission inspection, 2014

5.36 Maternity services were discussed again at the 26 September 2014 Trust Board meeting under the "Patient Story" item. The Chief Nurse presented a report which described the experience of a couple during the birth of their first child. The report highlighted the following issues: privacy and dignity not being maintained; a lack of information provided; unprofessional behaviour of some staff; and poor pain control. Since the concerns had been raised with the Trust, the couple had met with the matron and specific actions had been put in place. The Chief Nurse reported that this was not an isolated incident. Matrons and the Head of Midwifery would undertake improvements across all teams.

5.37 In discussion, one of the non-executive directors asked for assurance that there was sufficient resource available to embed the actions and learning highlighted in the "Patient Story". The Chief Nurse stated that staff listening events held following a CQC inspection had enabled staff to discuss their experiences positively. The Chief Nurse added that there were historic cultural and leadership issues which needed to be addressed.

5.38 In October 2014, the regional QSG received a report on the maternal death review and current maternity risks from the LSA. The report identified the following causes for concern: no regional maternity lead in place, which was impacting on the Trust's ability to focus on improvement, and a shortage in midwifery leadership.

5.39 The CCG reported in November 2014 that it was taking action following the CQC inspection. The local CCGs had been meeting with the Trust to gain assurance around both its progress in recruitment and its current birth to midwife ratios. The CCGs were working with the Trust to agree a new approach for holding the Trust to account for the quality of its maternity services, and would be implementing a revised maternity dashboard (a summary of maternity statistics) from the Clinical Network once published.

5.40 In January 2015, an East Kent Maternity Patient Safety Forum was established, following recommendations from the maternal death review.

Bullying and inappropriate behaviour within the Trust and maternity services

5.41 The very significant adverse impact of bullying and harassment, particularly at WHH, was referred to by many staff with whom the Investigation has spoken.

5.42 The 2013 national NHS staff survey recorded that staff engagement at the Trust was in the lowest 20% nationally. The percentage of Trust staff who had experienced harassment, bullying or abuse from other staff in the preceding 12 months (at 31% against a national average of 24%) was one of the Trust's bottom five ranking scores, and it was identified within the survey report as a starting point for local action.

5.43 The position markedly deteriorated the following year (2014), when the national NHS staff survey recorded that the percentage of Trust staff who had experienced harassment, bullying or abuse from other staff in the preceding 12 months had increased to 42% (against

a national average of 23%). Overall staff engagement also deteriorated in 2014 and was again in the lowest 20% nationally. The percentage for staff harassment, bullying and abuse was identified again as one of the Trust's bottom five ranking scores, and again the survey report recommended action.

5.44 The 2014 CQC report published on 13 August 2014 (reflecting CQC inspection visits in March 2014) also identified bullying and harassment within the Trust as a key finding.

5.45 This Report has already referred (in paragraph 1.87) to an anonymous letter sent to the Chief Nurse on 27 October 2014 from a member of staff within maternity services at WHH, which said:

> *I work on maternity at the William Harvey. I'm ashamed to say that I feel intimidated at work. I have been made to look stupid in front of patients and other staff at work. I feel completely unsupported by our most senior staff. At times I dread going to work with certain people … Management and those with authority are not approachable, there is a blame culture, a just get on with it and shut up attitude, slog your guts out and still get grief. It's ok if your face fits, we operate a one rule for one, and another rule for everyone else on maternity … you need to know that at times the unit is an awful place to be.*

5.46 In response to the issues of bullying and harassment raised within the national NHS staff surveys, the 2014 CQC report, the anonymous letter to the Chief Nurse and the concerns of the newly appointed Head of Midwifery (appointed on 1 July 2014), an investigation, led by the new Head of Midwifery and supported by HR, was opened to find out how it felt to work within the Trust's maternity services.

5.47 On 19 November 2014, following interviews with 30 staff, an interim report was provided to the Chief Nurse and Director of HR by a member of staff from the HR Business Partner (Specialist Services Division). The interim report included an account of the following behaviours and issues:

- Prickly, sharp, abrupt and sarcastic senior staff
- Instances of staff being shouted at, criticised and humiliated in front of others
- A daunting and unsupportive environment, with one person describing how they were frightened to attend work
- Staff feeling intimidated and undermined in front of patients, resulting in a loss of confidence and time off work with depression
- Allegations of racism.

5.48 The delivery of the report on 19 November 2014 prompted a meeting later that day between the Head of Midwifery, the Chief Nurse and others, in the course of which the Head of Midwifery was sufficiently concerned to express the view that maternity services at WHH were not safe for patients and should be closed.

5.49 In the event, maternity services were not closed, and the investigation continued. Some 110 members of staff were interviewed in November and December 2014, and just over half reported that they had experienced unsupportive behaviour while working in the Trust's maternity services.

5.50 On 6 February 2015, a consultant obstetrician and gynaecologist wrote to the CQC raising concerns. They had previously worked for the Trust but left because of *"a downward spiral of staff morale following poor leadership"*.

5.51 Following this, the Trust management team received a letter dated 9 February 2015. The Trust has redacted the name of the writer, who stated:

> *I am writing to you on behalf of the midwives and their support staff at the William Harvey Hospital. Following a recent Supervisors Surgery staff have expressed their concerns and distress at the current working environment. I felt this needed to be brought to your attention before the situation deteriorates. The unanimous recommendations from the discussion at the supervisory surgery were: that the concerns stated needed to be escalated; that we should ask for a management meeting with the* [names redacted] *and Human Resources.*

5.52 The writer made a number of requests in the letter, including: *"Improved communication, where staff are listened to and heard with democratic decisions being made for the greater good rather than being dictated to."* The Trust responded on 16 February: *"It has been decided to accept your letter as a raising concern and take forward in accordance with the Raising Concerns Policy and Procedure, a copy of which is provided for your information."*

5.53 On 29 December 2015, a Report Into Raising Concerns was sent to the relevant maternity staff identified in the letter of 9 February.

5.54 Further concerns were raised with the CQC on 23 March 2015, when a midwife rang to say that, following an incident at the hospital, which they described as an *"error of judgement"* on their part, they felt that they had been bullied and victimised as a consequence, in contrast to the Trust's response to more serious incidents involving other staff. They said that they and their colleagues felt there was a culture of bullying at the Trust, that staff were afraid to raise concerns for fear of reprisal, and that such pressures were putting their ability to provide quality care in jeopardy.

5.55 The midwife said that, following the incident involving themself, they had been redeployed in a similar role at QEQM; however, they said this was clearly a *"punishment"* for what they had done, even though their actions had not resulted in an SUI. The midwife added that they were in communication with the NMC in relation to their current issues and stated that it had told them that, based on their evidence, the hospital management did not appear to know what it was doing. The NMC can find no communication relating to this matter.

5.56 In March 2015, the Royal College of Midwives' Regional Officer lodged a collective grievance on behalf of midwives at the Trust. The Trust has informed us that 51 staff signed this letter on 11 March 2015.

5.57 While the 2014 CQC inspection mainly focused on bullying and inappropriate behaviours within midwifery, these problems were not limited to that professional group. In 2015, the Trust commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to carry out a review and to report on a number of behavioural and performance issues, which included concerns about relationships between midwives and obstetricians (see paragraphs 5.77–5.98).

The Report of the Morecambe Bay Investigation, 2015

5.58 *The Report of the Morecambe Bay Investigation* into serious incidents in the maternity department at the University Hospitals of Morecambe Bay NHS Foundation Trust was published in early 2015. It found that the origin of the problems at the Trust lay in the seriously dysfunctional nature of its maternity service, where the following issues were identified:

- Clinical competence was substandard, with deficient skills and knowledge.
- Working relationships were extremely poor, particularly between different staff groups such as obstetricians, paediatricians and midwives.
- There was a growing move among midwives to pursue normal childbirth *"at any cost"*.[4]
- There were failures of risk assessment and care planning that resulted in inappropriate and unsafe care.
- The response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.

5.59 Of particular concern is the fact that, through the spring of 2015, the Head of Midwifery at the Trust had noted the issues and lessons identified within the Morecambe Bay report and sought to raise similar issues of concern with the Trust leadership, but they were not listened to.

5.60 The Head of Midwifery produced a risk assessment dated 11 May 2015 which stated that *"similarities exist between the dysfunctional elements of the Morecombe Bay O&G* [obstetrics and gynaecology] / *Maternity Services MDT* [multi-disciplinary team] *and those within the same department at East Kent Hospitals"*.[5] The risk assessment went on to identify the following areas of risk:

- Poor clinical competence
- Insufficient recognition of risk
- Poor teamworking
- Inadequate clinical governance systems
- Poor-quality investigations – both internal investigations and those undertaken by supervisors of midwives
- Denial of problems
- Rejection of criticism
- Strong group mentality – "musketeers"
- Distortion of truth
- Model answers
- Disappearance of records
- Conflict of roles.[6]

5.61 The risk assessment also noted that *"there were several missed opportunities in dealing with the issues at MB* [Morecambe Bay] *and it is questionable if a similar external review occurred here in EKHUFT* [the Trust] *Maternity Services whether similar missed opportunities would be uncovered"*.

5.62 The risk assessment produced by the Head of Midwifery scored the risk at the Trust as "Extreme Risk – immediate action required".

5.63 The risk assessment was presented at a governance meeting on 12 May 2015, and the Head of Midwifery was due to present their assessment to a wider audience at an away day on 21 May 2015. However, this presentation did not take place.

Further concerns, 2015

5.64 Meanwhile, following the April 2015 regional QSG meeting, a conference call was held on 1 May 2015 between relevant stakeholders to discuss a paper that had been presented by the LSA Midwifery Officer (NHSE South). This identified the Trust as an outlier for maternity-related SUIs in 2014/15 and detailed concerns regarding the Trust's maternity performance: namely eight unexpected admissions to the NICU, two unplanned admissions to the Intensive Therapy Unit (ITU), two neonatal deaths and suboptimal care.

5.65 The intelligence-sharing call agreed that a "deep dive" into maternity services relating to these SUIs should be undertaken by external reviewers. NHSE helped to draw up the Terms of Reference (ToR) for this, and also identified the external clinical reviewers. The Canterbury and Coastal CCG agreed to take the lead. The review was planned to take place before the August CQC visit and the ToR constructed so live learning could take place. A letter from the CCGs to the Trust dated 3 June 2015 confirmed the ToR for an investigation into the management of serious incidents at the Trust.

5.66 The CCGs informed the June 2015 Kent and Medway QSG that the review was planned to take place during July. However, at the end of July the Trust advised NHSE that the "deep dive" was to be incorporated into a wider review of maternity services by the RCOG.

5.67 The meeting also heard that there had been seven serious incidents reported in 2015 involving maternity provision at the Trust.

5.68 On 21 May 2015, at a Closed Board† meeting, the Medical Director and the Acting Chief Nurse alerted the Board to cultural issues within obstetrics and gynaecology. A full investigation was taking place. In addition, the Trust was looking formally at serious incidents on StEIS. Early indications were that the situation had not changed.

5.69 The Thanet and South Kent Coast CCGs produced a report on 10 June 2015 which stated that maternity lessons from serious incident investigations were not being embedded. They also reported that the Deputy Head of Midwifery was currently acting as Head of Midwifery, with external support.

5.70 On 26 June 2015, at the Trust's Closed Board meeting, the Medical Director (under "Confidential Items") updated the Board on *"longstanding cultural issues"* in maternity services following concerns raised by staff to the CQC and the subsequent collective grievance (see paragraph 5.56). The situation had improved within maternity services, but further work was required.

5.71 The Trust had commissioned an external review of obstetrics, as, according to the Closed Board papers, *"mortality rates were above the national average"*. This refers to the work of the RCOG, mentioned above.

5.72 In addition, a complaint had been received from a patient who had overheard a conversation between obstetricians about the safety of the service. Obstetricians were invited to discuss their concerns and a review of job plans was being undertaken.

5.73 One of the non-executive directors asked if the issues reported should have been visible through internal governance systems. The Medical Director explained that there had been a

† Trusts can hold part of their Board meetings in private. This has generally been referred to as the "Closed" part of the meeting or "Part 2" of the meeting.

long history of cultural issues and leadership gaps within the service, which unfortunately had become normalised. This had been evidenced by the CQC during its visit in 2014.

5.74 The CQC inspected the Trust in July 2015 and rated it as "Requires Improvement". In August, the South Kent Coast and Thanet CCGs stated that they were undertaking further scrutiny following the receipt of a 72 hour report in relation to a maternity death SUI.

5.75 In September 2015, NHSE and NHSI noted that they were following up a perceived lack of pace between the Trust and the four local CCGs in jointly commissioning the RCOG clinical review into maternity services, particularly in agreeing the ToR and initiating a start date.

5.76 A regional QSG report in October 2015 stated that the Trust had reported a number of maternity serious incidents relating to cardiotocography (CTG) misinterpretations that had resulted in significant harm or death of a baby. The CCGs were not confident that training was effective and were seeking additional assurance.

Report of the Royal College of Obstetricians and Gynaecologists, 2016

5.77 The RCOG review was undertaken between 24 and 26 November 2015.

5.78 It was commissioned in response to concerns about the working culture within women's services (including relationships between midwives and obstetricians), inconsistent compliance with national standards among obstetricians, poor governance in relation to serious incidents, staffing, education, supervision of obstetric middle grades and trainees, consultant accessibility and responsiveness, and consultant presence on the delivery suite. The RCOG reported in February 2016 and made 23 recommendations.

5.79 The RCOG report included the following findings:

- Major clinical guidelines for maternity did not reflect current evidence-based best practice. The majority of obstetric guidelines were written by midwives with a lack of obstetric engagement in guideline development. Despite the CQC's recommendation in 2014 that clinical guidelines be updated, the RCOG found that some guidelines had long expired or were inaccurate. The RCOG emphasised that the successful implementation of guidelines required the consultants to take ownership.
- The LSA had in place measures to address the fact that the Trust was the second highest reporter of serious incidents in the area. Recommendations were made for the Trust to provide assurance of safe and effective maternity care services through identification, investigation and learning from the management of serious incidents and effective links with supervisory processes, with evidence of an active learning culture.
- In respect of root cause analysis (RCA) investigations, there was an apparent failure both to address medical practice issues and to make recommendations on issues perceived as not contributing to the outcome. If poor consultant performance was identified during an RCA investigation, the issue would not be reflected in the report's action plans. There was also a perception by the RCOG assessors that only staff involved in an incident got a copy of the RCA report findings, and there was little evidence of wider learning across the two maternity units.
- At WHH, all obstetric consultants participated actively on the labour ward and consultant attendance for labour ward rounds was in accordance with Trust guidelines,

with consultants staying on site beyond their shift if necessary and attending the unit when requested out of hours. At QEQM, however, there were three to four consultants who consistently failed to follow Trust guidelines. The RCOG found that *"this unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants"*.[7] The interviews conducted by the RCOG assessors revealed significant concerns about the failure of these three to four consultants at QEQM to conduct daily labour ward rounds, review women, make plans of care and attend when requested out of hours.

- Obstetric trainees on both sites reported problems with clinical supervision at weekends, while the absence of consultant input at QEQM during weekends caused increased pressure on trainees.
- While there was some evidence of good multi-disciplinary working, there was no evidence of escalation by either doctors or midwives to the consultant in cases of conflicting emergencies, and there was little evidence of the "fresh eyes" approach to managing complex cases.
- The assessors heard that consultant behaviour at meetings was perceived as disrespectful, but it was behaviour that was tolerated by the consultant workforce and not recognised as a problem. Consultants worked in silos and not between sites; consultants did not interact. The assessors felt that the consultant body should be more respectful and supportive of each other as individuals, and that consultants should aspire to work together between the two sites.
- Assessors repeatedly heard that medical and midwifery staff at both sites considered there was no point in reporting safety issues as no action would be taken by the Trust. In addition, "whistle-blowers" were made to feel unsupported by managers and got minimal or no feedback on the concerns raised. The assessors expressed concerns that staff on both sites were no longer raising concerns about unsafe practices, conduct or performance of colleagues that was affecting patient safety or care, because this had been done in the past without satisfactory resolution and had involved the harassment of staff.
- Other weaknesses identified by the RCOG assessors included a lack of engagement in national audits, poor labour ward facilities and environment on both sites, and high midwifery sickness rates across both sites.

5.80 In addition to a lack of consultant supervision, the RCOG report raised specific concerns about the use of locum registrars. Notably, even as early as around 2009, the Trust was said to be more reliant than it wanted to be on locums. At the time of the RCOG report:

- QEQM was found to be reliant on middle grade locum cover.
- The RCOG found inconsistency in consultant ward rounds on labour wards at both sites, though this was more apparent at QEQM. It also noted vulnerability of the QEQM unit out of hours due to non-attendance and/or reluctance to attend by on-call consultants when requested.
- Obstetric trainees on both sites reported problems with clinical supervision at weekends, including in the daytime, as they covered both obstetrics and gynaecology.
- Only consultants committed to teaching and supervision became educational trainee supervisors, and the RCOG assessors were concerned that this would result in consultants who were not committed to teaching and supervision being on call with middle grade locum doctors, potentially of unknown competence. This in turn would impact on the safety of care in the maternity unit.

5.81 The Investigation heard that, following submission of the report, the Trust had no further involvement with the RCOG despite the RCOG's attempted follow-ups. The Trust told the RCOG that it was unable to communicate how the recommendations were being taken forward because of an upcoming inspection by the CQC, and it did not respond to the RCOG's subsequent request for follow-up information. The Trust also failed to share the RCOG's report with the CQC.

5.82 Upon publication of the RCOG report, the Chief Nurse of the CCGs wrote to the Trust to express concern about the quality of the serious incident investigations. Ahead of a QSG intelligence-sharing call on 22 February 2016, it was made clear that the issues were longstanding and that there was a need for positive action. The CCG sent an email to the Acting Chief Nurse at the Trust.

5.83 A QSG intelligence-sharing call about maternity services took place on 22 February 2016. Following it, the Accountable Officer at South Kent Coast CCG emailed the Chief Nurse at the Trust, stating:

> *Having read the report my only non-clinical comment is that it is a really sad read. This is nothing that we didn't already know and were raising through other routes. The issues around consultant behaviour were visible to me when I was commissioning Maternity services. Whatever the outcome, I think there needs to be an understanding that this is very long standing and therefore the necessary change needs to be beyond what has previously been achieved. Obviously this was a theme through CQC and is being tackled in terms of midwifery culture already – but we would need positive assurance that the changes in train are having an impact and further work to capture the issues around consultants.*

5.84 On 31 March 2016, in internal emails sent between the Medical Director, the Head of Midwifery and the Clinical Lead for Obstetrics, it was suggested that consultant cover on the labour wards exceeded RCOG guidelines at that time. From the Trust's perspective, *"safety regarding the Consultant cover is not an issue"*. Rather, the issue was *"engagement of Consultants with ward rounds and also about them being proactive, in a woman's management of care, rather than reactive – this was seen to be more of an issue on the QEQM labour ward site"*. In what might be perceived as a lacklustre response, the Trust reminded consultants in writing of Trust policy regarding on-call duties on labour wards. The Trust also committed to a two-week audit of consultants on both labour wards; the results identified no significant concerns with regard to consultant attendance or behaviour at WHH, but several concerns at QEQM in relation to consultant non-attendance. The Trust committed to a re-audit within six months.

5.85 The Investigation heard that findings around a culture of consultants being unwilling to attend were challenged by Trust staff. On publication, the report was dismissed and described as *"a load of rubbish"* by some senior obstetricians. A number of staff were also unaware of the report altogether.

5.86 The RCOG report was discussed at a Women's Health Business and Governance meeting on 5 April 2016. However, despite it having been commissioned by the Trust in the first instance, the report was met with resistance, as the following actions demonstrate:

- The Trust informed the RCOG report reviewers of 20 areas of perceived factual inaccuracies, and submitted a narrative pointing out the lack of benchmarking around safety issues and a lack of comment about the workforce.

- Those attending the meeting considered the RCOG's concerns regarding the length of the RCA process but felt the reviewers had not looked at all the medical notes and did not have a full picture.
- One recommendation was dismissed and surprise was expressed that the RCOG had not identified another issue as a strength.
- The draft action plan included circulation of the RCOG e-learning resources to be accessed by all consultants. However, it appears that these resources were only circulated in August 2016, approximately four months after the meeting.

5.87 On 6 April 2016, the Trust Quality Committee reported that initial information from the recent RCOG report showed that, in the Committee's view, the Trust did not have an unsafe maternity service, but there was improvement work to do around how the service was run in some areas. The Closed part of the Board meeting heard that the Trust was developing an action plan in response to the RCOG recommendations.

5.88 The view that the unit was not unsafe was restated by the Head of Midwifery at a Quality Committee meeting on 4 May 2016. They advised that when they had joined the Trust there had been leadership concerns; many staff in post were acting rather than substantive; there were many vacant substantive posts; there was poor compliance with audit findings and guidelines; there was a lack of equipment; and there was no progression of maternity services in line with national standards. They set out a list of achievements in the previous year, and a non-executive director congratulated them on leading a transformation from poorly led to well-led midwifery services. The agenda item concluded with the Chair recalling that there had been questions raised at the last meeting about whether this was a safe unit. The Head of Midwifery advised that it was. The meeting was told that, compared with national figures, there were low mortality rates for babies at the Trust.

5.89 While the Trust challenged the RCOG report and deemed itself not unsafe, it was felt by Thanet CCG in April 2016 that concerns about maternity services met the threshold for NHSE to call a risk summit.

5.90 An action plan specific to the RCOG report was created in May 2016, with actions to be implemented by the end of October 2016. However, the Panel heard that the RCOG action plan was *"more of a tick box"* in comparison with the CQC investigation. Subsequently, the decision was taken to address the RCOG report within the Trust's general improvement plan. The Panel was told that this meant the response to the RCOG report became diluted and there was insufficient focus on maternity issues.

5.91 The improvement plan was not implemented completely as there were difficulties in securing the full engagement of those at the Trust. The Panel heard that, had the plan been fully implemented on time, it would have *"done the job"*. The improvement plan was then subsumed into the Birthing Excellence: Success Through Teamwork (BESTT) Maternity Transformation Programme in 2017. While it was considered a response to the RCOG report, the BESTT programme was built around a national agenda and some themes from the RCOG review were not included, such as halving the rate of stillbirths.

5.92 The risk arising from regulatory non-compliance in maternity was recognised as presenting an "extreme" risk, with potential harm to both pregnant women and neonates, and was approved as a risk for the Corporate Risk Register (CRR 26) in June 2016. This risk assessment was based on the report from the RCOG and gaps identified by the LSA. The challenges in embedding a *"mature and developed patient safety culture"* were approved as a separate "moderate" risk for the Corporate Risk Register in February 2017 (CRR 48), for reasons

including that the RCOG improvement plan was not being delivered on time and there was difficulty in gaining engagement among some teams, resulting in delays in prioritising quality transformation and education workstreams. The minutes from the March 2019 Board meeting record that the maternity residual risk score (under CRR 48) had been modified to a lower value following a positive visit from the CQC, and by April 2019 the risks relating to maternity services had been removed completely from the Corporate Risk Register.

5.93 In 2019, a review of the actions in response to the 2016 RCOG report found that these were incomplete and that fewer than 25% of the actions were robust and signed off. It was not until 2020, following the coroner's findings in respect of the death of baby Harry Richford, that every recommendation had a corresponding action. The RCOG recommendations were then incorporated into the next phase of the BESTT programme, which began in 2020. It was only in January 2020 that the RCOG report was shared with the General Medical Council (GMC).

5.94 Between publication of the RCOG report in February 2016 and July 2020, just 2 of the 23 recommendations could be evidenced as having been fully met, and only 11 were partially met. The Trust failed to successfully address the issues identified by the report, and any changes that were made were not sufficiently embedded to have any significant impact.

5.95 In a report produced by the Thanet and South Kent Coast CCGs on 10 August 2016, it is stated that a Trust maternity integrated action plan had been agreed in response to quality and safety issues highlighted in RCOG, LSA, CQC and Public Health England external reports and through performance monitoring. The Trust had also recently reported three SUIs in relation to births of twins and had identified some initial learning. The CCGs were seeking assurance through the Heads of Quality and Maternity meeting that learning and mitigating actions were in place during the investigations into the three SUIs.

5.96 Staff continued to raise concerns with the CQC. One example is a letter dated 4 August 2016 from a midwife who worked at the Trust from February 2010 until 2016. It is a long letter but highlighted concerns about the way the midwifery unit operated, including roster rules being broken, skill mix, staff not being consulted, requests for training being refused, a lack of equal opportunities in applying for jobs, high turnover of staff and some staff appearing to be uncaring. The writer acknowledged that these issues may appear trivial when viewed individually, but argued that one should take account of the bigger picture.

5.97 The CQC reinspected some of the Trust's services in September 2016, including maternity services, which it rated as "Requires Improvement" in a report published on 21 December 2016.

5.98 The Trust discussed the RCOG report at its meeting on 9 December 2016, when the Medical Director noted that the issues identified during that review were being addressed. The Chief Executive Officer (CEO) at the time acknowledged the work that was already under way to address the issues highlighted by the RCOG and proposed that concerns raised about engagement could be addressed outside of the Board meeting (via the Trust Quality Committee). NHSE reported in February 2017 that the Trust had stated that its RCOG action plan was being overseen by the clinical lead.

The death of baby Harry Richford

5.99 Harry Richford was born on 2 November 2017 at QEQM. He was the son of Sarah and Tom Richford.

Harry's delivery

5.100 Sarah had an uneventful pregnancy and was considered at low risk. She attended hospital two days before her due date when her contractions started but, following an examination, she was told that she could go home. She returned to the hospital later that evening as her contractions were becoming more painful, and she was admitted to the MLU at QEQM.

5.101 The following morning, 1 November, Sarah was moved to the labour ward for assessment due to lack of progress in labour. She was seen by a registrar, but she did not see a consultant obstetrician while on the labour ward. The CTG, which records fetal heartbeat and contractions, showed decelerations of the baby's heart rate and very frequent contractions suggestive of hyperstimulation of the uterus with Syntocinon, used to accelerate labour. A disagreement took place between the registrar and midwives – in front of Sarah and her family – regarding the appropriate rate of administration of Syntocinon for Sarah.

5.102 Sarah's care was handed over to a locum registrar who commenced a shift at 8pm on 1 November. Sometime around 2.15am, the locum registrar called the on-call consultant to report on Sarah's case – the cervix was fully dilated just before midnight, and she had started pushing just after 1am. The registrar's intention was to bring Sarah to theatre to attempt instrumental delivery for failure to progress and an atypical CTG. The consultant had not met or examined Sarah and was at home as usual when on call. The consultant said that they had offered to come into the hospital, but the registrar declined; it should be noted, however, that a registrar is not in a position to accept or decline a consultant's decision. The registrar was on their third night of providing locum cover at QEQM. The consultant had not worked with or supervised them previously.

5.103 Sarah was taken to theatre at about 3am, and the registrar attempted a forceps delivery, but was unable to lock the forceps blades. Sarah had signed a consent form for a caesarean section, and the locum registrar proceeded to a caesarean section. Up until this point, the atmosphere in theatre was *"not calm but being managed"*. The Panel heard that the tension in the room increased, and the atmosphere became panicked and uncomfortable. A more junior trainee doctor was instructed by the registrar to increase the size of the incision in Sarah's uterus but, having never done this before, they were not confident in doing so. The midwife who had been with Sarah since 8.30 the previous evening was instructed to push Harry's head back up the birth canal, something they had done only twice in their midwifery career.

5.104 Harry was delivered at 3.32am. The Panel heard that the scene in theatre was chaotic and had descended into people shouting at each other. At one stage there were between 20 and 25 people in theatre, but the consultant obstetrician was not yet in attendance. Harry was taken immediately to be resuscitated. The paediatric registrar who attended Harry was a relatively junior doctor and was unable to secure an airway. Harry's father, Tom, was escorted out of theatre, and Sarah asked to be anaesthetised, rather than stay conscious (*"I would rather not be in that room … because I didn't feel safe"*). There was considerable delay in resuscitating Harry and intubation was not achieved for 28 minutes, when the anaesthetist, after administering a general anaesthetic to Sarah, left her side to assist with the resuscitation. The anaesthetist successfully intubated Harry and he was taken to the SCBU for cooling treatment.

The days following Harry's birth

5.105 The consultant obstetrician and the consultant paediatrician on call both spoke to the family after the delivery and told them that Harry was very unwell, and it was likely that he would have cerebral palsy. The consultant obstetrician assured the family that there was going

to be an investigation and told them that they were unhappy with what had happened. The consultant paediatrician told the family that they had looked at the team who had carried out the resuscitation and they had followed protocol. The family recall being told that the paediatric team *"did everything they could".*

5.106 Harry was transferred by specialist ambulance to the NICU at WHH. Sarah and Tom followed later that day. They told the Panel that the week that followed was the worst of their lives. It was unclear whether Harry would survive, and he had seizures over the days that followed. Following an MRI scan showing the extent of damage caused to Harry's brain, Harry died seven days later on 9 November 2017, being held in his parents' arms for the first time since his birth. The cause of death was recorded as HIE.

Investigations following Harry's death

5.107 The weeks, months and years that followed Harry's death involved sustained efforts by his family to seek understanding and truth about what happened during his delivery.

5.108 Harry's death was recorded as a serious incident, and the Trust conducted an RCA. The family had a number of queries which they addressed to the Trust following Harry's death, and they believed that the RCA report would answer all their questions. When, after some delays, the report was made available to the family on 8 March 2018, it raised more questions for them than it answered.

5.109 The Panel heard that the RCA was complex, and more and more issues emerged which required resolution. The magnitude of the investigation was not appreciated by the Trust at the outset, and extensions to the deadline were required.

5.110 The RCA identified problems relating to Sarah's and Harry's care which echoed issues highlighted in the Trust's internal neonatal admissions review in 2010 and the RCOG report in 2016. These included:

- Delay in diagnosing the onset of labour
- Failure to escalate issues to the obstetric team
- Disagreement and communication issues among midwifery and medical staff
- Escalation issues to obstetric consultant and paediatric consultant
- Incorrect CTG interpretation and classification
- Locum registrar on their third night at the Trust whose level of competency had not been assessed
- Difficulties in resuscitation
- Lack of consultant presence in theatre.

5.111 The sense from the family was that the RCA investigation and report were inadequate and did not tell the full truth about what happened to Harry or to Sarah. The family identified a number of errors within the RCA report, such as the level of qualification of the locum registrar, a statement that resuscitation had been carried out in accordance with national guidance, and the complete absence of any critical comment about the lack of consultant attendance. The placenta was not sent for pathological examination as it should have been, and it was acknowledged in the RCA report that it should have been sent for histology at delivery (*"especially when there is a poor and unexpected outcome at delivery of a baby"*).[8] Notwithstanding this failing, the RCA included a comment that *"there is no suggestion that a detailed examination of the placenta would have provided any extra information"*.[9]

5.112 A meeting took place a few days later, on 14 March, between the family and the Trust to discuss the RCA's findings. This meeting appears to have been challenging for all involved (it was described to the Investigation by one member of staff as *"a complete car crash"* for the Trust). The meeting room furniture was disorganised, requiring the family to rearrange it when they arrived; one of the consultants arrived ten minutes late; and another consultant had to be called to attend from Ashford. There were disagreements among the clinicians within the meeting, and inaccuracies and inconsistencies in the report emerged throughout the meeting (for example, whether there were problems relating to CTGs within the unit). The family's impression was that they were treated poorly by the Trust, spoken to like children, and dismissed when they raised concerns.

5.113 A critical issue for the family was the Trust's failure to refer Harry's death to the coroner, a concern which was raised by Tom Richford shortly after Harry died. The RCA report addresses this question as follows:

> *The coroner was not informed as the cause of death was known to be hypoxia and death occurred later than 24 hours from birth. There was a clear sentinel event coupled with difficulty in resuscitation, this fits clearly with HIE. Again coupled with the MRI findings and the MRI report, there was no uncertainty with regards to causation and the death certificate.*[10]

It should be clear that this is a wholly inadequate reason to evade referral to the coroner, when both mother and baby had been healthy at the onset of labour.

5.114 During the RCA meeting on 14 March 2018, the family raised their concerns again, and were told that Harry's case did not need to be reported to the coroner because the Trust knew the cause of death was HIE and death was, therefore, considered *"expected"* because he had been admitted to hospital with severe HIE. The family's natural concern was that the reason for the HIE, and the circumstances that caused it, were not fully understood and required close examination by a coroner. Indeed, the Trust's own internal documents following Harry's delivery identified the outcome as *"unexpected"*; however, his death was recorded on the death certificate as *"expected"*.

5.115 It was only following lengthy discussion at the RCA meeting, during which the Trust representatives finally accepted that Harry's death had been avoidable, that the Trust agreed to speak to the coroner. This action was noted within the RCA report as a recommendation, but it nevertheless took over five weeks, and much contact and follow-up from the family, before the case was referred.

5.116 This practice of delay and avoiding external scrutiny presented itself again in connection with the Trust's obligation to notify NHS Resolution (NHSR) about Harry's death. Under the early notification scheme, the Trust was required to notify NHSR of the death within 30 days. Following enquiries by the Richford family in 2019, it transpired that the notification was only sent to NHSR on 22 March 2018, one week after the RCA meeting with the family and 123 days after Harry had died.

5.117 In June and July 2018, the Trust commissioned independent medical reports into the care received by Sarah Richford and the neonatal resuscitation of Harry Richford. Both reports were critical of the treatment provided by the Trust, yet neither report was shared with NHSE or NHSI at the time. Derek Richford, one of Harry's grandfathers, made a complaint to NHSI in December 2018, raising concerns that the Trust was not learning from incidents. The response from the Medical Director was that lessons had been learned by the Trust, and that on receipt

of the report from the Healthcare Safety Investigation Branch (HSIB), which was due in January 2019, the Trust would put in place a further action plan.

5.118 HSIB is an organisation which acts independently to investigate incidents and develop recommendations to improve patient safety. The Richford family had referred Harry's case to HSIB in April 2018. When HSIB published its report into the care received by Harry and Sarah in January 2019, its findings included:

- The lack of review by a consultant obstetrician during labour
- The use of a CTG interpretation method that was not recommended by the National Institute for Health and Care Excellence
- A failure to meet the requirements of Trust guidance
- Use of a locum registrar without assessing competence or providing appropriate supervision
- The failure of the consultant obstetrician to be present in theatre in accordance with RCOG guidelines and Trust guidelines
- The failure to send the placenta for pathological examination in accordance with Trust policy
- Communication failings between consultants and registrars
- Issues around resuscitation.

5.119 The Richford family also contacted the CQC regarding Harry's case. The CQC's initial assessment was that the issues related to one doctor who had made a mistake, but there were no systemic issues to investigate. Again through the persistence of the Richford family, the issue was escalated to the CQC's Chief Inspector of Hospitals, and in October 2020 the CQC announced that it was prosecuting the Trust in connection with the care provided to Harry and Sarah Richford. In March 2021, the Trust pleaded guilty to an offence of failing to provide safe care and treatment, resulting in avoidable harm to Harry and Sarah. The Trust was fined £761,170.

5.120 Overall, the Richford family felt that the information they received from the Trust was not always truthful, and they had to press and fight to be provided with the information they were looking for about what had happened to Harry. An example relates to the incorrect information submitted by the Trust to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), which produces annual perinatal mortality surveillance reports. The MBRRACE-UK form for Harry dated February 2019 confirmed (among other inaccuracies) that the placenta had been sent for histology, that the case had been discussed with a coroner (although this was only done following pressure from the family) and that there was a final, agreed cause of death following the results of the inquest and all investigations. This was incorrect as the inquest did not take place until the following year.

The inquest

5.121 The inquest into the death of Harry Richford was held over three weeks in January 2020 before an assistant coroner. In their conclusion, the coroner found that *"Harry Richford's death was contributed to by neglect"*. The coroner's report identified the following failures in Harry's care:

- *Harry was hyperstimulated by an excessive use of Syntocinon over a period of approximately ten hours.*[‡]
- *The CTG reading became pathological by 2am and Harry should have been delivered within 30 minutes, not 92 minutes later.*
- *The delivery itself was a difficult one. It should have been carried out by the consultant who should have attended considerably earlier than* [they] *did.*
- *The locum on duty that night was relatively inexperienced.* [They] *were not properly assessed, if at all and should not have been put in the position of being in charge unsupervised.*
- *There was a failure to secure an airway and achieve effective ventilation during the resuscitation attempts after birth leading to a prolonged period of postnatal hypoxia. The resuscitation afforded to Harry Richford failed to be of an appropriate standard.*
- *There was a failure in not requesting consultant* [paediatrician] *support earlier enough during the resuscitation attempts.*
- *There was a failure to keep proper account of the time elapsing during the resuscitation attempts with the result that control was lost.*

5.122 The coroner also issued a regulation 28 report – a report requiring action to prevent future deaths. This detailed 19 concerns identified during the inquest and the coroner's recommendations as to how they could be addressed to prevent future deaths. The recommendations included:

- Action to ensure proper review and assessment of locums and a reminder that it is the supervising consultant's responsibility to ensure the locum under their supervision is competent and experienced
- A review of Trust processes to ensure clarity around the actions required in the event of an obstetric concern or emergency developing
- A review of procedures to ensure staff understand the circumstances where consultant attendance is required
- Training and learning, including simulation training, covering neonatal resuscitation
- Cross-site paediatric working between QEQM and WHH
- Addressing confusion among staff regarding the guidelines and policies that apply to them, by reviewing staff awareness of governing clinical and operational guidance
- An audit of the quality of record keeping and documentation, as the record keeping on the obstetric unit was substantially substandard
- A review of Trust policies to ensure that the outcomes of independent reports are shared with Trust staff so that important learning takes place to prevent any future deaths.

The Trust's response

5.123 The Investigation was told that Harry's death *"caught the Executive off-guard"*. It was not raised in any detail with the Trust Board until late 2019, months before the inquest began and almost two years after Harry died. This was a significant failure of governance.

5.124 It was only in the aftermath of the coroner's findings and the regulation 28 report that the Trust took meaningful action in response to the failings identified in the Richford case. The Trust

[‡] This was the terminology used, although it should be noted that the hyperstimulation is of the uterus not the baby, leading to hypoxia of the baby.

established a Learning and Review Committee (LRC) with separate workstreams to look at the myriad issues emerging from the Harry Richford inquest, as well as previous investigations such as the RCOG report, the Richford RCA and the HSIB report. The LRC reported to the Board on its implementation of recommendations and actions, and all actions were completed by June 2020, when the LRC became the Maternity Improvement Committee.

Subsequent internal and external scrutiny

5.125 At a QSG meeting on 13 December 2017, the CCG Governing Body's Integrated Quality and Performance Report reported that concerns about maternity safety at the Trust in relation to reporting and escalating incidents had been escalated to the Maternity Performance meeting. The Trust had confirmed that it was providing training and support for staff to change the reporting culture. The Trust had also reported a Never Event within maternity services. This related to an obstetric registrar stitching a vaginal tear using a vaginal tampon, which was then unintentionally left in place after the procedure.

5.126 On 8 December 2017, the Board reported that, to celebrate the BESTT Maternity Transformation Programme, the Chair of the Maternity National Transformation Board had visited the Trust to discuss its transformation work and achievements. The Board recognised the significant progress made by the maternity team as part of BESTT. It noted key achievements so far: 100% of staff had signed up to attend essential life support in obstetrics training; the number of quality assured trainers had increased from 9 in 2016 to 76; and £33,000 had been put towards ultrasound training so that every woman could have a 36-week scan.

5.127 The 6 April 2018 Trust Board meeting discussed an item called "Patient Experience Story". The Chief Nurse asked the Board to note that the learning from this experience had resulted in improvements in teamwork and communication. The patient reported a good experience during the birth of her daughter, but she had become unwell afterwards due to a retained placenta and postpartum haemorrhage. The patient observed a lack of communication between the team and herself. There was no leadership in the room and no clear decision making around the bed, with the main issue not being addressed quickly enough. The patient highlighted that her bed covered in her blood being wheeled into the room had been traumatic for her husband.

5.128 The Trust Chair noted that the story was of a classic postpartum haemorrhage that had been poorly managed. It had changed the way the team shared, learned and addressed mistakes. The learning from the case was that the patient had not felt safe, because the staff were not working together or communicating. It was important for the team to be aware of the finer details. The Head of Midwifery noted that "Human Factors" training (training in human interactions, such as communication and teamwork) was bringing together a cohesive and holistic training approach.

5.129 The BESTT Maternity Transformation Programme had started in 2017 and had brought about a cultural shift, which the Head of Midwifery hoped would continue as more simulation training took place. One of the non-executive directors asked whether any competency issues were being addressed with staff. The Head of Midwifery noted that individual competency elements were included in the action plan, as well as whole team learning.

5.130 The Trust Chair highlighted that the patient's story had shown clearly that the clinical team had not worked well together. The Medical Director noted that perinatal blood loss was a key

measure in the National Maternity and Perinatal Audit, and it was an area on which the Trust now performed particularly well.

5.131 At the Board meeting on 10 August, it was reported that the MBRRACE-UK report on perinatal mortality indicated that the Trust's stillbirth and neonatal mortality rate was above the national average. Investigation had revealed that most of this local variation related to congenital non-survivable conditions.

5.132 In August 2018, the QSG report stated that, following nine serious incidents being reported in the maternity service, the CCG did not have assurance regarding the safety and quality of maternity services at the Trust.

5.133 On 6 September, the Board reported that the CQC had identified maternity as "Requires Improvement". The Closed Board meeting noted that an improvement in maternity services had been recognised at WHH due to the transformational work that had taken place.

5.134 On 4 December 2018, Derek Richford submitted a complaint to the NHSI National Medical Director stating that the Trust was not learning from incidents. NHSI contacted the Trust's Medical Director, who reported that, following the RCA, two independent reviews had been undertaken, by an obstetrician from the Maidstone and Tunbridge Wells Trust and by a paediatrician from the Dartford and Gravesham Trust. They stated that lessons had been learned by the Trust and changes had been made to practice. The HSIB report was due in January 2019 and would contain an assessment, conclusion and recommendations regarding the standard of care received by Sarah and Harry Richford. Following this, the Trust would put in place an action plan. The Trust reported to NHSI that they had told the CCG of this. However, the CCG reported that they only became aware when they declined closure of the RCA due to a number of queries.

5.135 At the Closed Board meeting on 6 December, it was reported that, further to an outbreak of pseudomonas infection in the NICU, no new cases had been reported but the incident remained open until the origin of the infection had been identified. Further to two maternal deaths, the Medical Director explained that there would be a meeting with HSIB in the coming week to compare the Trust's investigation with the HSIB investigation.

5.136 In February 2019, NHSI received an email from the Trust's Quality Improvement Director highlighting current key quality concerns. Maternity was not highlighted as a concern. In March, the CCG reported that maternity services were improving under the new leadership model. However, in May 2019, a letter sent to the Accountable Officer for East Kent CCGs by the NHS England and Improvement (NHSE&I) Director of Commissioning Operations following a formal assurance meeting stated:

> *There remain some significant and persistent quality failures at EKHUFT, which whilst raised appropriately by the CCGs, you have not managed to get action to achieve sustained improvements in the provider. The performance indicators are poor across EKHUFT across a range of areas including; Cancer Waits, Delayed Cancer Diagnosis, Maternity Services, Mixed Sex Accommodation, Never Events and A&E. The CCG will need to ensure that it is taking clear oversight and leadership in these areas.*

5.137 The Divisional Director for Women's and Children's Services returned to this theme at the Closed Board meeting on 4 July 2019. They confirmed that, following their report at the last meeting, they would be reviewing all the current referrals to the NMC, currently a total of ten.

5.138 The Chief Executive commented that, following the discussion at the Board meeting held that morning regarding staff who were under investigation, it was critical the Trust remained resilient as an organisation in supporting those staff and ensuring that the process was undertaken and completed promptly. The Trust needed to be robust in working with external agencies to ensure cases were investigated and closed as promptly as possible.

5.139 On 13 August 2019, the CEO of HSIB wrote to the CQC to say that HSIB had ongoing concerns around clinical safety for mothers and babies in the Trust and the Trust's response to these concerns, which they felt the CQC needed to be aware of.

5.140 On 27 August 2019, NHSE&I wrote to the Trust asking for an update on *"The impact of planned changes to improve labour ward senior medical cover"*. The Chief Nurse responded on 9 September that the Trust was considering extended consultant presence on the labour ward and a second registrar on shift. It was also reviewing guidelines on consultant out of hours cover or presence, and was sharing guidelines from neighbouring trusts for the clinical team to consider, which included examples of rotas.

5.141 The CQC wrote to the Trust on 1 October 2019 stating that it was opening a criminal investigation. The Regional NHSE&I Director referred to the letter as *"pretty unusual"*. In the same month, in a quality report to the NHSE&I Executive Quality Group, HSIB expressed concerns about senior medical cover on the Trust's labour wards.

5.142 At the Closed Board meeting on 10 October 2019, the Chief Nurse noted the current position with regard to the NMC and the 12 open cases for Trust staff, only two of whom remained employed with the Trust. There were five additional cases where the Trust was in liaison with the NMC.

5.143 HSIB returned to its concerns on 12 November, when it reported that the Trust was an outlier for referrals. It raised specific concerns about senior out of hours obstetric cover for the labour wards, escalation and CTG interpretation.

5.144 This culminated in a round-table discussion on 28 November 2019 about the Trust, where it was noted that there continued to be significant concerns with the lack of evidence that the Trust was learning from incidents in order to improve care. Following this, a report was commissioned by the Clinical Regional Quality Manager at NHSE&I. This was completed on 3 December 2019 and, in its introduction, the report said there was concern that there might be a risk to patient safety because the Trust's maternity services had not provided evidence that they were learning from serious incidents. It said that this related to a number of cases investigated by HSIB.

5.145 On 28 November, the Secretary of State for Health's Private Office contacted a Director in the Department of Health and Social Care (DHSC), to report that the Secretary of State:

> *… has asked about an operational incident at a maternity ward at William Harvey hospital in East Kent and whether we have any background. I'm afraid I don't have any further information but if this rings any bells and you are able to provide a factual briefing to share with the SoS I would be most grateful. We also have the option of putting this on the operational Quad agenda if you think it would be worth raising with Simon Stevens.*

A colleague of the Director replied to say that DHSC was unaware of the incident.

5.146 On 29 November, the Private Office official shared a briefing from NHSE&I on the issue. They said:

> *[T]he SE region have taken the decision this week (Thursday 28 Nov) to convene a single-item QSG looking at maternity services at East Kent University Hospitals. This is because they were made aware by the HSIB that the trust's referral rate of cases for investigation was notably higher per 1000 births than the national average.*

5.147 NHSE&I also referred to other actions that had been taken. First, HSIB had written to the CQC expressing its concern, which was the first time it had taken this step. In line with the general trend observed at the Trust, HSIB had referenced a specific death in November 2017, which would be subject to an inquest in January 2020. Second, the NHSE&I regional nursing team had led an intelligence-sharing call with system partners (HSIB, the CQC, NHSR and the CCG) to discuss their respective experiences and concerns, which informed the decision to refer the Trust to the QSG. The DHSC Director responded that *"NHS should do QSG asap"*, and this was relayed by the Private Office to the Secretary of State, who asked whether the QSG meeting was private. A member of the DHSC Director's team responded on 2 December: *"The guidance is clear that the QSG meeting should be conducted in an environment of confidentiality and trust, where members feel able to speak frankly and openly about concerns."* They later confirmed that the meeting had taken place on 10 December.

5.148 On 7 December 2019, the Trust's Chief Executive wrote to the Director of Nursing Professional and System Development at NHSE&I:

> *Having so many regulators involved is difficult re coordination and perspective. Particularly HSIB who as a new organisation (and not a regulator as such) are confusing regarding their role. They also work more slowly as they are building their staffing and competence. In similar circumstances in the past, one of the regulators taking the lead, setting the tone and coordinating the information requests, has been helpful. (NHSR have also been involved in this one too). I think with Shrewsbury going on and the tragic case of the Richford family, one of who is making contact with all regulators, MPs, the press etc, it would be easy for this current set of concerns, to be inappropriately calibrated. East Kent has recent history of a negative kind, of that there is no doubt. It is after all why I ended up here in the first place. However, I can see that the improvement programme is biting and the new leadership, particularly since* [the new Head of Midwifery] *arrived, has been having a great effect in maternity. The consultant leadership has also been changed too.*

5.149 On 12 December 2019, for the "Patient Story" item at the Board meeting, the Chief Nurse introduced Mrs X, who presented her daughter's experience in maternity services. Her daughter had been admitted for a planned induction and had also been diagnosed with pre-eclampsia, but did not receive the level of attention or pain relief she needed. Staff on the ward did not seem to have considered her additional needs and support requirements.

5.150 Mrs X stated that she had contacted the Maternity Matron to raise her concerns. The Maternity Matron had taken the time to listen to what she had to say. The Chief Nurse presented feedback to the ward staff in relation to lessons to be learned from this case, while keeping the patient and her family updated on the actions put in place. Mrs X emphasised the importance of staff considering the patient's perspective and taking into account any pre-existing mental health conditions when delivering care. The Chief Nurse also highlighted that it was vital that staff listened to patients, and drew attention to the importance of having robust handover procedures in place. Patients should have positive experiences while in hospital, and the Chief Nurse was always visible on the wards to allow poor experiences to be raised with them directly.

5.151 In December 2019, the Medical Director presented a report to the Closed Board meeting to inform the Board, following concerns raised by regulators, about trends in perinatal mortality,

external scrutiny and the actions being taken to mitigate risks to patient safety. Key specific issues included CTG interpretation, medical staffing cover and escalation. The Medical Director reported that actions to address these issues included adoption and rollout of physiology-based CTG interpretation, identification of gaps in medical staff cover and actions to address these, identification of additional support requirements, and provision of daily labour ward safety huddles during the day and out of hours.

5.152 The Medical Director referred to the RCOG report, which they said had resulted in the Trust adopting the BESTT improvement and transformation programme. The Chief Executive commented that it would be beneficial to review the BESTT programme and whether it had too large a focus and needed to be revised, defining a few specific key areas going forward. The Chief Executive emphasised the need to increase consultant presence on the labour wards, with a minimum requirement to recruit an additional two consultants. There was also a requirement for additional middle grade clinical support. This would, it was claimed, provide additional support for the oversight of locums.

5.153 On 17 December 2019, the Regional Chief Nurse of NHSE&I wrote to the Trust's Chief Executive, the Medical Director and the Head of Midwifery to follow up the "Single Item" QSG meeting on 10 December. The meeting acknowledged good progress made by the Trust on maternity services but outlined the following areas of concern: medical staffing, leadership, management of care, and learning from a recent coroner's case. NHSE&I listed the support it would like to offer.

5.154 An Extraordinary Trust Board meeting took place on 30 January 2020, with the single agenda item of maternity. The Trust has told us that it can locate no notes of this meeting, and that it was an informal meeting held to consider and discuss the next steps following the inquest into Harry Richford's death and to consider the setting up of an oversight group, with an external Chair reporting to the Board. This oversight group was subsequently established as the Trust's LRC.

5.155 The Board met again on 13 February 2020. The Chair reported that the format of this Board meeting would be amended, as the Board recognised and understood that recent media reports on the Trust's maternity services would have raised concerns with East Kent families who were either currently expecting a baby or who had been under the Trust's maternity care in the past. Acknowledging the importance of this issue, half of the Board meeting would be allocated to discussion and questions regarding maternity services. The Chair explained that the Chief Executive and Medical Director would present their respective reports, and time would be allocated to allow them to receive questions from members of the public. The remaining half of the Board meeting would be used to discuss the other agenda items.

5.156 The Chair extended apologies on behalf of the Board and the Trust to the family of baby Harry Richford for his tragic death and for their heartbreak. Recognising that the Trust had not always provided the right standard of care for every woman and baby in its hospitals, the Trust extended apologies wholeheartedly to those families for whom it could have done things differently. The Chair provided assurance that the Trust had made significant changes to its maternity services in recent years to improve the care of women and their families. The Trust would continue to work to improve its services, ensuring the provision of a high standard of care. It was working with the NHS Maternity Safety Support Programme, which was providing support to the Trust to make rapid and sustainable improvements to its services.

5.157 In the item "Chief Executive's Report", the Chief Executive expressed heartfelt condolences on behalf of the Trust, themself and their colleagues to the family of Harry

Richford and to every family that had not received the level of maternity care they deserved. The Chief Executive acknowledged that any death, and particularly that of a baby, was tragic and touched everyone. They assured the public and the Board of the Trust's commitment to listening to feedback from patients and their families regarding any poor care received and their suggestions for improvement. As well as taking into consideration recommendations regarding areas of suggested improvements, the Chief Executive acknowledged the work required with regard to improving the Trust's culture and listening to patients and their families. They would be extending an invitation to the families who had lost a baby to meet them.

5.158 The Chief Executive reported serious concerns raised in 2014 about inadequate staffing, poor teamwork and inadequate equipment in the Trust's maternity services. This had resulted in the Trust being put into Quality Special Measures. They stated that, since they had been in post as the Trust's Chief Executive, a new maternity senior team had been introduced, with the appointment of a Head of Midwifery and a new leadership team. These changes had resulted in successful improvements to maternity services, as detailed in the Chief Executive's report. The Trust was recruiting six additional consultants as well as middle grade doctors to support the consultants and senior clinicians already in place.

5.159 The Chief Executive confirmed that the CQC was continuing to monitor and review the Trust's maternity services. The Trust was working closely with NHSE&I to support these ongoing reviews. The Trust was also working closely with HSIB, with quarterly meetings taking place.

5.160 The Chief Executive stated that an internal review had been put in place. Its aim was to review and confirm the steps implemented to ensure that the Trust moved in the right direction to achieve the necessary improvements in providing excellent standards of care to every mother and baby who used its services.

5.161 The Medical Director reported that they would be working with external support and would be reviewing all perinatal deaths to identify those that were preventable. The Chief Executive commented that the Trust's staff wished to be associated with a "Trust of excellence", and that all staff were focused and energetic in supporting this improvement programme and would not rest until the Trust, the public and regulators were confident that an excellent standard of care was being provided. The Panel was surprised that the Trust had not been doing all of this before, given how long it had been since very similar problems were first identified.

5.162 The Medical Director highlighted areas of improvement, which included medical engagement, incident reporting, availability and presence of consultants on the labour wards and escalation. They reported the actions recommended by the family at the inquest into the tragic death of Harry Richford and indicated that there had not been sustained and embedded learning within maternity services. The Trust recognised the importance of embedding learning and the need to make changes. The Medical Director also stated that the independent HSIB review of the Trust's maternity incidents reflected themes evident nationally.

5.163 Quarterly meetings were being held with HSIB and key recommendations included medical staff engagement, which, according to the Medical Director, had significantly improved. Other key elements included escalation and communication between staff and the two sites. The Medical Director confirmed that the coroner's conclusion had been received; this included 19 recommendations, of which 2 were national recommendations. The Richford family had also submitted 42 recommendations for the coroner to consider, covering six broad areas as detailed in the coroner's report. They also submitted for consideration support for bereaved mothers with regard to accommodation, a dedicated support worker and counselling. The Medical Director highlighted the changes that had been implemented to date in addressing these

recommendations, and concluded by stating that a programme of improvement work had been put in place around learning and support in midwifery, paediatrics and obstetrics. This would be overseen by the internal overview panel, chaired by an external obstetrician.

5.164 At the Closed Board meeting on the same day, the Medical Director confirmed the completion of the review of all RCAs between 2012 and 2019 in relation to perinatal deaths and identification of any potential avoidable deaths. They reported that 11 deaths had been identified as preventable, with a further 4 potentially preventable. The Chief Executive confirmed that 25 cases had been referred to HSIB, including cases of baby deaths and babies who had recovered after receiving neonatal therapeutic cooling. The Medical Director reported that quarterly meetings continued to be held with HSIB and that update reports from these meetings would be presented to the Trust Quality Committee.

5.165 The Chief Executive confirmed that an independent review into East Kent maternity services would be undertaken by Dr Bill Kirkup. This would include a review of perinatal deaths to identify any potential avoidable deaths.

5.166 On 5 March 2020, East Kent maternity services were discussed at a Health Overview and Scrutiny Committee (HOSC) meeting. The Trust's Deputy CEO introduced the item by saying that the Trust had recognised in 2015 that the position in maternity services needed to improve and had commissioned the RCOG to undertake a review. A HOSC member asked why things had gone so wrong despite the RCOG review taking place in 2015. The Medical Director explained that themes from that review had been repeated in subsequent reports, which suggested that any changes made had failed to be embedded.

5.167 Asked how East Kent residents could be assured that the Trust's Board was adequately monitoring the implementation of best practice, when it had failed to do so in 2015, the Deputy CEO explained that, following the coroner's report, the Trust had established an externally chaired Board (a sub-committee of the main Board) which in turn had seven "task and finish groups", each with their own area of focus. The Chair of the new Board was independent, in order to provide external opinion as well as assurance. The seven workstreams were being overseen by clinicians, which the Trust felt demonstrated a real shift. The Deputy CEO also felt it was important that the Trust accepted the additional clinical support on offer. The Medical Director pointed out that each of those present at the meeting was an East Kent resident and therefore had a vested interest in making the services the best they could be. A consultant said that, as a relatively new employee of the Trust, they felt that the employer was recruiting people with different skillsets in order to build its workforce and that it was being open about the challenges it was facing.

5.168 A consultant acknowledged that there were lots of things to be done, and they were having to be prioritised. Examples of actions that had been, or were being, taken included:

- Remote fetal monitoring (where consultants could monitor a fetus from any location)
- Further investment in training and development for both technical and non-technical skills
- Implementing controls to ensure increased consultant presence on the wards
- Appointment of three specialist midwives (one specialising in the Better Births agenda and two in fetal wellbeing)
- A piece of work to scope out continuing care and what that meant for women and families in East Kent

- Out of hours safety huddles to ensure ward leads had a strategic view of the service at that time
- Investing in and expanding the Getting It Right First Time programme
- The Chief Nurse holding "floor to Board" meetings to gather intelligence and ensure staff felt listened to.

5.169 Meanwhile, the RCOG had offered earlier in the year to provide support to the Trust. This culminated in a site visit to the Trust from 11 to 13 March 2020. The proposed output from this was a service development action plan, a governance action plan and a workforce action plan.

5.170 The Trust Board met again on 12 March 2020, when it received a report from the LRC. The Chief Executive asserted that this provided the Board and the regulators with assurance around transparency and openness, given that the internal review was being externally chaired and led by an independent community representative. The Chair of the LRC reported that they had met with the individual workstream leads and were confident that actions were being taken seriously and implemented. They explained the aim of the LRC in relation to reviewing the Trust's response to the internal review and whether it had implemented the recommendations from previous historical reports. The LRC would also assess whether the BESTT improvement programme addressed these past and current action plans. The LRC would identify the information needed to assure the Board that the Trust's maternity and neonatal services were safe, well led and sustainable. It was noted that the actions in relation to how the Trust employed locums were not yet complete, but the LRC was assured that these were being taken forward and were being appropriately prioritised.

5.171 A non-executive director asked whether there was sufficient engagement, openness, determination and commitment from the Trust's clinicians to support and embed the improvement programme. The Chair of the LRC assured the Board of this commitment from the workstream clinical leads, who were fully engaged and appreciative of being given protected time to undertake this work.

5.172 There was further activity in DHSC relating to the publication of an HSIB report, including briefing to ministers on 24 March. The briefing stated that *"the summary report was produced by HSIB at the request of DHSC. It is not a routine report that HSIB would produce or publish under their maternity investigation programme as maternity reports are only shared with the family and trust. The report has been shared with the Trust."* The briefing continued:

> *We have reviewed the contents of the report and do not think there is anything contentious in it or that it highlights issues that have not already been addressed with the Trust that would prevent it from publication. CQC have shared its report with the Trust and the Trust have published the letter from CQC on their website therefore publication of this report, would be consistent with their approach. The terms of reference for the independent review commissioned by NHS England are in the process of being agreed and this report is not dependent on the outcome of the review.*

5.173 However, in light of the Covid-19 pandemic, DHSC officials advised that publication should be delayed, as it *"may detract media and public scrutiny from the vital work the Trust is doing to respond to the pandemic"*.

5.174 Ministers were again briefed on 25 March, with a draft response to a Prevention of Future Deaths report from the coroner in relation to Harry Richford. The briefing advised that the ministers' response:

> *… highlights the NHSEI and RCOG work on guidelines in relation to locum doctors in maternity services. In addition, the suggested response acknowledges the work undertaken by regulators and other national bodies to scrutinise and support the safety of maternity services at the East Kent Trust; as well as the commissioning by NHSEI of the independent investigation of East Kent maternity services led by Dr Bill Kirkup.*

Chapter 6: Areas for action

Introduction

6.1 Chapter 1 of this Report sets out the findings of the Panel's Investigation of maternity services at East Kent Hospitals University NHS Foundation Trust (the Trust). It describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes – in many cases disastrous. It highlights an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their care and afterwards, when they sought answers to understand what had gone wrong. It delineates grossly flawed teamworking among and between midwifery and medical staff, and an organisational response characterised by internal and external denial with many missed opportunities to investigate and correct devastating failings.

6.2 Chapters 2 to 5 provide the evidence to support these findings, gathered through family listening sessions, reviews of clinical records and interviews with managers, staff and others. We have reviewed the emerging findings against a large body of documentation provided to us by organisations with an interest in the Trust during the period under scrutiny.

6.3 As indicated in Chapter 1, this chapter puts forward an approach that is different from the norm: in particular, we have not sought to identify multiple detailed recommendations. NHS trusts already have many recommendations and action plans resulting from previous initiatives and investigations, and we have no desire to add to their burden with further detailed recommendations that would inevitably repeat those made previously, or conflict with them, or both. We take those previous recommendations and the resulting policy initiatives as a given.

6.4 Instead, we identify four broad areas for action based firmly on our findings but with much wider applicability. None is susceptible to easy analysis or a "quick fix", but we believe that they must be addressed, because the simple fact is that the traditional approach has not worked: supposedly one-off catastrophic failures have continued to happen, despite assurances that each would be the last. The approach here aims to identify the fundamental problems that underlie these recurrences, however difficult.

Key Action Area 1: Monitoring safe performance – finding signals among noise

The problem

6.5 There is a dearth of useful information on the outcome of maternity services. This may be a surprising statement, because plenty of data are certainly collected; however, a large majority are process measures of dubious significance, such as caesarean section rates. The minority that are related to outcomes are high level and conceal events susceptible to clinical intervention among a larger, unrelated group, such as perinatal mortality.

6.6 The unit-level information that is available tends to be presented in the form of "league tables", based on rankings in some form. These merely serve to conceal the variation between different units, with no indication of whether one or more units at the top or bottom of the rankings are there because they are outliers, or merely through chance. If units are presented only as part of a group, such as the top or bottom ranked 5%, interpretation is even more problematic for an individual unit.

6.7 The Trust exemplifies all these difficulties. It has used high-level information inappropriately as reassurance, taking comfort from the grouping that at least there were other trusts in the same boat. At times, it has used this false reassurance as a bolster against the plethora of evidence from other sources that there were very significant problems in its maternity services.

The future

6.8 There are huge benefits to the effective monitoring of outcomes. Clinicians can see where there is scope to improve effectiveness and address problems of service safety, and evidence from other specialties shows that – perhaps after a little early reluctance – they embrace this enthusiastically, with demonstrable improvement in outcomes and patient safety. Trusts can identify warning signs and take action where necessary, before problems and behaviour become embedded and perhaps intractable. Regulators, including NHS England (NHSE) and the Care Quality Commission (CQC), can identify units that are outliers and investigate appropriately before a trust descends into catastrophic failure. All parties can have a conversation based on relevant shared information about safety performance, rather than what otherwise might become a stand-off based on prejudice and refutation.

6.9 There are two overall requirements. The first is the generation of measures that are meaningful (that is, related clearly and straightforwardly to outcomes); risk adjustable (that is, they take into account the complexity of work in a unit and its effect on outcomes); and available (that is, they can be garnered from among the array of data already routinely collected, as we have no desire to suggest any data returns additional to the large array currently required). They must also be timely.

6.10 The second requirement is that the measures are analysed and presented in a way that shows both the effects of the random variation inherent in all measures, and those occurrences and trends that are not attributable to random variation. The random variation is often referred to as "noise", and the outlying event as the "signal". There are sound, statistically based approaches to detecting the signal among the noise, and presenting this graphically to show not only the level of variation but also the significant trends and outliers in the form of statistical process control charts and funnel plots. Useful work on these techniques is already being carried out by NHSE, but it is important that this is extended to clinically relevant outcome measures.

6.11 Deriving valid measures that meet these requirements is a little more problematic in maternity care than in some specialties because pregnancy and childbirth are physiological in most cases, and poor outcomes are less common. Perhaps this has underlain the lack of progress so far. It is, however, perfectly possible to overcome these problems and generate a suite of outcome measures available for the use of clinicians, units, trusts, regulators and the public. We have resisted the temptation to describe this as a "toolkit" because it is not something optional from which to pick and choose: the approach must be national, and it must be mandatory.

Recommendation 1

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

The problem

6.12 Caring for patients in any setting requires not only technical skills but also kindness and compassion. This is no less true for mothers and babies in maternity care. Yet we heard many graphic accounts, from staff as well as families, that showed just how far from the required standards behaviour had fallen at the Trust. Previous experience has shown the danger in assuming that such serious lapses of such a distressing nature are restricted to one trust alone.

6.13 Failing to meet basic standards of clinical behaviour has obvious effects on colleagues and those receiving care. Unprofessional conduct is disrespectful to colleagues and endangers effective and safe working; it undermines the trust of women. Lack of compassion significantly affects the wellbeing of women, often leading to unnecessary long-term harm. When families are treated unkindly in the aftermath of a safety incident, as is often evident, it compounds and prolongs the harm caused by the event itself. Failure to listen directly affects patient safety, as we found repeatedly in the Trust's maternity services, because vital information is ignored.

6.14 Because compassion is such an integral part of belonging to any caring profession, it is particularly difficult to comprehend how such failures can come about. Whether or not traits of empathy and compassion form part of the selection or assessment of new entrants, the need to be professional and to listen will surely be emphasised as part of initial education and training. What we saw and heard was that it was when clinicians were exposed to the behaviour of senior colleagues that their standards began to slip. The influence of role models, those whose positions more junior staff would aspire to fill one day, can be significantly greater than classroom teaching. If those role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards.

6.15 Once such a negative cycle is established, it can prove remarkably persistent because of another feature evident in the Trust's maternity services: normalisation. Behaviour that would otherwise be challenged becomes tolerated, because "that's the way we do things here". In this way, inexorably, patterns of unprofessional behaviour, lack of compassion and failure to listen become accepted and embedded, to an extent that is genuinely shocking when seen through fresh eyes.

6.16 When such problems are brought to light, perhaps through whistleblowing or external review, they remain difficult to correct. We saw this exemplified in the Trust in the form of the grievance which stopped the investigation of bullying and harassment by midwives in its tracks, and in the failure to address grossly unprofessional conduct on the part of some consultant obstetricians who were refusing to fulfil labour ward responsibilities including attending when on call.

6.17 The Trust is far from alone in finding great difficulty in addressing unprofessional consultant behaviour. Consultants have, or perceive themselves to have, considerable freedom to act on their own responsibility without taking direction from others. The majority, of course, use this freedom wisely in line with their senior and highly qualified status; but in the minority who act unprofessionally, it serves as a shield to deflect any attempt to correct aberrant behaviour. A trust or its medical director who attempts to intervene has few sanctions available other than dismissal, with the prospect of facing lengthy processes and a likely loss at an employment tribunal against a strong legal defence funded by a protection society. This is such an unequal battle that a consultant subject to challenge is often advised to resign and claim constructive dismissal.

6.18 This is not to deny that consultants have sometimes been victimised by trusts, or that their employment rights must be protected fairly; nor is this a question of clinical competence. But it remains the case that a stubborn, poorly behaved consultant can cause havoc in a clinical unit that imperils its performance, as well as the wellbeing of staff and patients over a prolonged period. This cannot be right.

The future

6.19 Compassionate care lies at the heart of clinical practice for all healthcare staff. If some are able to lose sight of that, then it needs to be re-established and re-emphasised. Every interaction with a patient, mother and family must be based on kindness and respect. This will not be achieved through well-meaning exhortation in classrooms or by professional leaders, but through the attitudes and daily behaviour of clinicians themselves, at every level but most particularly those in more senior positions who are role models for less experienced staff.

6.20 Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels. It must not be something learned during the earlier academic stages of training, only to be forgotten later.

6.21 There is a need for all staff to acknowledge and accept the authority of those in clinical leadership roles. These are not sinecures to be done for a couple of years on a rotating basis: they are integral to the effective and safe functioning of services. While some clinicians accept this, it is clear that many do not. Those in clinical leadership roles need to have the skills and time to carry them out effectively.

6.22 Reasonable and proportionate sanctions are required for employers and professional regulators so that poor behaviour can be addressed before it becomes embedded and intractable. The existence of such sanctions would itself act as a deterrent to the defiant reactions to challenge exhibited by an unreasonable minority.

6.23 The importance of listening to patients must be re-established as a vital part of clinical practice. This will require it to be embedded not only in continuous professional development, but also in the academic components of early training. The rapid rise in technical and diagnostic possibilities understandably puts pressure on academic curricula, but this must not be to the detriment of skills such as listening.

Recommendation 2

- **Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.**
- **Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.**

Key Action Area 3: Flawed teamworking – pulling in different directions

The problem

6.24 Clinical care increasingly depends on effective teamworking by groups of different professionals who bring their own skills and experience to bear in coordination. Nowhere is this more important than in maternity and neonatal services, but nowhere has it proved more problematic. Where it works well, care can be outstanding, but in almost every failed maternity service to date, flawed teamworking has been a significant finding, often at the heart of the problems.

6.25 Maternity services at the Trust were no exception. The Panel found that there was dysfunctional teamworking both within and across professional groups. The lack of trust and respect between midwives and obstetric staff, and between paediatric and obstetric staff, posed a significant threat to the safety of mothers and their babies. We found many examples of how this caused conflict, made staff feel vulnerable, prevented information from being shared, and encouraged complacency and a lack of accountability. After a safety incident, the most common response was to find somebody to blame for it – often the most junior midwife or doctor involved – preventing important lessons from being learned. The consequences for mothers and their babies were stark.

6.26 There is one feature of flawed teamworking that is particularly striking in maternity care: the divergence of objectives of different groups. A team that lacks a common purpose will struggle, working in an environment of competing interests which may rapidly descend into conflict, inappropriate hierarchies and power plays. It is evident that there was a struggle for "ownership" of maternity care in the Trust, and it is clear that this also applies elsewhere. Rather than contributing as equal partners, midwives may be encouraged to see themselves as being "there for women", defending them from the "medicalisation" of maternity care. This polarisation of approach and objectives cannot help but put them in conflict with obstetricians.

6.27 In this context, the language used around "normal birth" may have significant unintended consequences, raising expectations among women and maternity staff that this is an ideal to be aspired to by all. But it is far from ideal for all, and promoting it unselectively can leave women feeling unfairly that they have failed in some way; in some cases it can expose them to additional risk.

6.28 Poor morale among obstetric trainees is a common feature and contributed significantly to the problems in the Trust's maternity services. Trainees felt pressurised, unsupported and

obliged to carry out clinical tasks they were not ready for; unsurprisingly, there were recruitment difficulties and overuse of locum doctors who were not always properly assessed. Necessary changes to doctors' hours and training have had unintended consequences, including fragmenting care and increasing handovers. They have also removed the "firm" system previously in widespread use, which saw teams of staff with one or several consultants who would work together both in routine practice and while providing on-call services, offering support and increasing knowledge of capabilities and ways of working.

The future

6.29 We need to find a stronger basis for teamworking in maternity and neonatal services, based on an integrated service and workforce with common goals, and a shared understanding of the individual and unique contribution of each team member in achieving them. Crucially, this must be based on an explicit understanding of the contribution of different care pathways and when and how they are best offered. National guidance on this must be the same for all staff involved, and not suggest that there are different objectives for obstetricians and midwives.

6.30 Teams who train together work better together. The most frequent claim of joint training is that it is used in emergency drill training. This is very valuable, but it is not enough. There are opportunities at every stage of training – from undergraduate education onwards – not only to increase understanding of others' roles and responsibilities, but also to become used to working with other disciplines and the contributions they make.

6.31 We need to re-evaluate the changed patterns of working and training for junior doctors, and in particular how the unintended consequences of fragmentation of work and lack of support can be avoided or mitigated.

Recommendation 3

- **Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.**
- **Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.**

Key Action Area 4: Organisational behaviour – looking good while doing badly

The problem

6.32 The default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation, as is evident from a great many instances within the NHS and much more widely. Many risk registers will identify reputational damage in several contexts as something to be mitigated. If this were only a single part of a more complete response that was based on identifying failure and learning from it then it might be considered reasonable. But repeated experience says that it is not.

6.33 On the contrary, the experience of many NHS organisational failures shows that it is the whole basis of the response in many cases. Further, it has clearly led to denial, deflection, concealment and aggressive responses to challenge, in the Trust as elsewhere. Not only does this prevent learning and improvement, it is no way to treat families, who are heartlessly denied the truth about what has happened when something has obviously gone wrong, compounding the harm that they have already suffered. Refusal of scrutiny may extend to the manipulation of information for the CQC, and misrepresenting deaths (for example, as "expected") to avoid inquests.

6.34 In the case of NHSE, there is a particular issue evident when a trust is in difficulties with clinical services: naturally, NHSE wishes to take decisive action and to be seen to do so, but its scope for intervention is limited when problems relate to clinical dysfunction. One of the few levers available is the replacement of chief executives and chairs, and we have seen evidence of a pattern of reaching for this lever repeatedly, with questionable consequences. Of course, there are questions of accountability for failing to act, as we have pointed out, and perhaps of competence; however, much more often it seems that neither is the reason, as individuals were simply moved to equivalent posts elsewhere. The only reasonable conclusion is that NHSE is espousing the idea that a fresh face, or faces, will solve the problems that others could not, described to us as the "heroic leadership" model.

6.35 There are two consequences evident. First, any steps towards recovery will be halted, as staff have to adapt to new ideas and new ways of working. Second, the incentive to be less than frank about emerging problems is intensified, as individuals naturally prefer stability, and having choice over their circumstances of departure.

The future

6.36 The balance of incentives for organisations needs to be changed. The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment. The current small risk to an organisation does not match the risk of loss of public confidence in one of its vital services.

6.37 It seems that previous attempts to encourage organisations to change this behaviour by identifying the pernicious, damaging consequences for those harmed have not worked – even when taking into account the duty of candour in relation to individual clinical incidents, typically regarded as satisfied by a single conversation. It is time to introduce legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open. This has previously been outlined in a Public Authority (Accountability) Bill, known colloquially as the "Hillsborough Law".

6.38 When families experience harm, the response must be based on compassion and kindness as well as openness and honesty. Healthcare organisations have a lasting duty of care to those affected.

6.39 A review of the regulatory approach to failing organisations by NHSE would identify alternatives to the "heroic leadership" model, including the provision of support to trusts in difficulties and incentives for organisations to ask for help rather than conceal problems. The identification of problems should not be seen as a sign of individual or collective failure, but as a sign of readiness to learn.

Recommendation 4

- **The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.**
- **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.**
- **NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.**

East Kent Hospitals University NHS Foundation Trust

6.40 For essentially the same reasons, we have not sought to set out a detailed list of things that the Trust must do – and the Trust has had numerous previous action plans that have not worked. Its problems are not susceptible to top-down point by point guidance: they are at once straightforward and deep-rooted. The new leadership of the Trust will read this Report and can see exactly what has gone wrong and what needs to be put right.

6.41 They are already aware that there are deep-seated and longstanding problems of organisational culture in their maternity units, and they can see spelled out in the words of families and their own staff the nature of the disgraceful behaviour and flawed teamworking that were previously left to fester. They will know what assistance they can commission from external bodies, including NHSE, and must receive full support. They must work in partnership with families who wish to contribute, and report publicly on their approach and its progress. We expect that staff will want to give their full engagement and cooperation, having seen the harm that resulted from previous behaviour that had become normalised.

6.42 The first step in the process of restoration is for all those concerned to accept the reality of what has happened. The time is past to look for missing commas in a mistaken attempt to deflect from findings. The damage caused to families is incalculable, and their courage in coming forward to ensure this came to light is exemplary, but it should not have been necessary. This must be acknowledged without further delay. Only then can the Trust embark on trying to make amends.

Recommendation 5

The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Appendix A: Terms of Reference

Written Ministerial Statement

Written statement by Nadine Dorries, former Minister of State, Department of Health and Social Care, 11 March 2021

On the 13 February 2020 I confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust).

The Review will be known as the 'Independent Investigation into East Kent Maternity Services' (the Independent Investigation).

We take the patient safety concerns at East Kent maternity services very seriously. The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions.

The Terms of Reference have been finalised now the views of the families affected have been taken into account and are published today on the Independent Investigation (Independent Investigation into East Kent Maternity Services: https://iiekms.org.uk/) and NHSE website (https://www.england.nhs.uk/publication/independent-investigation-into-east-kent-maternity-services-terms-of-reference). The Terms of Reference include the scope and arrangements that are to be put in place to support its functions and confirm the Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, when the Trust came into being, until 2020. The terms of reference include the scope and arrangements that are to be put in place and confirm the independent investigation will examine maternity and neonatal services in East Kent, in the period since 2009, when the Trust came into being, until 2020.

The Independent Investigation will draw conclusions as to the adequacy of the actions taken at the time by the Trust and the wider system and will produce a report to be disclosed first to the affected families and then to NHSEI as the commissioning organisation and then to the Department of Health and Social Care prior to publication.

The work of the Independent Investigation is expected to complete by the Autumn of 2022 and arrangements will be made for the final report to be presented to the Secretary of State; Ministers will subsequently publish the report to Parliament, and a response will be provided in due course.

A copy of the Terms of Reference will be deposited in the Libraries of both Houses.

Independent Investigation into East Kent Maternity Services Terms of Reference

Introduction

1. Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust). The Review will be known as the 'Independent Investigation into East Kent Maternity Services' (the Independent Investigation).

2. This is to set out the Terms of Reference for the Independent Investigation, including its scope and the arrangements that are to be put in place to support its functions, detailed in an accompanying Protocol.

3. Dr Bill Kirkup is appointed by NHS E/I to chair the Independent Investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at East Kent University Hospitals NHS Foundation Trust during the period since 2009 (when the Trust came into being) drawing upon the methodology followed in the Morecambe Bay investigation.

4. The Independent Investigation was also confirmed in Parliament on 13 February 2020 by Nadine Dorries, Minister of State for Patient Safety, Mental Health and Suicide Prevention. At the same time the Minister announced that the Chief Midwifery Officer, Jacqueline Dunkley-Bent, had sent an independent clinical support team to the Trust to provide assurances that all possible measures were being taken.

Scope

5. The Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, by looking in particular at the following four layers:

i. What happened at the time, in individual cases, independently assessed by the investigation.

ii. In any medical setting, as elsewhere, from time to time, things do go wrong. How, in the individual cases, did the Trust respond and seek to learn lessons?

iii. How did the Trust respond to signals that there were problems with maternity services more generally, including in external reports?

iv. The Trust's engagement with regulators including the CQC. How did the Trust engage with the bodies involved and seek to apply the relevant messages? And what were the actions and responses of the regulators and commissioners?

Purpose

6. The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions. This includes:

A. Determining the systems and processes adopted by the Trust to monitor compliance and deliver quality improvement within the maternity and neonatal care pathway.

B. Evaluating the Trust's approach to risk management and implementing lessons learnt.

C. Assessing the governance arrangements to oversee the delivery of these services from ward to Board.

7. The Independent Investigation will draw conclusions as to the adequacy of the actions taken at the time by the Trust and the wider system. Taking account of improvements and changes made, the Independent Investigation will aim to provide lessons helpful to East Kent but also to share nationally to improve maternity services across the country.

8. The Independent Investigation will focus on the experience of the families affected and the actions, systems and processes of the Trust, (with reference to clinical standards for maternity and neonatal care during the period). The Independent Investigation will listen to the concerns of the affected families, use their experience to shape the key lines of enquiry and provide an opportunity for them to be heard. The Investigation should also consider the processes, actions and the responses of regulators, commissioners and the wider system as they are relevant to the provision of maternity and neonatal services at the Trust.

9. The Independent Investigation will produce a report to be disclosed first to the affected families and then to NHS E/I as the commissioning organisation and to the Department of Health and Social Care prior to publication. The Report will be published and presented to Parliament.

10. The Investigation will agree with NHS E/I steps it might take at the completion of its work to help ensure that the lessons identified are understood and acted upon. These steps might include presentations to NHS groups.

Timescale

11. The Independent Investigation will aim to complete its Terms of Reference by Autumn 2022.

Protocol

Access to documents

- All relevant NHS organisations, regulators and the Department of Health and Social Care are required and expected to cooperate with the Independent Investigation as is normal, professional practice, including supplying documentation, as and when requested by the Investigation.

Contact with families and the public

- The Independent Investigation team will be responsible for managing liaison with families whose cases are relevant to the Independent Investigation

Methodology and case review

- The Independent Investigation will decide how best to deliver its Terms of Reference including by drawing upon:

  a. the experiences of families affected by maternity services in East Kent and the impact on those families looking as widely as necessary to understand the whole of that experience and impact;

  b. the medical records of patients;

  c. the corporate records showing how the Trust discharged its responsibilities for

maternity services, how it communicated and engaged with patients, their families and representatives and with regulators and others over concerns with maternity services;

d. interviews with those whose work involved maternity services;

e. interviews with regulators, NHS England and Improvement, HSIB and others;

f. its assessment of what went wrong in individual cases and lessons aimed at ensuring improvements which should be made to maternity services in East Kent and elsewhere.

- In applying its methodology, the Independent Investigation will consider individual cases where there was:
  i. a preventable or avoidable death;
  ii. concern that the death may have been preventable or avoidable;
  iii. a damaging outcome for the baby or mother;
  iv. reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong.
- The Independent Investigation will take account of other relevant work including the following but will be responsible for reaching its own assessment, findings and conclusions:
  - HSIB Reviews
  - The invited review by the RCOG in 2015/16
  - The invited RCPCH review in 2015
  - Perinatal Mortality Review Tool data and reports
  - Intelligence from the CQC/associated reports/recommendations
  - Letters and findings from HM Coroners
  - Each Baby Counts reviews (the Royal College of Obstetricians and Gynaecologists national quality improvement programme)

Resources and governance

- Resources for the Independent Investigation will be provided by NHS England and NHS Improvement. The Independent Investigation will establish with these resources a team with sufficient expertise and capacity to carry out the work
- The Chair will appoint those with appropriate experience in order to help deliver these terms of reference, including:
  - An expert panel and specialist advisers
  - Secretariat functions
  - Clinical input
  - Legal advice
  - Communication functions
  - Engagement with and support for families
  - Engagement with relevant staff from the Trust
  - Information governance and management

- The Independent Investigation team will keep in regular contact with NHS England and NHS Improvement via the SRO and their team but will not provide a running commentary on the Investigation's findings. Through this contact, NHS England and NHS Improvement will keep in touch with progress of the Independent Investigation, ensure that sufficient resources are available and are being deployed appropriately.
- If the Independent Investigation identifies areas of concern with current patient safety in East Kent Maternity Services, it will contact the Chief Midwifery Officer, Jacqueline Dunkley-Bent in her role described by the Minister in the House of Commons on 13 February 2020.

Consent and information governance

- Specific consent will be sought from the families for their information to be shared with the Independent Investigation team, if initial contact has been via NHS England/ Improvement, or the Trust. The Independent Investigation will secure suitable consent from families for their information to be used as part of the investigation.
- The Independent Investigation will have an information handling and privacy policy that will set out the approach the Investigation takes to handling information appropriately and complying with information legislation.

Fact checking and opportunity to comment

- The Independent Investigation will notify individuals and organisations who are referred to in the investigation's conclusions and provide them with an opportunity to respond to any significant criticism proposed for inclusion in its Report.

Disclosure

- The arrangements will include disclosure first to the families and to NHS England, NHS Improvement and the DHSC so that they are aware of the content of the Report to be published.

---

1 The trust was placed on the Maternity Safety Support Programme which involves improvement advisors supporting the trust with maternity improvement.

Appendix B: How the Investigation conducted its work

The importance of independence

B.1 National Health Service England/National Health Service Improvement (NHSE&I) commissioned the Independent Investigation into East Kent Maternity Services in February 2020, following concerns raised by families and others about the quality and outcome of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust (the Trust).

B.2 From the outset, the independence of the Chair and the Panel of experts was considered key to ensuring the credibility of the Investigation and the confidence of any families who would be involved. A guiding principle was that, in search of the truth, the Investigation should go in whichever direction the evidence took it, both to maximise the likelihood that families would be provided with the information they needed to address their questions and concerns, and to ensure that the knowledge and insights gained would be of benefit to the Trust and the wider NHS. In practice, this meant that we would determine the process we would follow to establish the facts, we would speak without fear or favour, and we would not shy away from difficult or contentious issues.

B.3 Our process was designed to listen to families, to understand their concerns and the reasons why they felt so aggrieved and let down. It was with the families that we first shared messages and updates during the course of the Investigation; and it was with the families that we first shared our findings and recommendations at the conclusion of the Investigation.

B.4 We did this while maintaining independence and objectivity, which is what the families affected would have wanted and what the public would have expected. We endeavoured to maintain a balanced and proportionate approach, as well as a sustained and high-quality level of engagement with those directly affected, at all times showing sensitivity and understanding.

How we worked with families

"Families first" principle

B.5 The Investigation adopted a "families first" approach. This principle is not defined in statute but forms the basis of many investigations and inquiries: for example, it was included in the Terms of Reference for the Hillsborough Independent Panel formed in 2010 in response to the Hillsborough disaster of 1989, and it was used by the Gosport Independent Panel, which reported in 2018.

B.6 Not only did the "families first" principle guide our approach to the gathering and scrutiny of evidence, it also informed how we shared our findings. In particular, our intention

from the start was to make sure that families would be the first to hear the conclusions of our Investigation and to have access to the written Report.

B.7 For the purposes of investigating and reviewing the care families received, access to personal information was needed. To ensure that the Chair and the Panel had the operational independence to determine what lines of enquiry to follow and what evidence to gather and process, Data Controller status was conferred on the investigation team.

Engagement with families

B.8 As set out in our Terms of Reference, the Investigation was tasked with looking at individual cases where there had been: a preventable or avoidable death; a concern that the death may have been preventable or avoidable; a damaging outcome for the baby or mother; or reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong. Understanding the experiences of the families was a key part of the Investigation process.

B.9 Early on, informal conversations with families took place to answer any questions they had about the Investigation and to assure them of its independence and determination to get to the truth. We also hoped that this would help build a relationship of trust and confidence and alleviate any concerns the families might have had about participating.

B.10 On 23 April 2020, we launched the Investigation formally and invited families who wished to share their experience of the maternity and neonatal services at the Trust during the period 2009 to the end of 2020 to contact us. Then, in October 2020, the Panel Chair appealed for other families to come forward if they wished to, mindful that there needed to be a cut-off date for families to be involved. One year later, on 23 April 2021, we stopped accepting new cases to the Investigation, except in exceptional circumstances where the Panel felt that the cases added significantly to the Investigation's findings.

B.11 The Investigation received approaches from three families who wished their cases to be considered but who, on assessment, were found to be outside the scope of the Terms of Reference. In two other cases, the Panel was not able to review the woman's care because their medical notes were not available. These five cases were therefore not included in the analysis undertaken for the purposes of Chapter 2 of this Report.

Consent

B.12 In every case, we obtained the written consent of each family to:

- Access their clinical records and other documentation relating to their case
- Approach relevant organisations that may have held personal data relevant to the Investigation, and for those organisations to share that personal data with the Investigation team
- Use the information we obtained about their case to develop questions or issues for other witnesses or organisations to answer or explore on an anonymised basis
- Include in the Investigation Report personal information about the experiences they shared with us, on an anonymised basis or with their additional consent if the information may be identifiable.

Family listening sessions

B.13 Our family listening sessions provided the opportunity for families to meet the Panel and talk about their experience of care at the Trust. We encouraged them to tell us what had happened in full, including the impact on themselves. The sessions took place between January and September 2021, and the majority were conducted via video. Where families preferred to meet the Panel in person, arrangements were made at their convenience. Each session was attended by at least two members of the Panel and one of the specialist advisers to the Panel. The Investigation's family engagement lead also attended.

B.14 The family listening sessions were deliberately unstructured, with families given free rein to speak as they wished; the Panel asked questions as the need arose in order to clarify or seek further information. Each session was recorded and families were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

B.15 All the families who contributed to the Investigation through a family listening session were provided with a summary of their spoken account to ensure that it captured the key facts and essence of their experience. The Panel Chair agreed that any comments made by a woman or a family member during their family listening session would not be attributed to them in the Investigation's final Report without their express permission.

B.16 Families who did not wish to meet with the Panel were given other options: to submit information in writing or to give consent for their records to be looked at without any active participation on their part. A small number took up these offers.

B.17 Importantly, the family listening sessions included mothers, fathers and in some cases other family members. In preparing our Report, we have referred variously to mothers, women, fathers, partners* and, on occasion, husbands. In our use of terminology, we hope that we have followed accurately the circumstances of each family and their wishes. We have kept the terms used simple in order to aid the flow of the Report, but we are mindful of the possibility of situations where the term "birthing partner" would be more apt.

Trauma-informed counselling

B.18 Mindful of the additional anxiety and distress that might be caused to them by the necessity of having to recount and possibly relive their experiences and share personal details, we offered each family the opportunity to attend a session with an expert counsellor after they had met with the Panel. We selected a professional counsellor with extensive experience of working therapeutically with people who have been harmed during healthcare, with professional knowledge and experience as an academic, and with research expertise in trauma-informed counselling for healthcare harm.

B.19 Trauma-informed counselling is based on principles intended to *"promote healing and reduce the risk of retraumatisation for vulnerable individuals"*.[1] This approach takes account of the events or series of events that contribute to a traumatic reaction and includes the principle that self-referenced trauma is as valid as that which is diagnosed clinically. In other words, despite the narrow medical definition of trauma, if people believe that they have suffered from trauma, they should be accepted as having done so. Given that so many families referred to their experience or aspects of their experience as being traumatic, this approach turned out to be wholly appropriate.

* The term 'partners' refers to married and unmarried partners, whether male or female.

B.20 Our counsellor was able to signpost families to other support, when additional or ongoing support was needed.

Individual disclosure

B.21 Because so many of the families had unanswered questions about the care they received or the outcome they experienced, the Investigation Chair undertook to meet with any family who wished to do so after publication of the Investigation Report, to answer any questions that the relevant family may wish to put to the Panel about their individual circumstances.

How we worked with the Trust

Clinical records review

B.22 With the consent of the families involved, as detailed above, and the full cooperation of the Trust, we carried out a thorough review of the clinical records of each woman's and baby's care. This included reviewing original hard copy clinical notes as well as accessing copies of them via a secure online portal.

B.23 The Panel members worked together to review individual records. They also had ongoing access to the online versions, to continue their work individually.

B.24 In addition to the clinical records, the Trust provided other documentation, such as complaints correspondence, investigation reports and exchanges with GPs, which helped the Panel build a picture of the woman's or baby's care and the events surrounding it.

Interviews with Trust Board members, senior managers and staff

B.25 Members of the Trust Board, the senior management team and staff were selected for interview with the Panel based on their period of employment with the Trust, their position (or positions) during that time, their involvement in governance and patient safety matters, and, in some cases, their involvement in particular cases reviewed by the Panel. Everyone invited was considered by the Panel to be in a position to provide information about the management, delivery and culture of the services under review, at both a service and a corporate level, during the period covered by the Investigation.

B.26 They were invited by letter to attend an interview with the Panel. The letter explained that the Investigation had conducted listening sessions with a number of affected families and now wanted to hear from past and present Trust staff, and others, who were involved in the delivery, management and/or regulation of maternity and neonatal services at the Trust during the period under scrutiny.

B.27 We recognised that individuals may wish to be accompanied by a friend, colleague or trade union official, and we offered them the option of bringing one person to support them. However, we were clear that their support person would not be able to answer questions or act in a representative capacity.

B.28 The interviews were arranged at a time convenient to the interviewee and the option was provided to attend in person or via video. Each interview was attended by at least two Panel members. In order to facilitate an open dialogue and to meet the Investigation's Terms of Reference, the Panel Chair agreed that any comments made by an individual during their interview would not be attributed to them in the Investigation's final Report without their express permission.

B.29 In advance of the interviews, individuals were provided with an outline agenda of the themes to be discussed. If they were being invited to discuss a particular case, they were provided with the details in order that they could prepare fully; they were also given access by the Trust to the relevant clinical records.

B.30 The interviews were recorded and a written summary of the interview was provided to each individual. They were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

Review of Trust records and other material provided

B.31 Corporate records were reviewed to understand how the Trust discharged its responsibilities for maternity services and how it communicated and engaged with patients, with their families and representatives, and with regulators.

How we worked with stakeholders

B.32 An early task was to identify organisations that might have material pertinent to the matters under investigation or that could inform the work of the Investigation more broadly. These organisations were then contacted in order that the work of the Investigation and its Terms of Reference could be explained; we requested that no documents that might have a bearing on the Investigation should be destroyed.

B.33 Following on from this early contact, meetings were set up to establish with each organisation whether they had material of interest to the Investigation and to inform them that interviews might be needed with key staff to explore matters arising from our review of that material.

B.34 While documents were being provided to the Investigation for review, interviews with staff from stakeholder organisations were scheduled.

B.35 The interview process was similar to that described above. Interviews were arranged at a time convenient to the interviewee and the option was provided to attend in person or via video. Outline agendas were provided and the Panel Chair agreed that any comments made by an individual during their interview would not be attributed to them in the Investigation's final Report without their express permission.

B.36 The interviews were recorded and a written summary was provided to each individual. Participants were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

How we assessed individual cases

B.37 Having reviewed the evidence gathered from families and Trust staff, the Panel met as a group to consider each case in turn and determine where care was suboptimal when assessed against the standards expected nationally and its relationship with the subsequent outcome. This multi-disciplinary process of assessment was key to the Investigation. The findings were structured according to the validated classification of suboptimal care adopted by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI). Not only did this enable the

Panel to draw evidence-based conclusions about the overall quality and safety of care provided by the maternity and neonatal services at the Trust, but it also allowed us to ascertain the key facts in each case, in order that the Panel could report back to individual families about what had happened in their case.

B.38 The CESDI scoring system comprises four levels of suboptimal care based on the relationship to the outcome (see Table B1).

Table B1: CESDI scoring system

Level of suboptimal care	Relevance to the outcome
Level 0	No suboptimal care
Level 1	Suboptimal care, but different management would have made no difference to the outcome
Level 2	Suboptimal care, in which different management might have made a difference to the outcome
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome

B.39 In addition to grading the level of suboptimal care, the Panel determined the degree of harm in each case. For this purpose, we used a scoring system adapted from the NHS National Reporting and Learning System (NRLS) definitions of degrees of harm (see Table B2).†

Table B2: Degrees of harm

Degree of harm	Outcomes	Impact on woman and/or baby
None	No harm	There was no impact on the woman or her baby
Minimum	Maternal injury; baby birth injury	The woman or her baby required extra observation or minor treatment
Moderate	Maternal injury; baby birth injury	There was short-term harm and the woman or her baby required further treatment or procedures
Severe	Maternal injury; brain damage, including hypoxic ischaemic encephalopathy (HIE) and/or cerebral palsy attributable to perinatal hypoxia	The woman or her baby suffered permanent or long-term harm
Death	Stillbirth; neonatal death; late neonatal death; maternal death	The woman or her baby died

B.40 The Panel's conclusions drawn from its assessment of cases are set out in Chapter 2 of the Report.

† Although there are plans to replace the NRLS with the Learn from Patient Safety Events (LFPSE) service, which does not define degrees of harm in the way the NRLS does, the Panel found it helpful to use a form of assessment of harm that is recognisable and understood when reviewing the cases subject to our Investigation.

Organisations contacted by the Investigation

B.41 The organisations and stakeholders listed in Table B3 were contacted in order to provide evidence or other information in line with the Investigation's Terms of Reference. A number of these organisations have contributed information and documents to the Investigation, but a proportion of these stakeholders did not have any relevant documents to contribute.

Table B3: Organisations contacted by the Panel

Organisation name
Action against Medical Accidents (AvMA)
Birth Trauma Association
Bliss
British Medical Association
Care Quality Commission
Child Death Overview Panel
Department of Health and Social Care
Fairweather Solicitors
General Medical Council
Health and Safety Executive
Health Education England
Healthcare Safety Investigation Branch
Healthwatch
Her Majesty's Senior Coroner (Mid Kent & Medway, North East Kent, Central & South East Kent)
Kent Community Health NHS Foundation Trust
Kent County Council
Kent Police
Local Maternity System
Maternity Voices Partnership
MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)
Medical Defence Union
Members of Parliament
National Childbirth Trust
National Guardian's Office
NHS England and NHS Improvement
NHS Kent and Medway Clinical Commissioning Group
NHS Resolution
Nursing and Midwifery Council
Parliamentary and Health Service Ombudsman

Public Health England
Royal College of Anaesthetists
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Sands (Stillbirth and Neonatal Death Charity)

Appendix C: The Investigation team

Panel members

Dr Bill Kirkup CBE (Chair)

Heather Brown (Obstetrics)

Valerie Clare (Midwifery)

Alison Fuller (Clinical Governance)

Helen MacTier (Neonatology)

Denise McDonagh (Data/Information Management)

Specialist advisers

Nicky Lyon

James Titcombe

Legal advisers

Innovo Law

Counselling support

Linda Kenward

Secretariat

Members of the Secretariat have included:

- Ken Sutton (Secretary to the Investigation)
- Altin Smajli (Deputy Secretary)
- Caroline Allen
- Annette Beckham
- Caroline Browne
- Peter Burgin
- Lynn Cabassi
- John Cairncross
- Ann Ridley

Endnotes

Chapter 1

1 Clinical Commissioning Groups. Quality Report to National Health Service England. June 2013.

2 Clinical Commissioning Groups. Quality Report to National Health Service England. August 2013.

3 *The Report of the Morecambe Bay Investigation*. 2015. www.gov.uk/government/publications/morecambe-bay-investigation-report (accessed 12 July 2022).

4 Royal College of Obstetricians and Gynaecologists. Maternity Services Review Report. 2016.

Chapter 3

1 Nursing and Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. 2015, updated 2018. www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (accessed 14 July 2022), p.6.

2 General Medical Council. *Good medical practice*. 2019. www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf (accessed 14 July 2022), p.21.

Chapter 5

1 East Kent Hospitals University NHS Foundation Trust. *Annual Report 2008/09*. 2009, p.3.

2 NHS Kent and Medway and East Kent Hospitals University NHS Foundation Trust. Maternity Services Review. 2011, p.1.

3 National Health Service England. Maternal Death Review. 2014.

4 *The Report of the Morecambe Bay Investigation*. 2015. www.gov.uk/government/publications/morecambe-bay-investigation-report (accessed 24 August 2022), p.7.

5 Head of Midwifery, East Kent Hospitals University NHS Foundation Trust. Risk Assessment. May 2015.

6 Ibid.

7 Royal College of Obstetricians and Gynaecologists. Maternity Services Review Report. 2016.

8 East Kent Hospitals University NHS Foundation Trust. Root Cause Analysis Report. 2018, p.10.

9 Ibid., p.71.

10 Ibid., p.10.

Appendix B

1 Wolf, M.R., Green, S.A., Nochajski, T.H., Mendel, W.E. and Kusmaul, N.S. “We’re civil servants”: the status of trauma-informed care in the community. *Journal of Social Service Research*, 40:1 (2014), pp.111–20.

NHS Resolution

Maternity Incentive Scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

May 2023

Contents

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions'

evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

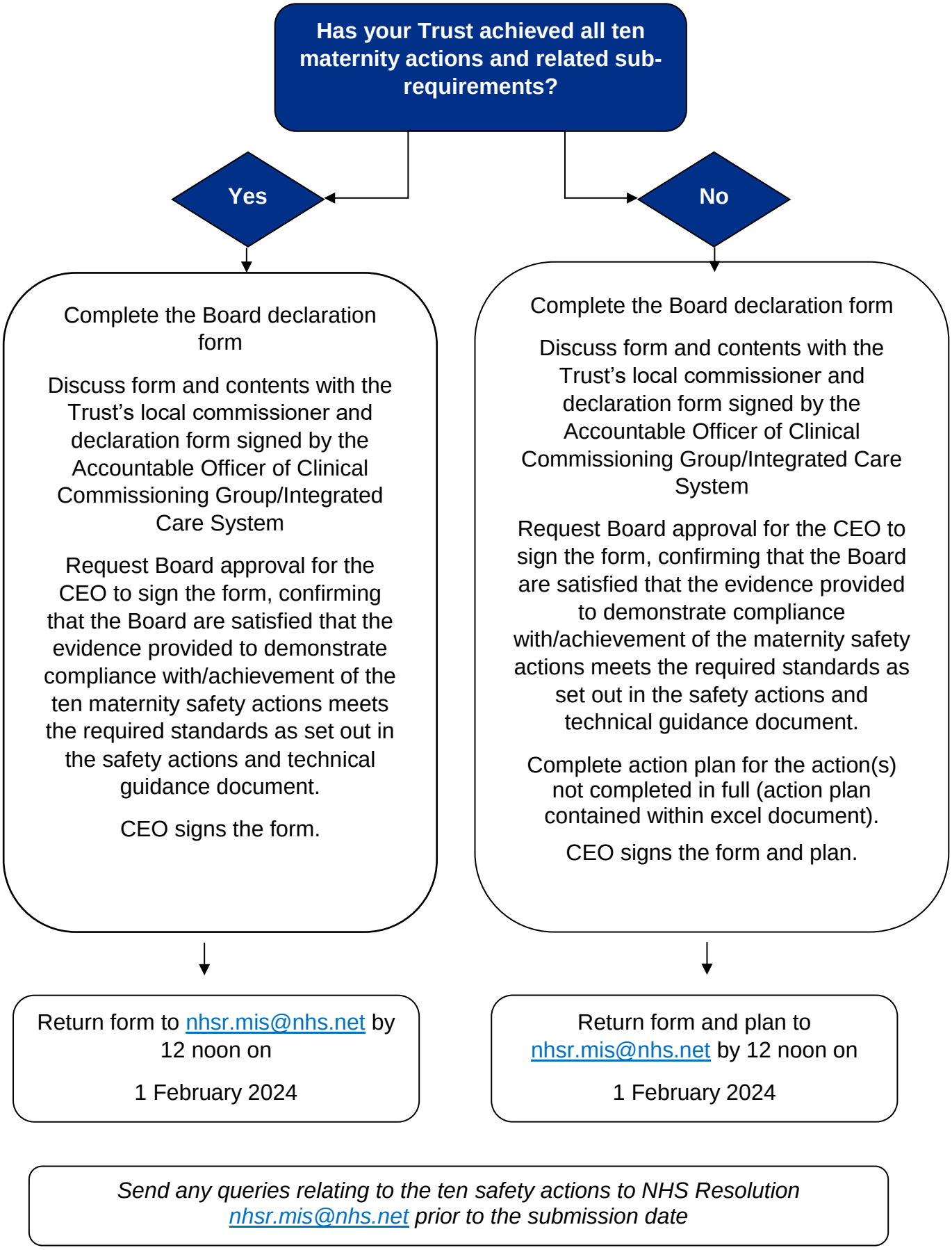
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
CEO signs the form and plan.
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until add **7 December 2023**

What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from 30 May 2023 onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required

	mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to the assigned to another Trust for additional information then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
What is meant by "reviews should be completed to the draft report	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See

stage completed to the draft report stage"?	www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.
What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1,	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.

especially on starting a review?	
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. Please note that these reports will only show summaries, issues and action plans for reviews that have been published therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK.

	This can be done through the ‘contact us’ facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT ‘message of the day’.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: **Midwifery Continuity of carer (MCoC)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

	If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services DashBoard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard	a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

	• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.
	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring **OR** An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies >36 weeks to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. This review includes A high-level review of the primary reasons for all admissions should be completed, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year, and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
TC audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template, however the audit needs to include aspects of the local pathway.  ATAIN%20CASE%20 NOTE%20REVIEW%2(We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/

	https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) **Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations

listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.

If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

	If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.

	3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.

Where can I find the documents relating to long term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.**

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.
LNU	**Tier 1**

Local Neonatal Unit	At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**
SCU **Special Care Unit**	**Tier 1**

	A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

	• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ○ The midwife to birth ratio ○ The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior

	midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available
Minimum evidential requirement for Trust Board	1) The Three Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool will be available by the end of June to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. The tool will be based on the interventions, key process and outcome measures identified within each element, so providers can begin implementation of the Care Bundle Version 3 now with confidence, while the tool undergoes final user testing. Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available, and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool once available. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: • Use of the implementation tool once it is made available.

	• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ This will include details on the Saving Babies' Lives Care Bundle v3 Implementation tool, and a link to the SBLCB v3 Technical Glossary once available which will include the numerators and denominators for all of the process indicators. Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity DashBoard National Maternity DashBoard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool (once available) will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2***

	Information Standard Notice compatible format, including SNOMED-CT coding.
What are the indicators for Element 1	*Process Indicators* i. Percentage of women where CO measurement and smoking status** is recorded at: a. Booking appointment b. 36 week appointment ii. Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service. ii. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* i. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. ii. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant women with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* i) Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. ii) Percentage of pregnancies where a Small for Gestational Age (SGA) fetus is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. iii) Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators* I. Percentage of live births and stillbirths <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). II. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation

What are the indicators for Element 3	*Process Indicators* i) Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). ii) Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth. *Outcome Indicators* I. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. II. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* i. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness. ii. Percentage of staff who have successfully completed mandatory annual competency assessment. ii. Fetal monitoring lead roles appointed. *Outcome Indicators* i. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].
What are the indicators for Element 5	*Process Indicators* *i.* Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU).

	ii. Percentage of women giving birth before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. iii. Percentage of women giving birth before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. iv. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. v. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. vi. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. vii. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. viii. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *Outcome Indicators* I. Mortality to discharge in very preterm babies (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). II. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia III. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue. IV. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton

	pregnancy giving birth (non-viable, liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* I. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). II. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. III. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. IV. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. V. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise. *Outcome Indicators* I. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashBoard (aiming for >95% of women). II. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the

	start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	If your Trust is planning on using the maternity dashboard to evidence compliance, please be advised that there is a three-month delay between data submission and publication with MSDSv2 data.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12noon**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to cover all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups. This should be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth
	• A link to forthcoming national intrapartum fetal surveillance programme. (ABC?)
	Toolkit for high quality neonatal services (October 2009)
	http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

What training should be included for the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. 4. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota.

	• Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.** • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
I am a Medical Obstetric Emergencies and Trauma (MOET) instructor, do I still need to attend the maternity emergencies and multiprofessional training (Module 3)?	Yes, you do still need to attend the maternity emergencies and multiprofessional training (Module 3)
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training:

	• All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.
I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates
What training should be covered for the neonatal emergencies?	Neonatal emergency scenarios must be run with the neonatal team and aligned with Module 6: Neonatal basic life support
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for Trust Board	**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality

	meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st July 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress

	made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is undertaken alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 July 2023. • Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented. This must have been undertaken within 9 months of their teams starting the Perinatal Culture and Leadership 'Quad' Programme.
What is the deadline for reporting to NHS Resolution?	By **1 February 2023** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Add in link to Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety

	champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician
What do we need to include in the dashBoard presented to Board each month?	The dashBoard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashBoard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here https://resolution.nhs.uk/2021/10/28/2021-scorecards-launch/?utm_medium=email&utm_campaign=Resolution%20Matters%20October%202021&utm_content=Resolution%20Matters%20October%202021+CID_ac638a61c8ce1ac278298e3233f234af&utm_source=Email%20marketing%20software&utm_term=2021%20Scorecards%20launch https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by MatNeoSIP?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that survey findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the survey findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/CQC//MNSI from **30 May 2023** to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from **30 May 2023** until **7 December 2023**. C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/CQC/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.

What is the relevant time period?	Reporting to HSIB – from **30 May 2023** to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from **30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/CQC/MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/CQC/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from 1 April 2022 going forward	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury.

	The Trust must share the HSIB/CQC/MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/CQC/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/CQC/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/CQC/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution.
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/CQC/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/CQC/MNSI investigation where the baby has a normal MRI. • Cases that HSIB are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB reference number (document the HSIB reference in the "any other comments box"). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/CQC/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/CQC/MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have reported a case to NHS Resolution?	Following the HSIB/CQC/MNSI investigation, and on receipt of the HSIB/CQC/MNSI report and MRI report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family requests this.

Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/CQC/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/CQC/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIB/CQC/MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/CQC/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10, standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc.

	For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net

Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process and Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.
Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed.

	In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB/CQC

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.

NHS England

Three year delivery plan for maternity and neonatal services

March 2023

Contents

Summary

With this plan we aim to make care safer, more personalised, and more equitable, by:

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide “PSIRF” approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new “MEWS” and “NEWTT-2” tools by 2025.
- In 2023, NHS England’s new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Introduction

1. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. We are grateful to the many people and organisations that have shared what needs to be done including NHS staff, Donna Ockenden, Dr Bill Kirkup, and organisations representing families. Most importantly, we would like to thank those using maternity and neonatal services for informing this plan. While the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve.

2. The summary above sets out the benefits we expect to deliver for families through this plan. This will continue to require the dedication of everyone working in NHS maternity and neonatal services in England, who work tirelessly to support families and improve care. Most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved with over 900 more families welcoming a healthy baby each year compared to 2010.

3. But we must acknowledge that there are times when the care we provide is not as good as we want it to be. Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. We know that families from some groups, especially ethnic minorities, have had particularly poor experiences. We must work together to change this, and this plan sets out how we will do this.

4. In preparing this plan we have listened to what you have to say. We know all staff want women and babies to be at the centre of care, and with so many improvement initiatives it can be difficult to know what to prioritise. We know gaps in staffing mean those who provide care do not always have time to learn and improve, and on occasion, struggle to provide care to the highest standards. We have heard that some people feel disempowered by negative team cultures and a lack of strong leadership.

5. For the next three years, we are asking services to concentrate on **four high level themes**. Please take some time to consider these themes, what they mean to you and to the women and babies you care for. Working together, we can make a real difference.

Responsibilities

6. This plan sets out what we need to have in place, and responsibilities for each part of the NHS:

   - Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.
   - Integrated care boards (ICBs) commission most maternity services. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.
   - NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional specialised commissioning teams and operational delivery networks (ODNs).

7. It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. We have sought to improve our approach to quality surveillance at trust, ICS, regional, and national level. This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

What you told us

8. We could not develop this delivery plan without talking to people who use, work in, lead, or have an interest in these services. We want to thank everyone who shared their views to inform this plan. We held 50 meetings reaching over 1,000 attendees, including 191 service users, 419 workforce members, 329 leaders of services, systems, and regions, and 106 stakeholders. We additionally received 2,128 responses to our survey from 782 service users, 1,133 workforce members, 105 leaders, and 108 stakeholders.

9. While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this plan also applies to these individuals; particularly the principles described in Theme 1.

10. While each of the groups who helped inform this plan had different areas they gave greatest importance to, there was clear agreement on what the plan's focus should be. This consensus has shaped the four themes, and the objectives within each of these.

11. The most consistent priority among those using and providing services was safe care. Delivering safe care remains central to this delivery plan.

    "Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right." (Service user)

    "We need to take action and make a pledge to improve the safety of every maternity service in England." (Leader)

12. You told us how important improving equity and equality is. We have a dedicated objective on improving equity.

    "Those that are most vulnerable should be enabled to have a strong voice within maternity care provision." (Stakeholder)

13. You told us that we need to be clear about who is responsible for doing what, and to bring the asks of services and systems into one place. This delivery plan sets out clear responsibilities and measures of success across services and systems.

    “One clear plan that looks to encompasses the recommendations from various reports such as Better Births, Ockenden, Kirkup.” (Workforce member)

Listening to and working with women and families with compassion

14. You told us that personalised care supports safety, makes women feel valued, and avoids families needing to re-tell their story – who they are or what they need. You told us it is important to join up care across maternity and neonatal pathways.

    “To be treated as an individual human being.” (Service user)

    “Consistency! I saw so many different people I had to tell them my 'story' every time.” (Service user)

    “Being fully informed without judgement on pros and cons of all care offered.” (Service user)

    “Listening to the families using the care and embedding their voices along all pathway.” (Leader)

    “Supporting parents to be actively involved in the care of their baby on the neonatal unit (family integrated care).” (Service users)

Growing, retaining, and supporting our workforce

15. You told us that there needs to be enough staff in services, with the time and training to support their effectiveness as well as to protect their wellbeing.

    “Safe staffing that will then provide safe and personalised care.” (Leader)

    “Enough staffing to feel supported, safe and provide care when it is needed.” (Service user)

    “Adequate staff with the appropriate training working in the right environment. Having the time and resources to listen to women and their families.” (Workforce member)

Developing and sustaining a culture of safety, learning, and support

16. You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion.

    “Listening, learning and facing up to failings.” (Stakeholder)

"Confidence in the care provider, trust, integrity and honesty if mistakes occur." (Leader)

"Leadership training to enable managers to better manage teams and support them." (Workforce member)

"Psychological safety at work and teams that work together with a shared vision and a foundation of kindness." (Stakeholder)

Standards and structures that underpin safer, more personalised, and more equitable care

17. You told us that we need to improve our data collection to help oversight and improvement, among other important standards and infrastructure. Our fourth theme focuses on these crucial elements that support the other themes.

"Notes to be available to all staff when required rather than just to one person." (Service user)

"Delivering high quality, evidence-based care in a local environment for service users." (Workforce member)

"Improved data collection and IT systems - joined up maternity and neonatal electronic patient record systems which are user friendly and accessible." (Workforce member)

"Organisational transparency and providing in depth data to provide meaningful data that can be used to prevent as well as respond to trends and themes." (Leader)

Theme 1: Listening to and working with women and families with compassion

1.1 Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Better Births identified that "women wanted to be listened to about what they want for themselves and their baby, and to be taken seriously when they raise concerns". The Ockenden report into maternity services at Shrewsbury and Telford described how families who raised concerns "were brushed aside, ignored and not listened to". This section sets out actions for personalised care, improving equity, and working with service users.

1.2 Key commitments for women and families include:

Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.

Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.

Rolling out perinatal mental health services to improve the availability of this specialist care.

Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.

Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.

Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.

Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Objective 1: Care that is personalised

1.3 Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story. While many women and babies experience excellent personalised care (CQC, 2023), it is clear from independent reports that not all do.

1.4 Our ambition is:

- Women experience care that is always kind and compassionate. They are listened and responded to.
- Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected.
- All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.
- Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.
- Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced.
- All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.
- Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8

weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.

- Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.
- Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.

How we will make this happen

1.5 It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.
- Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

1.6 It is the responsibility of integrated care boards (ICBs) to:

- Commission for and monitor implementation of personalised care for every woman.
- Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.
- Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.

1.7 NHS England will:

- Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.

- Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.
- Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.
- In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.
- Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.
- By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.
- Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.

Objective 2: Improve equity for mothers and babies

1.8 Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022). Though we know NHS staff want to provide the best care to every woman and baby, a National Institute for Health and Care Research funded study found that “multiple structural and other biases exist in UK maternity care”. (Knight, M et al, 2021).

The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

1.9 Our ambition is:

- To reduce inequalities for all in access, experience, and outcomes.
- Targeted support where health inequalities exist in line with the principles of proportionate universalism.
- Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships

ensure all groups are heard, including those most at risk of experiencing health inequalities.

- The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022).

How we will make this happen:

1.10 It is the responsibility of trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.
- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

1.11 It is the responsibility of ICBs to:

- During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.
- Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.

1.12 NHS England will:

- Provide regional and national support for the implementation of LMNS equity and equality action plans.
- Pilot and evaluate new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.
- Continue to work with the Maternity Disparities Taskforce to explore disparities in maternity care and identify how to improve outcomes.

- In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.

Objective 3: Work with service users to improve care

1.18 Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users.

1.19 Our ambition is:

- MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- MNVPs have strategic influence and are embedded in decision-making.
- MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

1.20 In addition, neonatal parental advisory groups represent service user experience as part of operational delivery networks.

How we will make this happen:

1.21 It is the responsibility of trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

1.22 It is the responsibility of ICBs to:

- Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.
- Ensure service user representatives are members of the local maternity and neonatal system board.

1.23 NHS England will:

- Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.
- Through operational delivery networks, support parent representation in the governance of neonatal services.
- Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.

Determining success for Theme 1

1.24 We will determine overall success by listening to women and their families:

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.
- We will use these progress measures:
  - Perinatal pelvic health services and perinatal mental health services are in place.
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
  - The proportion of maternity and neonatal services with UNICEF BFI accreditation.
- Evidence which ICBs can use includes:
  - Feedback on personalised care gathered via MNVPs from a wide range of service users.
  - Local evidence of working with women and families to improve services, including co-production.
- Relevant regulation and incentivisation includes:
  - The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections.
  - The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs.

Case Study: Seeking Sanctuary Clinic - to enhance the maternity care of anyone seeking sanctuary

The Seeking Sanctuary Clinic, hosted in Berkshire West, is a specialist maternity clinic developed in 2021 from co-production between Royal Berkshire NHS Foundation Trust maternity team, and Berkshire West public health team, to enhance the maternity care of anyone seeking sanctuary such as refugees, asylum seekers, those fleeing conflict, undocumented migrants and people who have been trafficked.

This is a 'one stop shop' style clinic held in a children's centre, delivered in two-hour sessions held every two months, aimed specifically for these families, in addition to their usual antenatal and postnatal care. The barriers to access and inequalities that these families may be experiencing are removed where possible. For example, women are able to bring their partners and children with them, there are interpreters booked for every language in attendance, refreshments are provided and transport is available to support people to get to the clinic.

There are many health care professionals and voluntary organisations that come together at the clinic including midwifery and obstetrics. There is also accessible antenatal education with New Directions, sexual health, health visiting, a tuberculosis service, health in pregnancy advisors, Compass Recovery College (mental health and wellbeing support), Reading Refugee Support and Reading Voluntary Action.

The clinic is ever evolving, and additional professionals and organisations are invited to sessions to meet the bespoke needs of the group. Local charity The Cowshed donated to the clinic enabling each family that attends to be provided a ready-made birth bag to assist them on their journey.

The local Maternity Voices Partnership also attends to offer feedback sessions for these groups. While the project is in an initial evaluation phase, feedback so far has been very positive from service users, with more than fifty families supported so far, predominantly from Afghanistan, Syria, and Ukraine.

Theme 2: Growing, retaining, and supporting our workforce

2.1 The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. We need to change that. The plan is informed by the best available evidence, including the QMNC framework which underpins the NMC midwifery standards. This theme sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills.

2.2 Key commitments for women and families include:

NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.

Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.

Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.

Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Objective 4: Grow our workforce

2.3 The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and

psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements.

2.4 Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.

2.5 Our ambition is for:

- Workforce capacity to grow as quickly as possible to meet local needs.
- Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training, absence, and leave.
- Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.

How we will make this happen

2.6 It is the responsibility of trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

2.7 It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

- Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.

2.8 NHS England will:

- Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.
- Boost midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.
- Increase medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services.
- Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.

Objective 5: Value and retain our workforce

2.9 Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services. We need to do more to improve the experience of all our staff, to retain them within the NHS.

2.10 Our ambition is:

- Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.
- All staff are included and have equality of opportunity.

- A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

How we will make this happen

2.11 The NHS Long Term Plan and NHS People Plan set out how improving the experience of our NHS people will encourage them to stay with us for longer.

2.12 It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

2.13 It is the responsibility of ICBs to:

- Share best practice for retention and staff support.
- Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.

2.14 NHS England will:

- Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.
- Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.
- In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.

- In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.
- Continue to address workforce inequalities through the Workforce Race Equality Standard.
- Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.
- By July 2023, develop a safe clinical learning environment charter for trusts; by April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.

Objective 6: Invest in skills

2.15 Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff (for example, Stulberg et al, 2020, McCulloch et al, 2008).

2.16 Our ambition is:

- All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.
- All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards.
- Training is multi-disciplinary wherever practical to optimise teamworking.

How we will make this happen

2.17 It is the responsibility of trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

2.18 NHS England will:

- Refresh the curriculum for maternity support workers (MSWs) by June 2023.
- Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.
- Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.
- Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks.
- Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.
- Through action set out above to grow the workforce, help to address pressures on backfill for training.

Determining success for Theme 2

2.19 We will determine overall success by listening to staff:

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.

  - To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.
- Evidence that ICBs can use includes:
  - Progress against workforce, retention, succession, and training plans.
  - Local staff feedback mechanisms.
  - Progress against the nursing and midwifery high impact retention interventions.
- Relevant regulation and incentivisation includes:
  - The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development.
  - The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place.

Case study: One stop obstetric ambulatory service

The Chelsea and Westminster Hospital NHS Foundation Trust cares for approximately 5,500 maternity patients per year. The maternity team identified common themes in complaints about their service, including delays in receiving care and long waits for obstetric or scan reviews. The team felt they could improve triage management, patient experience and care, through a truly multidisciplinary approach so set up a ‘one stop’ service since January 2021.

The team recognised a key cause of delay within the department was delays in obstetric reviews. They were able to increase consultant presence and recruit a clinical fellow with obstetric ultrasound training to work solely in the triage department for five mornings a week, to deliver a ‘see and treat’ set up, comparable to the way emergency departments are run.

The triage team also includes midwives and maternity support workers, who greet attendees, perform initial observations and a dedicated receptionist who enables clinicians to focus on care rather than administrative tasks. Some midwives have developed professionally to perform tasks that are usually undertaken by obstetricians, such as prescribing and performing presentation scans.

From October 2022 to February 2023 the service has had on average 850 visits per month, with around 100 ultrasound scans performed. The department answers approximately 2,500 phone calls per month, with one midwife allocated to answer phone calls each day to triage and support women.

Improvements in the new obstetric ambulatory service triage system mean the department works more efficiently and safely with staff feeling better supported. Waiting times have been reduced, with 80-95% of women seen within 15 minutes of arrival which exceeds the national KPI (within 30 minutes) for maternity triage services. Feedback from women has also been increasingly positive. The team are exploring future opportunities to expand the service hours and increase the scope of midwifery and maternity support workers, supporting the team’s development and dynamic skillset.

Theme 3: Developing and sustaining a culture of safety, learning, and support

3.1 An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. This theme sets out actions in three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

3.2 Key commitments for women and families include:

> Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.
>
> Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.
>
> Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Objective 7: Develop a positive safety culture

3.3 Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

3.4 Our ambition is:

- All staff working in and overseeing maternity and neonatal services:
  - Are supported to work with professionalism, kindness, compassion, and respect.

  - Are psychologically safe to voice their thoughts and are open to constructive challenge.
  - Receive constructive appraisals and support with their development.
  - Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'.
- Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.
- Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.
- Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

How we will make this happen

3.5 It is the responsibility of trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.
- Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.

3.6 It is the responsibility of ICBs to:

- Monitor the impact of work to improve culture and provide additional support when needed.
- Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.

3.7 NHS England will:

- By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Objective 8: Learning and improving

3.8 Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs.

3.9 Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services.

3.10 The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria. The responsibilities for trusts and ICBs set out below, also apply to these, or any other external investigations.

How we will make this happen

3.11 It is the responsibility of trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.
- Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.

- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.
- Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).

3.12 It is the responsibility of ICBs to:

- Share learning and good practice across all trusts in the ICS.
- Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.

3.13 NHS England will:

- Throughout 2023, support the transition to PSIRF through national learning events.
- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

Objective 9: Support and oversight

3.14 While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

3.15 Our ambition is:

- Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.
- Well led services, with additional resources channelled to where they are most needed.
- Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.

How we will make this happen

3.16 It is the responsibility of trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.

3.17 It is the responsibility of ICBs to:

- Commission services that enable safe, equitable, and personalised maternity care for the local population.
- Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.
- Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.

3.18 NHS England will:

- Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.
- Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.
- Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).
- Work to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.
- During 2023/24, test the extent to which the PQSM has been effectively implemented.

- By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

Determining success for Theme 3

3.19 Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in frontline services.

3.20 Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.

- The evidence ICBs can use across maternity and neonatal services includes:
  - Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.
  - Whether trust boards regularly share and act on learning.
  - Staff feedback on how incidents and issues of concern are managed.
- Relevant regulation includes:
  - The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.

Case study: NFaST - Neonatal Families and Staff Together, supporting neonatal units to become more emotionally supportive environments

In 2021, the North West Neonatal Operational Delivery Network commissioned Spoons, a Greater Manchester-based charity specialising in neonatal family support, to research how their neonatal units could become more emotionally supportive environments for service users and staff.

The project worked with 13 neonatal units and a 28-family focus group, collecting data from more than 260 parents and 250 staff members, exploring their emotional needs. The project identified that the experience of neonatal care has a profound long-term impact on parents and their infants. In turn, the experience of working on a neonatal unit is emotionally challenging and can have significant impact on a staff member's individual wellbeing.

Volunteer peer supporters, who had personal experience of neonatal care, were trained for the units. Psychological training was provided to 100 staff across four neonatal units, including doctors, nurses, and support staff. Reflective practice group sessions were led by a clinical psychologist, to help the teams collaborate and understand each other and the needs of their babies and families better.

The pool of volunteer peer supporters continues to grow, and additional peer support training has been commissioned, with a model of ongoing supervision in development. This project demonstrates the power of true collaboration between the NHS, service users and third sector partners.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

4.1 To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.

4.2 Key commitments for women and families include:

Making care safer by consistently implementing best practice, including:

- By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.

In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.

By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.

Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Objective 10: Standards to ensure best practice

4.3 Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

4.4 Nationally defined best practice already exists, including:

- The Saving Babies Lives Care Bundle, a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- The national maternity early warning score (MEWS)and updated newborn early warning trigger and track (NEWTT-2) tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care.
- NICE guidance, which sets out the evidence based best practice in maternity and neonatal care.

4.5 Our ambition is:

- Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.
- Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice care.
- Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance.
- Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines.
- Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.

How we will make this happen

4.6 It is the responsibility of trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

4.7 It is the responsibility of ICBs to:

- Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.
- Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.
- Monitor and support trusts to implement national standards.
- Commission care with due regard to NICE guidelines.

4.8 NHS England will:

- Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.
- Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.
- Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.
- Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the FutureNHS platform.

Objective 11: Data to inform learning

4.9 The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects.

4.10 Our ambition is:

- Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.
- Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports.
- The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work.

How we will make this happen

4.11 It is the responsibility of trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

4.12 It is the responsibility of ICBs to:

- Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.

4.13 NHS England will:

- At a regional level, understand any variation in outcomes and support local providers to address identified issues.
- Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.

- Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.

Objective 12: Make better use of digital technology in maternity and neonatal services

4.14 Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

4.15 Our ambition is:

- Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.
- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

How we will make this happen

4.16 It is the responsibility of trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.

- Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

4.17 It is the responsibility of ICBs to:

- Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- Support regional digital maternity leadership networks.

4.18 NHS England will:

- Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Determining success for Theme 4

4.19 We will determine overall success by focusing on clinical outcomes:

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.

  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
  - A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
- The evidence that ICBs can use includes:
  - Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.
  - An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
  - Progress against locally planned improvements.
- Relevant regulation and incentivisation includes:
  - The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions.
  - The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.

Case Study: Ask A Midwife - using social media to communicate with service users

Ask A Midwife (AAM) is a social media messaging service managed by midwives, which empowers service users to make timely and informed decisions about their maternity care. AAM is coordinated centrally to ensure consistency of delivery and messaging by the Humber and North Yorkshire local maternity and neonatal system (LMNS), and four acute trusts are now working collaboratively to offer the service via Facebook, Instagram, and email.

The service is staffed by trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. Questions from women and families range from pregnancy, birthing options, appointments, and the care of a new-born baby.

More than 94% of queries can be answered immediately and midwives can refer women to other health professionals and support organisations where required. The service routinely averages 800 queries per month, with more than 8,500 queries answered overall in 2022 and 508 onward referrals to health professionals, maternity units, NHS 111, and pharmacies. Patient confidentiality is conducted in the same way as telephone queries would be in a hospital, but the usual ways of contacting the hospital maternity team, such as by phone, are also available.

The service also allows the LMNS to cascade timely public health updates for pregnant women, including communications around vaccinations, perinatal mental health, postnatal care, and infant feeding. For example, when the AAM team saw an increase in messages around winter viruses they responded by posting self-help information.

AAM is promoted through Maternity Voices Partnership groups, with printed postcards and posters distributed in maternity settings, Children's Centres, through direct referral by midwives, and attendance at community outreach events, such as one in Spring 2023 specifically for people from the Romanian and Polish community.

Support available to staff, trusts, and systems

The maternity hub on the FutureNHS platform has relevant material for each theme.

Theme 1: Listening to and working with women and families with compassion

- Personalised care and support planning guidance and the Personalised Care Institute
- Equity and Equality guidance for Local Maternity and Neonatal Systems
- NHS statutory guidance for working in partnership with people & communities
- National maternity voices partnership toolkit
- Service specification for care of pregnant and post-natal women in detained settings
- Delivering Midwifery Continuity of Carer at full scale
- Maternal medicine network national service specification

Theme 2: Growing, retaining, and supporting our workforce

- Nursing and midwifery retention self-assessment tool
- National preceptorship framework
- Advanced Clinical Practice: capability framework for midwifery
- RCOG advice and guidance on workforce planning and flexibility
- A 'how to' guide and templates to reflect the Core Competency Framework

Theme 3: Developing and sustaining a culture of safety, learning, and support

- Maternity and Neonatal Safety Champions toolkit
- NHS national freedom to speak up policy and guidance

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Support for quality improvement through patient safety collaboratives
- The Maternity self-assessment tool
- The recommendations register
- NICE guidance
- Saving Babies Lives Care Bundle
- An MSDS guidance hub
- For digital health there is Digital Maternity Leaders training course and the Shuri Network brings together women from minority ethnic groups

Acknowledgements

This plan has been developed with contributions from clinical leaders within NHS England and a wide range of partners, including but not limited to:

- The Independent Working Group, chaired by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Members include:
  - British Association of Perinatal Medicine
  - Royal College of Paediatrics and Child Health
  - Royal College of Anaesthetists
  - Obstetric Anaesthetists Association
  - Society of Radiographers
  - Care Quality Commission
  - The Department of Health and Social Care
  - Health Education England
  - Service user voice representatives.

- Hearing from around 3,000 people via events and a survey. This included:
  - People who use maternity and neonatal services
  - National and regional service user voice representatives
  - Frontline professionals, including midwives, obstetricians, and neonatal colleagues
  - Integrated care boards
  - NHS England regional teams
  - Voluntary, community, and social enterprise organisations
  - National Guardian's Office
  - National stakeholders.

We remain committed to working closely with partners as we deliver this plan. Thank you to all the individuals and organisations who have shared their time, expertise, and experience so far.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request.

Embedding the Three Year Delivery Plan into BNSSG ICB/LMNS
Theme 1: Listening to, and working with, women and families with compassion

Objective	LMNS/ICB Responsibility (outlined in TYDP)	Current Position	RAG	Existing workstream	Outcome (set in TYDP)	Outcome met (Y/N)	New area of work identified	Deadline for implementation (as set by TYDP)	Maps to
1. Care that is personalised	Commission for and monitor implementation of personalised care for every woman	PCSP's have been launched in both Trusts as of Feb 23- audits will be supported by LMNS			Audit of PCSP's- Women's experiences from CQC maternity survey- feedback from MNVP's		Await NHSE national postnatal guidance due Spring 2023- Await a patient reported experience measure (PREM) by 2025 to help ICB's monitir and improve personalised care		
	Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent and treat common pelvic floor problems in pregnant woman and new mothers	Pelvic health services already commissioned in BNSSG		Perinatal pelvic health	That the service is in place		Await NHSE national service specification for perinatal pelvic health as well as implemenation guidance		
	Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care	Both Trusts have Perinatal mental health services but quite inequitable - both Trusts have MALT midwives		Perinatal mental health	That the service is in place		Ensure bereavement services available 7 days a week by end 2023/24		
2. Improve equity for mothers and babies	During 2023/24 continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODN's, working across organisational boundaries	To be published		Equity and equality					
	Commission MNVP's to reflect the ethnic diversity of the local population and reach out to seldom heard groups	BNSSG MNVP undergoing a period of transition with recruitment- already linked with ODN to support MVP-MNVP-		Equity and equality	Local evidence of co-production & working with women and families				
3. Work with service users to improve care	Commission and fund MNVP's to cover each trust within their footprint, reflecting the diversity of the local population	MNVP needs to recruit		Equity and equality					
	Renumerate and fund MNVP leads and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and ICB. All MNVP members should have reasonable expenses reimbursed	MNVP now hosted by Healthwatch and funding agreed for next 3 years							
	Ensure service user representatives are members of the local maternity and neonatal system board	MNVP attend and present at LMNS board							

Embedding the Three Year Delivery Plan into BNSSG ICB/LMNS
Theme 2: Growing, retaining and supporting our workforce

Objective	ICB/LMNS Responsibility (outlined in TYDP)	Current Position	RAG	Existing workstream	Outcome (set in TYDP)	Outcome met (Y/N)	New area of work identified	Deadline for implementation (as set by TYDP)	Maps to
4. Grow our workforce	Commission and fund safe staffing across their system				Establishment, in-post and vacancy rates for obstetricians, midwives, MSW's, neonatologists captured		Monitor progress against workforce, retention, succession and training plans		
		Vacancy rate remains a concern but improving		Safer staffing/ workforce strategy	from provider workforce return data				
	Agree staffing levels with trusts, following NHS England workforce planning principles, for those heathcare staff where an evidence based planning tool does not yet exist. National guidance should be considered	Awaiting publication of National Guidance		Safer staffing/ workforce strategy	planning guidance there will be an annual census of maternity and neonatal staffing groups, this will give us baseline data		Monitor local staff feedback mechanisms such as staff surveys		
	Align commissioning of services to meet the ambitions outlined in the delivery plan with the availble workforce capacity. It is expected that from 2024/25 ICB's will assume delegated responsibility for the commissioning of neonatal services								
	Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements	Strong links in place with UWE							
5. Value and retain our workforce	Share best practice for retention and staff support	Both Trusts have retention leads but differing hours and pay grades- to support to allign		Safer staffing/workforce strategy	Continue to monitor staff turnover				
	Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach								
6.Invest in skills	No specific ICB reponsibility in this section								

Embedding the Three Year Delivery Plan into BNSSG ICB/LMNS
Theme 3: Developing and sustaining a culture of safety, learning and support

Objective	ICB/LMNS Responsibility (outlined in TYDP)	Current Position	RAG	Existing workstream (set in TYDP)	Outcome	Outcome met (Y/N)	New area of work identified	Deadline for implementation (as set by TYDP)	Maps to
7. Develop a positive safety culture	Monitor the impact of work to improve culture and provide additional support when needed	Discussed at every LMNS board, Kirkup action plans			Staff surveys and SCORE culture survey results to be shared with LMNS- Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture- that trust boards share and act on learning				
	Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other	We have shared learning days- to continue with these- perinatal day in planning stage and to link further study days with TYDP to keep track of progress		LMNS Safety and Quality led days at Engineers House					
8. Learning and improving	Share learning and good practice across all trusts in the ICS	Learning and good practice is shared throughout LMNS both at board and within safety & quality meetings. Shared with ICB at learning panel and system quality group							
	Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place	NBT early adopter with shared learning opportunities with UHBW- will be regularly monitored in LMNS safety & quality group							
9. Support and oversight	Commission services that enable safe, equitable and personalised maternity care for the local population	PCSP's and equity and equality work		Equity & Equality					
	Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives	PQSM reported in LMNS safety & quality meeting . Maternity and neonatal objectives are in the ICB Joint Forward Plan		Safety & Quality					
	Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts	achieve this both dashboard and work towards centralised triage services							

Embedding the Three Year Delivery Plan into BNSSG ICB/LMNS
Theme 4: Theme 4: Standards and structures that underpin safer, more personalised and more equitable care

Objective	ICB/LMNS Responsibility (outlined in TYDP)	Current Position	RAG	Existing workstream (if applicable i.e.Ockenden IEA)	Outcome	Outcome met (Y/N)	New area of work identified	Deadline for implementation (as set by TYDP)	Maps to
10. Standards to ensure best practice	Prioritise areas for standardisation and co-produce ICS wide clinical policies such as for the implementation of the Saving Babies Lives Care Bundle	Need to consider how version 3 will be embedded		Safety & Quality			National MEWS and NEWTT-2- Local implementation of SVBLV3-ATAIN data- babies born below 27 weeks		
	Oversee and be assured of trusts declarations to NHS Resolution for the maternity incentive scheme	Need to to link to MIS yr 5		Safety & Quality					
	Monitor and support trusts to implement national standards	Continue to work on system wide clinical pathways which will support centralised triage vision		Safety & Quality			Clinical audits of shared standards		
	Commission care with due regard to NICE guidelines								
11. Data to inform learning	Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made	PQSSG- link with buddy LMNS's		Safety & Quality			An ICB wide dashboard to support benchmarking and improvement		
12. Make better use of digital technology in maternity and neonatal services	Have a digital strategy and, where possible, procure on a system wide basis to improve standardisation and interoperability	BNSSG wide procurement of Badgernet underway with implementation September 23							
	Support Women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users	will be embedded within Badgernet							
	Support regional digital maternity leadership networks	Currently have digital midwives at Trust level							

Key	
Blue	Already BAU
Green	Being met through existing workstream
Amber	Partially being met but further work to do to meet standard
Red	Not being met or in any existing plans

Classification: Official

Publication reference: PRN00130

Saving Babies' Lives Version Three

A care bundle for reducing perinatal mortality

Version 3, 1 June 2023

Contents

.

Executive summary

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality.

The NHS has worked hard towards the national maternity safety ambition to halve rates of perinatal mortality from 2010 to 2025, and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there is more to do to achieve the Ambition in 2025.

Version 3 of the Care Bundle (SBLCBv3) has been co-developed with clinical experts including front-line clinicians, Royal Colleges, and professional societies; service users and Maternity Voices Partnerships; and national organisations including charities, the Department of Health and Social Care and a number of arm's length bodies (see Appendix A: Acknowledgements).

Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are now 6 elements of care:

- **Element 1** focuses on **Reducing smoking in pregnancy** by implementing NHS-funded tobacco dependence treatment services within maternity settings, in line with the NHS Long Term Plan and NICE guidance. This includes carbon monoxide testing and asking women about their smoking status at the antenatal booking appointment, as appropriate, throughout pregnancy. Women who smoke should receive an opt-out referral for in-house support from a trained Tobacco Dependence Adviser who will offer a personalised care plan and support throughout pregnancy.

- **Element 2** covers **Fetal Growth: Risk assessment, surveillance, and management.** Building on the widespread adoption of mid-trimester uterine artery Doppler screening for early onset fetal growth restriction (FGR) and placental dysfunction, Element 2 seeks to further improve FGR risk assessment by mandating the use of digital blood pressure measurement. It recommends a more nuanced approach to late FGR management to improve the assessment and care of mothers at risk of FGR, and lower rates of iatrogenic late preterm birth.

- **Element 3** is focused on **raising awareness of reduced fetal movement (RFM).** This updated element encourages awareness amongst pregnant women of the importance of detecting and reporting RFM, and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. Induction of labour prior to 39 weeks gestation is only recommended where there is evidence of fetal compromise or other concerns in addition to the history of RFM.

- **Element 4** promotes **Effective fetal monitoring during labour** through ensuring all staff responsible for monitoring the fetus are competent in the techniques they use (IA and/or CTG) in relation to the clinical situation, use the buddy system, and escalate accordingly when concerns arise, or risks develop. This includes staff that are brought in to support a busy service from other clinical areas, as well as locum, agency of bank staff**.**

- **Element 5** on **reducing preterm birth** recommends three intervention areas to reduce adverse fetal and neonatal outcomes: improving the **prediction** and **prevention** of preterm birth and **optimising perinatal care** when preterm birth cannot be prevented. All providers are encouraged to draw upon the learning from the existing BAPM toolkits and the wide range of resources from other successful regional programmes (e.g. PERIPrem resources, MCQIC).

- The new **Element 6** covers the **management of pre-existing diabetes in pregnancy** for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes. It recommends multidisciplinary team pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes clear documentation of assessing glucose control digitally; using HbA1c to risk stratify and provide additional support/surveillance (National Diabetes Audit data); and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control.

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all Maternity and Neonatal services and is essential to achieving the National Safety Ambition. Each element in SBLCB v3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

SBLCBv3 also sets out a number of important wider principles to consider during implementation. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the six elements.

Forewords

ONS data suggests that because of the improvement in the perinatal mortality rate since 2010, at least 900 more babies will return home safely with their families this year. That is an important achievement, and all those who work in Maternity and Neonatal services should be incredibly proud of our progress towards the National Safety Ambition for a 50% reduction in the stillbirth and neonatal mortality rates by 2025.

More recent data from 2021 however showed a rise in the perinatal mortality rate compared to 2020, which is likely to be related to the direct and indirect effects of the COVID-19 pandemic and is a stark reminder that there will always be challenges to reducing stillbirths and neonatal deaths. The trajectory to meet the national ambition was unlikely to ever be a simple linear progression, particularly as the factors that lead to avoidable perinatal mortality are many and varied. We should all acknowledge that while we have reduced avoidable deaths, there is more to be done.

If we are to meet the national ambition, we need to address longstanding inequitable outcomes associated with ethnicity and levels of deprivation. While it is clear that some solutions lie beyond the control of the health sector, our services must do everything possible to mitigate against the wider social determinants of health to continue to drive down the perinatal mortality rate.

The need to continuously iterate and improve care is why we have developed Version 3 of the care bundle at pace. Clinical experts, professional bodies, charities, women, families and national regulators have collaborated to develop national best practice.

It is important to remember that the care bundle is just one of a series of interventions to help reduce perinatal mortality and pre-term birth and shouldn't be implemented in isolation. The Three year delivery plan for maternity and neonatal services describes more broadly how providers should continue to implement best practice care wherever possible and a set of wider principles are included in this version of the Care Bundle.

Despite the recent rise in perinatal mortality rates, the stillbirth rate was still 19% lower in 2021 than in 2010, and the neonatal mortality rate 30% lower. Thank you to all those who have worked tirelessly to drive improvement in our maternity services, whether they be NHS employees, parents or charities. I am confident that the collaborative approach modelled by the Saving Babies' Lives Care Bundle will continue to deliver improvements in outcomes and reduce the number of families who have to face the tragedy of perinatal bereavement.

Matthew Jolly National Clinical Director for Maternity and Women's Health, NHS England

NHS England

On behalf of the Royal College of Midwives, I welcome the publication of this third version of the Saving Babies' Lives Care Bundle. We continue to support the ambition to achieve a 50% reduction in stillbirths and maternal and neonatal deaths by 2025. The care bundle to date has made a vital contribution to achieving this.

The RCM know that the relationships that professionals form in the workplace, in their teams and with women, are key to safety and preventing the avoidable tragedies of stillbirth and the death of babies. We are therefore pleased to see continued emphasis on professionals working together and with women to help them to make choices about their care and reduce the risks to their baby.

Gill Walton
Chief Executive, Royal College of Midwives

As Saving Babies' Lives Care Bundle (SBLCBv3) enters its third edition and its 7th year, it continues to innovate and drive forward quality improvement in key areas of maternity care. We welcome the addition of an element covering diabetes in pregnancy and the continued development of the other successful five elements. This version builds on versions 1 and 2, to focus on supporting those caring for pregnant women and to help support women to make choices about their care and reduce unnecessary intervention. Whenever a new guideline is introduced, it will always have limitations and there will be compromises to be made influenced by lack of current evidence and resource requirements to support successful implementation. However, the premise of the bundle is to reduce variation and provide a framework for continuous improvement. This will be supported by ongoing learning from evaluation of the bundle and is key to its success and value.

The Saving Babies' Lives Care Bundle is part of a number of initiatives to improve maternity care and safety. However, there are areas that we urgently need to address if we are to ensure a continued reduction in perinatal mortality for all women and babies. We must, therefore, harness the expertise and experience of obstetricians and specialists in fetal and maternal medicine, frontline maternity teams, academics and policymakers to tackle inequality and the social determinants of health in the pregnant population.

BMFMS is honoured to have worked closely on all three versions of SBLCB and fully supports the initiatives within this new version and the opportunity to work to deliver improvements in maternity care.

Katie Morris
President, British Maternal and Fetal Medicine Society

British Maternal & Fetal Medicine Society

Every day, maternity services support thousands of women and their families through pregnancy and childbirth. The majority of those using maternity services have good outcomes and report a positive experience of care but maternity care is complex and, unfortunately, adverse events occur.

Recent public inquiries into maternity care have emphasised the importance of continued learning and action on improving safety. The Royal College of Obstetricians and Gynaecologists warmly welcomes the publication of the third version of the Saving Babies' Lives Care Bundle, which will support further progress towards a 50% reduction in the rate of stillbirths, neonatal mortality and serious brain injury and a reduction of pre term births from 8% to 6% in the UK by 2025, as set in the NHS Long Term Plan.

Maternity care is delivered through multi-professional teams working together to support all women, requiring a wide range of skills, knowledge and expertise, and a supportive context in which these can be applied. By implementing the evidence-based, best practice elements of the Saving Babies' Lives Care Bundle, local maternity teams can ensure women receive personalised care that will continue to reduce perinatal mortality.

Importantly, each element of the care bundle includes action to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas. Maternity systems must continue work to embed these into their local action plans.

The care bundle aligns with and complements a range of other important maternity safety initiatives and tools, including wider work being taken forward through the Maternity Transformation Programme as well as initiatives such as the Avoiding Brain Injury in Childbirth (ABC) programme.

The Royal College of Obstetricians and Gynaecologists will continue to work with partners, including other Royal Colleges, national policymakers and safety leaders, to support the NHS to implement these together, to improve the quality and safety of care that women and babies receive in the UK.

Dr Ranee Thakar
President, Royal College of Obstetricians and Gynaecologists

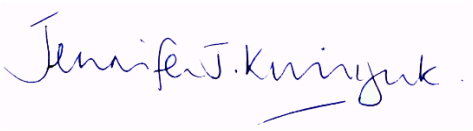
Royal College of Obstetricians & Gynaecologists

Having achieved the first national ambition milestone of reducing by 20% the perinatal mortality rate by 2020 the focus is now on achieving the further 30% reduction by 2025. This will require accelerated progress in the face of having probably dealt with the 'easier' problems to prevent and manage.

Activities on multiple fronts are going to be required which is why, amongst other actions, the full implementation in all trusts of the Saving Babies' Lives Care Bundle is needed. This, the third version of the Care Bundle, is a welcome reminder of the five elements from version two and the introduction of a sixth new element to improve diabetic management in pregnancy for women with type 1 and type 2 diabetes.

As demonstrated in the National Diabetes in Pregnancy Audit, monitoring and managing tight glycaemic control from pre-pregnancy and throughout pregnancy is key to reducing the risks of adverse outcomes including congenital anomalies and perinatal death. The 2022 MBRRACE-UK maternal confidential enquiry illustrated the risks to both diabetic pregnant women and their babies of poorly managed diabetic ketoacidosis.

The steps outlined in element six of the new version of the Care Bundle provide practical advice for service delivery to support improved management for this high-risk group of mothers and babies. Achieving the improvements that could be realised from the full implementation of all six elements of the new version of the Care Bundle will provide some of the essential pieces of the jigsaw of activities still needed to further reduce the national rate of perinatal deaths.



Professor Jenny Kurinczuk, Professor of Perinatal Epidemiology,
Director, National Perinatal Epidemiology Unit,
National Programme Lead MBRRACE-UK/PMRT,
University of Oxford

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Despite falls in perinatal mortality in recent years, too many parents and families are still devastated by the death of their baby. The exact impact of Covid 19 is as yet unclear but it's very possible that the pandemic has had a significant negative impact not just on women and pregnant people's experiences of maternity, but crucially on outcomes for both them and their babies. Importantly, the government is unlikely to meet the National Ambition to halve stillbirths and neonatal baby deaths by 2025.

Coming in the wake of further investigations into poor care such as the Ockenden and East Kent reports, this third version of the Saving Babies' Lives Care Bundle has urgency towards ensuring better, safer care. This new version maintains the focus of version two but adds another crucially important element around caring for women with Type 1 and Type 2 Diabetes who we know to be at 4-5 times increased risk of losing their baby. This version also encourages awareness among those who are pregnant of the importance of early warning signals that something may be wrong, such as noticing and reporting reduced fetal movements (RFM).

An innovation in this version is an assurance tool to help Trusts track their progress in implementation, thereby removing the need to have regular implementation surveys.

Listening to bereaved parents' experiences is vital in understanding why babies die, and learning from every baby's death is essential part of the continual improvement that underpins this Care Bundle. Parents tell us that if lessons can be learned from the death of their baby it can help them live with their grief, providing an important and lasting legacy.

This updated, third version of the Saving Babies' Lives Care Bundle carries essential knowledge for every healthcare professional who supports and works with those who are pregnant. It helps address inequalities with the same emphasis of continuity of carer, especially for those from black and minority ethnic backgrounds and those living in areas of social deprivation. When the worst happens, it ensures standards in bereavement care, in line with the National Bereavement Care Pathway.

We welcome its implementation and believe that it provides an opportunity to protect babies' lives in the future.

Clea Harmer
Chief Executive, Sands

Sands
Stillbirth & neonatal death charity

Tommy's work is dedicated to reducing rates of pregnancy complications and baby loss as we know the heartbreak and devastation this causes far too many parents and families. Despite ambitious targets, the rates of stillbirth and preterm birth are not falling as quickly as we would have hoped, and indeed the stillbirth rates sadly rose in 2021. It is also clear that variation in care continues, and not all women and birthing people have the same chance of taking home a healthy baby – the outcome every family deserves. So, we warmly welcome Version 3 of the Saving Babies' Lives Care Bundle as a vital resource for all professionals involved in supporting people to have a safe and healthy pregnancy and birth.

Research is continually advancing understanding and growing evidence and it is vital this is translated into improvements in care. While this guidance has been produced before the evaluation of Version 2, we support the fast tracking of new evidence so that everyone can benefit as quickly as possible, and potentially more babies' lives can be saved.

We know from the MBRRACE data that some communities continue to experience much poorer outcomes than others. This is unacceptable and we're therefore particularly pleased that Version 3 has been reviewed from an inequity standpoint and highlights the promotion of equity and equality as an important principle to apply when implementing the care bundle. It is also positive to see that continuity of carer is explicitly noted as a key intervention to improve equitable outcomes.

A key addition to Version 3 is the management of diabetes in pregnancy. The number of women and birthing people with diabetes is on the rise and perinatal mortality rates for pregnant people with Type 1 and Type 2 diabetes have remained very high for the last five years. This practical guidance should standardise pathways and join these up with other aspects of maternity care to reduce risk.
The care bundle also contains a renewed focus on reduced fetal movement (RFM). This is such an important message given the relationship between episodes of RFM and stillbirth, and the vital role of timely hospital attendance and fetal monitoring. Everyone must feel they can and should contact their hospital if they are worried that their baby's movements have changed.

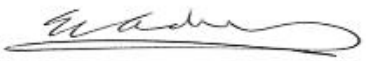
This version of the bundle is another important step on the journey to safer pregnancy and birth. We know that when all maternity units follow these actions, fewer families will face the heartbreak and devastation of pregnancy complications and loss.

Kath Abrahams, Chief Executive, Tommy's

Tommy's
Together, for every baby

*Preterm birth causes 78% of deaths in the neonatal period (first 28 days of life)*and is also a major contributor to childhood disability and poorer neurodevelopmental outcome. Interventions to reduce the impact of prematurity on morbidity and mortality must therefore be a major focus to move towards the national ambition to halve the rate of stillbirth, neonatal death, maternal death and serious intrapartum brain injury by 2025.*

BAPM therefore welcomes expansion of element 5 in the SBLCB v3 which aims to reduce preterm birth where possible and optimise perinatal care where preterm birth cannot be prevented. Given the importance of the interventions in improving outcomes, BAPM strongly encourages trusts to ensure that appropriate time is allocated to the neonatal medical and nursing leads of the preterm birth team, in addition to the maternity and obstetric leads, to allow rapid implementation.
**National Child Mortality Database Thematic Report: The contribution of Newborn Health to Child Mortality across England. July 2022*



Eleri Adams, BAPM President

British Association of Perinatal Medicine

Introduction

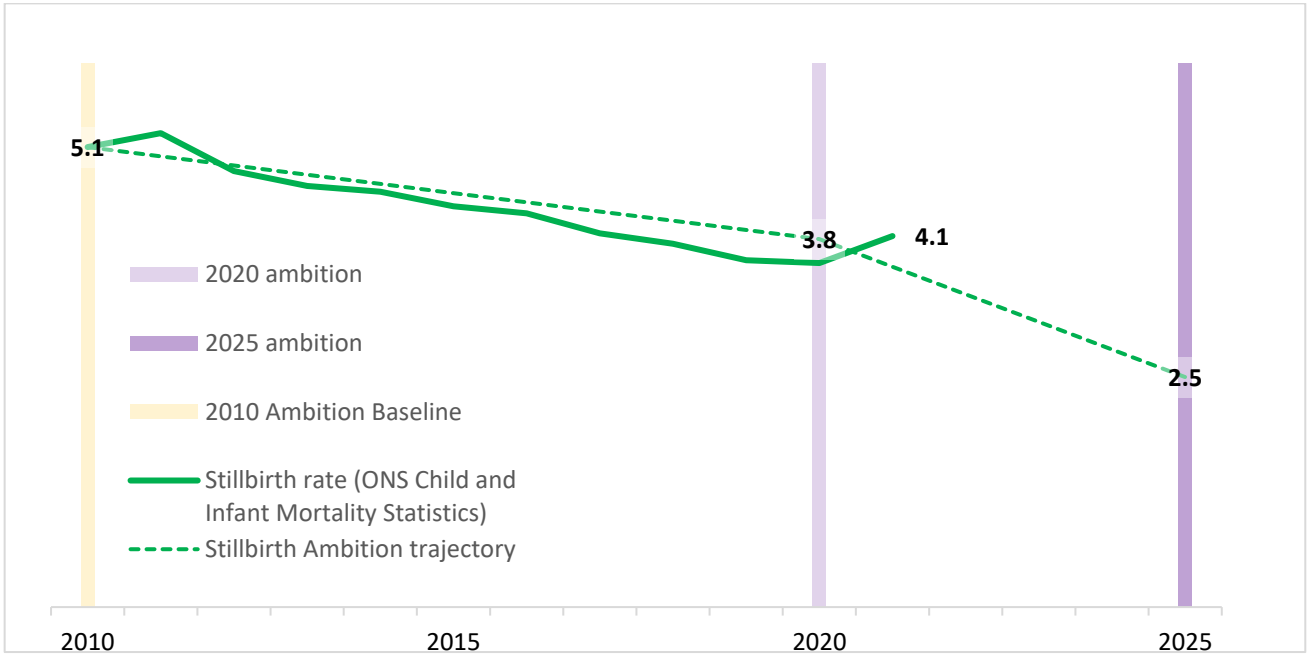
Progress towards the National Safety Ambition

In 2015, the Secretary of State for Health announced a national safety ambition, to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020. In 2017, the ambition was extended to include a reduction in the rate of preterm births from 8% to 6%, while the date to achieve the ambition was also brought forward to 2025.

Office for National Statistics (ONS) data (shown in **Figure 1**, below) demonstrated a 25% reduction in stillbirths between 2010 and 2020 from 5.1 to 3.8 per thousand births, showing the 2020 milestone had been exceeded for stillbirths. It is not absolutely clear why stillbirth rates increased during the Covid pandemic, but it is likely that the direct effects of the Covid virus as well as the indirect impact of the pandemic on accessing services played a part in the increase of the stillbirth rate from 3.8 per 1000 births in 2020 to 4.1 in 2021. The neonatal mortality rate also increased between 2020 and 2021 from 1.3 to 1.4 per 1000 live births at 24 weeks gestation and over. Despite the significant challenges faced by the NHS, these rates remain 19% and 30% lower (respectively) than in 2010. This equates to more than 900 families returning home with a healthy baby in 2021, than if the rates had remained unchanged from 2010.

The latest data on serious brain injury shows that rate of occurrence during or soon after birth fell by 9% between 2014 and 2019 to 4.25 per 1000 live births. Further reduction in the rate is needed to meet the 2025 ambition, a rate of 2.16 per 1000 live births.

Figure 1: National Maternity Safety Ambition – Summary of progress on stillbirths



Despite the achievements of the past few years and in light of the recent statistics, there is clearly much more to be done to achieve the ambition by 2025. In particular, there is a need to address inequitable outcomes associated with ethnicity and levels of deprivation. MBRRACE-UK Perinatal Mortality Surveillance data show that the lowest stillbirth rates were for babies of White ethnicity from the least deprived areas, at 2.78 per 1,000 total births. The highest stillbirth rates were for babies of Black African and Black Caribbean ethnicity from the most deprived areas, at around 8 per 1,000 total births. The pattern is similar for neonatal deaths. Maternity services alongside other partners must do everything possible to mitigate against the wider social determinants of health in order to continue to drive down the perinatal mortality rate.

Progress of the Saving Babies' Lives Care Bundle

The first version of the Saving Babies' Lives Care Bundle (SBLCBv1) was published in March 2016, and focused predominantly on reducing the stillbirth rate. An independent evaluation in 2018 showed a decrease in stillbirths in participating Trusts, concluding that despite being one of many concurrent interventions, it was highly plausible that SBLCBv1 had contributed to the reduction.

The evaluation helped inform the development of version 2 of the SBLCB (SBLCBv2). Launched in March 2019, SBLCBv2 aimed to go further in reducing stillbirth while also minimising unnecessary intervention. In answer to the expansion of the national safety ambition in 2017, it introduced Element 5 on reducing pre-term birth, and further decreasing perinatal mortality.

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Published 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available and it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

While SBLCBv3 would ideally be informed by the evaluation of SBLCBv2, this has been delayed due to the pandemic. Stakeholders agreed that improvements to best practice couldn't be delayed when evidence is readily available for improvements to several elements. The evaluation of SBLCBv2 remains a priority and will be

published in 2023. Findings will help inform the next iteration of SBLCB, which will also include important innovations from the Avoiding Brain Injury in Childbirth (ABC) collaboration along with anticipated updates to Green Top Guidance.
SBLCBv3 should not be implemented in isolation, but as one of a series of important interventions to help reduce perinatal mortality and preterm birth. It is important that providers continue to implement best practice care whenever possible, including by following NICE guidance and using the National Maternity and Neonatal Recommendations Register to assess their organisations' compliance with recommendations from confidential enquiries and other key national reports.

Implementing Version 3 of the Care Bundle

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

Overseeing implementation

An implementation tool is being developed and will be available on the Maternity Transformation Programme's Future NHS platform. This tool will support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory.

To reduce assurance burdens, national implementation surveys are being stepped down. Instead, trusts will be asked to use the implementation tool in two ways to ensure local oversight:

1. Track and demonstrate compliance to the Trust Board and ICBs. 'Full implementation' of the care bundle means completing all interventions for all six elements.

2. Holding quarterly quality improvement discussions with the ICB. These provider-commissioner discussions should include, at a minimum:
    - Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
    - Progress against locally agreed improvement aims.
    - Evidence of sustained improvement where high levels of reliability have already been achieved.
    - Regular review of local themes and trends with regard to potential harms in each of the six elements.
    - Sharing of examples and evidence of continuous learning by individual trusts with their local ICB and neighbouring Trusts.

While there will be no routine, deadline-based submissions of data to the national NHS England team for the purposes of assurance, the maternity team will review data stored on trust implementation tools on an ad-hoc basis to assess national progress in implementation.

Organisational roles and responsibilities

Successful implementation of SBLCBv3 requires providers, commissioners, and networks to collaborate successfully. National levers including NHS Planning Guidance, the NHS Standard Contract, and Safety Action 6 in the CNST Maternity Incentive Scheme will be updated in due course to reflect the following organisational responsibilities:

- **Providers** are responsible for implementing SBLCBv3, including baselining current compliance, developing an improvement trajectory, and reporting on implementation with their ICB as agreed locally. They are also responsible for submitting data nationally relating to key process and outcome measures for each element.
- **ICBs** are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. Where there is unresolved clinical debate about a pathway, providers may wish to agree a variation to an element of the care bundle with their integrated care board. An integral part of ICSs, **Local Maternity and Neonatal Systems (LMNSs)** are accountable to ICBs and have the system's maternity and neonatal expertise to support planning and provide leadership for improvement, facilitating peer support, and ensuring that learning from implementation and ongoing provision of SBLCBv3 is shared across the System footprint.
- **Clinical Networks and Regional Maternity teams** are responsible for providing support to providers, ICBs and LMNSs to enable delivery and achieve expected outcomes. It is important that specific variations from the pathways described within SBLCBv3 are agreed as acceptable clinical practice by their Clinical Network.

Principles to be applied when implementing Version Three

It has been necessary to restrict the scope of the SBLCBv3 to ensure it is deliverable. Nevertheless, it is just one of a series of important interventions to help reduce perinatal mortality and preterm birth. The following principles should be considered alongside implementing the Care Bundle.

Promoting Equity and Equality

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Equity in maternity and neonatal care means that all mothers and babies have a fair and just opportunity to attain the best health outcomes. To achieve equity and reduce inequalities, action must be universal, but with a scale and intensity proportionate to the level of disadvantage; this is known as 'proportionate universalism' (Marmot 2010).

England is one of the safest countries in the world to give birth. However, stillbirth rates and neonatal death rates are higher for some groups, such as women who are Black, Asian and those living in the most deprived areas. This emphasises the need for a continued focus to address these inequalities when implementing the care bundle. This includes ensuring that services reflect the needs of different groups, with support increasing as health inequalities increase. This requires use of quantitative and qualitative data on the local population and their health needs, along with co-production, to inform pathways and processes during implementation. Maternity and neonatal services also need to respond to each person's unique health and social situation — so that care is safe and personal for all.

Continuous improvement activity related to each element of the care bundle will routinely require consideration of access, experience, and outcomes in relation to protected characteristics and other variables influencing inequalities, such as factors related to deprivation. Pathways and processes should be changed, or additional supportive activity carried out, to address any inequity or inequalities identified.

While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services.

The role of Midwifery Continuity of Carer

The implementation of Midwifery Continuity of Carer has been challenging particularly in the context of the pandemic and workforce pressures. Whilst the ambition remains for MCoC to be the default model of care for all women, in September 2022, NHS England published a letter confirming that there is not a national target timeframe for this to be achieved and asking trusts to review their staffing levels and decide to either: continue existing MCoC provision and continue to roll out; cease further rollout and continue with current levels of provision; or immediately suspend existing MCoC provision.
MCoC remains an important intervention to address higher perinatal mortality rates in Black and Asian women and women from economically disadvantaged groups. In line with the CORE20PLUS5 strategy, LMNS, regional and national colleagues will continue to support Trusts with sufficient staffing to focus rollout of MCoC to neighbourhoods with high numbers of women from Black, Asian, and Mixed ethnic groups, and women living in deprived areas, for whom CoC is linked to significant improvements in clinical outcomes[3] .

Informed choice and personalised care

Evidence shows that better outcomes and experiences, as well as reduced health inequalities, are possible when pregnant women can actively shape their care and support. Personalised care means pregnant women have choice and control over the way their care is planned and delivered, based on best available evidence, 'what matters' to them and their individual strengths, needs and preferences. Pregnant women receiving maternity care make informed decisions. They and their maternity professionals discuss evidence-based options together exploring preferences, benefits, risks, and consequences to enable a safe and positive experience.

For any given situation where a decision needs to be made, women are supported by their maternity professionals to understand their options, the benefits, harms and consequences of each. They have all the information they need for shared decision making and give consent, in line with the Montgomery ruling.

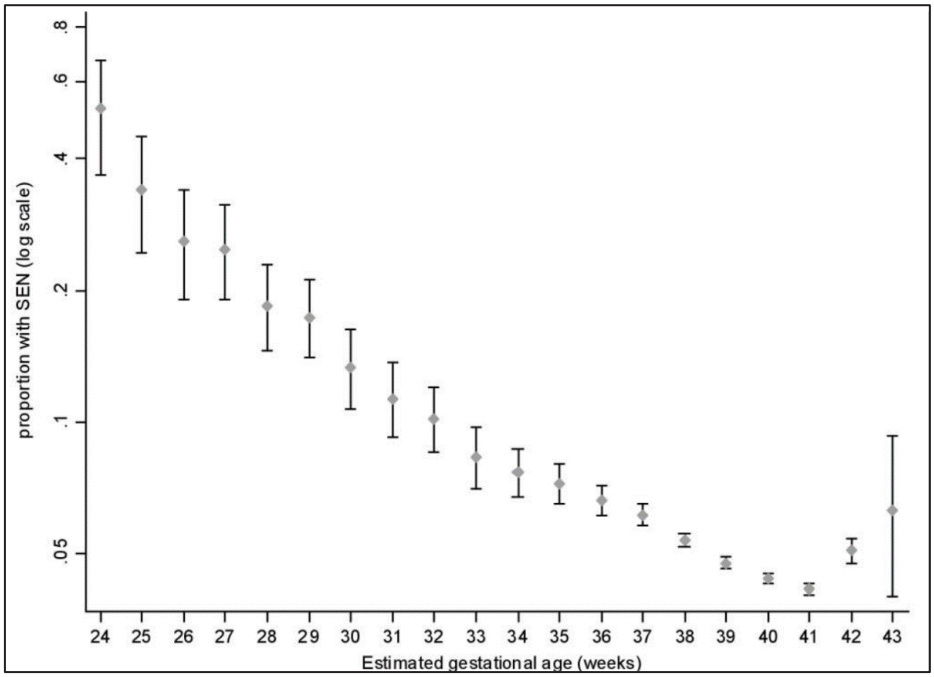
Linked to this principle, the following areas are of particular relevance to implementing a number of Elements in Version 3:

Informing women of the long-term outcomes of early term birth

One of the key interventions in elements 2 and 3 of the SBLCBv3 is offering early birth for women at risk of stillbirth. It is important that this intervention is not extended to pregnancies not at risk. The Avoiding Term Admissions Into Neonatal units (Atain) programme has identified that babies born at 37 – 38 weeks gestation were twice as likely to be admitted to a neonatal unit than babies born at later gestations. There are also concerns about long term outcomes following early term birth (defined as 37 and 38 weeks). These concerns relate to potential long term adverse effects on the baby due to birth prior to reaching maturity, for example, the baby's brain continues to develop at term[4]. Birth results in huge changes to the

baby's physiology, for example, the arterial partial pressure of oxygen increases by a factor of three to four within minutes following birth and it is plausible that earlier exposure to these changes could alter long term development of the child's brain and data exist to support this possibility[4]. One example is the risk that the child will subsequently have a record of special educational needs (SEN). The risk of this outcome is about 50% among infants born at 24 weeks of gestational age and it progressively falls with increasing gestational age at birth, only to bottom out at around 40 – 41 weeks.

Figure 2: Prevalence of special educational needs by gestation at birth[4].



After adjusting for maternal and obstetric characteristics and expressed relative to birth at 40 weeks, the risk of SEN was increased by 36% (95% CI (confidence interval)) 27 – 45) at 37 weeks, by 19% (95% CI 14 – 25) at 38 weeks and by 9% (95% CI 4 – 14) at 39 weeks. The risk of subsequent SEN was 4.4% at 40 weeks. Hence, assuming causality, there would be one additional child with SEN for every 60 inductions at 37 weeks, for every 120 inductions at 38 weeks, and for every 250 inductions at 39 weeks compared with the assumption that they would otherwise have delivered at 40 weeks[4]. Recent data from the UK Millennium Cohort Study confirmed the finding that children born at early term gestational ages (37 to 38 weeks) were more likely to fail to achieve the expected level of attainment in primary school but, interestingly, there was no association between early term birth and poorer attainment at secondary school [5.] Moreover, as the current data are based on the observed gestational age at birth, the negative associations with later outcome may be explained by the factors that determined early term birth rather than a direct effect of gestational age. However, induction of labour prior to 39 weeks should continue to be considered as a significant medical intervention which requires appropriate justification.

Considering how the risks of induction of labour change with gestational age

For uncomplicated pregnancies NICE guidance on induction of labour should be followed. In all cases of induction, it is important women receive a clear explanation about why they are being offered induction and that the risks, benefits and alternatives are discussed.

At 39+0 weeks gestation and beyond, induction of labour is not associated with an increase in caesarean births, instrumental vaginal birth, fetal morbidity or admission to the neonatal intensive care unit[6]. The NICE guidance and data from the ARRIVE study[6] provide contradictory evidence as to whether induced labours are associated with a longer hospital stay or more painful labours. Induction of labour may also increase the workload of the maternity service which has the potential to impact the care of other women.

Safe and Healthy Pregnancy Information' to enable women and their families to make informed choices regarding their health and reducing risks to their babies.

It is important that women have access to high quality information before and during their pregnancy to enable them to reduce risks to their baby. The Office for Health Inequalities and Disparities and Sands have developed some key messages:

Figure 2: Summary of Safe and Healthy Pregnancy key messages

Pre-pregnancy:

- Choose when to start or grow your family by using contraception.
- Consult with your GP if taking medication for long-term conditions (e.g., diabetes, hypertension, epilepsy) as your medication may have to change prior to pregnancy.
- Eat a healthy balanced diet and be physically active to enter pregnancy at a healthy weight.
- Take a daily supplement of 400 micrograms (400 µg) folic acid before conception (some women will require a higher dose of 5mg as advised by a healthcare professional).
- Ensure that you are up to date with routine vaccinations e.g., measles, rubella, Coronavirus (Covid 19), flu.
- Find out if you think you or your partner could be a carrier for a genetic disorder.
- Stop smoking and/or exposure to second hand smoke.
- Reduce/stop alcohol consumption.

During pregnancy:

- Continue to take 400 micrograms (400 µg) folic acid until the 12th week of pregnancy (some women will require a higher dose of 5mg as advised by a healthcare professional).
- Pregnant women should have 10µg of vitamin D a day.
- You may be advised to take aspirin from 12 weeks of pregnancy.
- Alcohol – the safest advice is to not drink alcohol, if you are concerned, talk to your midwife, or doctor and help and advice is available for you.
- Don't smoke and avoid second hand smoke; support is available to help with this.
- Do tell your midwife if you use illegal street drugs or other substances, help is available for you.
- Eat healthily and be physically active to maintain a healthy weight while pregnant.
- Maintain oral hygiene. Free dental care is available to all pregnant women and up to a year after the birth.
- Recommended vaccinations and boosters: seasonal flu; pertussis (whooping cough); Coronavirus (Covid-19)
- Always check with your pharmacist, midwife of doctor about medicines and therapies used in pregnancy, even if you have taken them for a long time on prescription or think they are harmless.
- Avoid contact with people who have infectious illnesses, including diarrhoea, sickness, childhood illnesses or any rash-like illness.
- Reduce the risk of Cytomegalovirus (CMV) Toxoplasmosis, Monkeypox infections etc.,
- Attend all antenatal appointments.
- Contact the maternity service promptly if you are worried about reduced fetal movements, vaginal bleeding, watery or unusual discharge, signs of pre-eclampsia or itching. Don't wait!
- In later pregnancy (after 28 weeks), it is safer to go to sleep on your side than on your back.

Appendix B provides more detailed information on how women can plan, prepare, and look after themselves before and during pregnancy. This information is also available at NHS.uk and the Safer Pregnancy website developed by Sands.

Working within Networks for more specialist care

In a number of specialist fields, Maternity services are working within networks so that women and babies with complex needs have consistent access to the most specialist care, while also encouraging local expertise, and ensuring that care remains as close as possible to home.

While a networked model has been in place for a number of years in fetal medicine and in neonatal care, NHS England announced the creation of 14 Maternal Medicine Networks March 2023, which are now in operation across England.

All providers should be engaging in these networks and contributing to the development of joint protocols and ways of working. In this vein, new elements of best practice shouldn't be implemented in isolation locally. Providers should consider what implications or opportunities this presents for ways of working agreed within wider Maternal Medicine, Fetal Medicine, or Neonatal Operational Delivery Networks.

Implementing relevant NICE guidance

Integrated Care Systems/ Boards (ICS/ICBs) are under an obligation in public law to have regard for NICE guidance and to provide clear reasons for any general policy that does not follow NICE guidance.

Providers and commissioners are encouraged to implement NICE guidance relating to antenatal, intrapartum and postnatal care. In particular, implementation of the NICE guidance on the management of diabetes in pregnancy, hypertension in pregnancy and multiple pregnancy, along with service provision for women with complex social factors are key to addressing some of the most significant contributors to perinatal mortality.

Best practice care in the event of a stillbirth or neonatal death

Despite the reduction in stillbirth rates, sadly thousands of parents each year will experience the devastation of their baby dying before, during or shortly after birth. A best practice pathway for the clinical management of women experiencing stillbirth is available on the North West Coast (NWC) Strategic Clinical Network website.

Sands have developed a National Bereavement Care Pathway (NBCP) to help ensure that all bereaved parents are offered equal, high quality, individualised, safe and sensitive bereavement care when they experience pregnancy loss or the death of a baby. The NBCP is available at www.nbcpathway.org.uk.

The national Perinatal Mortality Review Tool (PMRT) is used to support hospital reviews by providing a standardised, structured process so that what happened at every stage of the pregnancy, birth and after, from booking through to bereavement care is carefully considered by staff reviewing care. This online tool may help staff understand why a baby has died and whether there are any lessons to be learned to save future lives.

Continuous improvement and Maternity and Neonatal Services

As part of the update of SBLCBv3, we are maintaining an approach of continuous improvement. Within each element the focus is on a small number of outcomes with fewer process measures. Implementation of the elements will require a more comprehensive evaluation of each organisation's processes and pathways and an understanding of where improvements can be made.

Each organisation will be expected to look at their performance against the outcome measures for each element with a view to understanding where improvement may be required. We have provided suggested areas for improvement within each element, but these lists are not meant to be exhaustive.

There is an expectation that as well as reporting on the organisation's implementation of each element, there will be complementary reporting of ongoing improvement work (with associated detail of interventions, and improvement in process measures and outcomes) within each element. An integral component of this improvement work will be a focus on learning from incidents or enquiry, especially any instances where harm may have occurred in relation to implementation of or non-compliance with an element described in the care bundle. The use of the Perinatal Mortality Review Tool will complement the investigation and learning in this context.

Element 1: Reducing smoking in pregnancy.

Element description
Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser[a] is offered to all pregnant women who smoke, using an opt-out referral process.

Interventions	
1.1	CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment.
1.2	CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.
1.3	Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.
1.4	Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.
1.5	Nicotine replacement therapy (NRT) should be offered to all smokers and provision ensured as soon as possible.
1.6	The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.
1.7	Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should be immediate notification back to the named maternity health care professional.
1.8	Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result.
1.9	All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection).
1.10	Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards

[a] The role of tobacco dependence adviser (TDA) is also known under alternative names, including smoking cessation adviser, stop smoking adviser and smoking cessation practitioner. Irrespective of role name or grade, these roles are underpinned by appropriate training to deliver tobacco dependence treatment interventions (see 1.10).

Continuous learning

1.11 When analysing patient safety incidents, maternity care providers should review smoking status throughout pregnancy and determine whether the appropriate pathway of care for this was followed.

1.12 Maternity providers should regularly review (a minimum of quarterly) their smoking-related data to understand performance and develop improvement plans (this list is designed to provide a steer and is not exhaustive):

A. Identification of women who smoke – Determine any factors that would optimise CO testing rates and enquiry about smoking status, from both the provider/pathway and service-user perspective and make changes to pathways and processes as appropriate.
B. Training of staff – Ensure all staff involved in identification, referral and treatment of women who smoke, and provision of VBA are appropriately trained.
C. Engagement – Determine and address any barriers to engagement with treatment services or compliance with treatment interventions from both the provider/pathway and service-user perspective.
D. Referral – Determine and address any factors that are influencing opt-out referral, from both the provider/pathway perspective and service-user perspective.
E. Quit rates – Consider the pathway holistically to determine which steps can be optimised to facilitate quit attempts and successful quits.
F. Relapse – Determine factors that are contributing to relapse and whether additional support or changes to pathways may address these.
G. Inequalities – Consider all the above by protected characteristics and other variables influencing inequalities, such as factors related to deprivation. Make changes to pathways and processes, or carry out additional supportive activity, to address any inequity or inequalities identified.

1.13 In order to monitor quality and effectiveness of pathways, maternity services should set ambitions for their pathway with regular review (a minimum of quarterly) of data and targeted quality improvement work to ensure they are being achieved.

1.14 Based on highly performing areas, stretching ambitions to achieve effective implementation of the full Element may include:

A. 95% of women where CO measurement and smoking status is recorded at their booking appointment.
B. 95% of women where CO measurement and smoking status is recorded at their 36-week appointment.
C. 95% of smokers have an opt-out referral at booking for treatment by a TDA within an in-house service.
D. 85% of all women referred for tobacco dependence treatment engage with the programme (have at least one session and receive a treatment plan).
E. 60% of those referred for tobacco dependence treatment set a quit date.
F. 60% of those setting a quit date successfully quit at 4 weeks.
G. At least 85% of quitters should be CO verified.

1.15 Individual providers should examine their outcomes in relation to other providers or systems with similar smoking prevalence or populations. National benchmarking is available through the Maternity Services Dashboard and will be available to ICS/LMS as the Tobacco dependence patient level collection is established.

Process Indicators	Outcome indicators
1a. Percentage of women where there is a recorded of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date.	1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks.
* a “smoker” is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). ** Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.	

Rationale

Smoking increases the risk of pregnancy complications, such as stillbirth, preterm birth, miscarriage, low birthweight and sudden infant death syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far-reaching impact on the health of a child throughout their life. Whilst a number of studies have found that the risk of a number of poor pregnancy outcomes can be reduced to that of a non-smoker if a successful quit is achieved early in pregnancy. Others show increased risk with any smoking in pregnancy, and increasing risk with continued smoking. This reinforces the need to support women to quit smoking as early as possible in pregnancy to reduce the risk of poor pregnancy outcomes.

Smoking at time of delivery (SATOD) rates have declined since the release of previous versions of the care bundle, albeit at a slower rate than required to meet the government’s 2022 national ambition of 6% (and ultimately a smokefree generation by 2030). Although there is significant variation, the national SATOD rate was 9.1% in 2021/22, demonstrating that further work to reduce smoking during pregnancy is required.

This element is evidence-based and provides a practical approach incorporating the NHS Long Term Plan pathway for a smokefree pregnancy and core elements of NICE guidance. It builds on the previous version of the care bundle’s focus on CO testing to support identification of smokers, with referral to in-house tobacco dependence treatment services and ensuring that effective treatment is available to

all pregnant women who smoke. Research indicates that pregnant women expect to be asked about smoking by their maternity care provider and if the issue is not raised it can be incorrectly interpreted that smoking is not a problem for the pregnancy. Learning from front line services demonstrates a need for a treatment offer that is part of the maternity pathway and the woman's maternity journey. This should include processes for referral, treatment, and feedback that are timely and optimise engagement, with dedicated leadership within the maternity service that has oversight of the full pathway. To support this, consistent messages should be given from all clinicians who the woman comes into contact with during pregnancy.

This element impacts positively on the other care bundle elements. Reducing smoking in pregnancy will reduce instances of fetal growth restriction, intrapartum complications and preterm birth. This demonstrates the complementary and cumulative nature of the care bundle approach.

This element also reflects the wider prevention agenda, impacting positively on the health of babies and the long-term outcomes for families and society.

Implementation guidance

Key factors for effective implementation include:

In-house pathways: Clinical leadership, delivery and oversight of the service and its outcomes remains with maternity. Services are considered as in-house when the woman's care for treating their tobacco dependence remains within the maternity service i.e., is not referred out to another provider like a local authority stop smoking service[b].

Opt-out referral pathways: Effective pathways are in place to ensure that as soon as a smoker is identified there is rapid referral to the tobacco dependence adviser on an opt-out basis. Immediate referral and consultation with the tobacco dependence adviser is the ideal, but as a minimum the woman should be contacted within 1 working day and seen (ideally face-to-face) by a TDA within 5 working days.

Nicotine Replacement Therapy: Pathways should ensure provision of long and short acting nicotine replacement therapy at the earliest opportunity to facilitate quitting at an optimal time to improve perinatal outcomes and maximise engagement with referral and treatment services. Ideally this should be at the earliest opportunity when maternity care has commenced, even if prior to a formal booking appointment.

Recent Quitters: The definition of a smoker includes those who have smoked within the past 2 weeks. However, it is good clinical practice to offer support to all women who have quit smoking since conception given that changes in first trimester pregnancy symptoms may affect smoking habits.

[b] In-reach services where a third party, such as the local authority stop smoking service, provide services as part of the maternity team with the patient staying under the care and management of the maternity service would count as in-house.

CO testing: All pregnant women should be offered CO testing at the antenatal booking and 36-week antenatal appointment, with testing offered at all other antenatal appointments after booking to groups identified within NICE guidance NG209. All staff providing antenatal care should have access to a CO monitor and training in how to use it and interpretation of results. Appropriate procurement processes should be in place for obtaining CO monitors and associated consumables (for example, tubes and batteries).

CO verified non-smokers at 4 weeks: this corresponds to the 4-week quit that is regularly captured by stop smoking services and is a comparable indicator that can be used to assess the quality of the intervention.

CO Levels: The most common reason for a raised CO level is smoking, however exposure may come from other sources such as second-hand smoke, faulty boilers, faulty heating/cooking appliances or car exhausts (and can happen at home or at the workplace). If women have raised CO levels and are non-smokers environmental exposure from a source in the home should be considered and the women should be advised to contact the Gas Emergency Line on 0800 111 999 for further advice. Referral for further medical advice should be sought if symptoms are consistent with CO poisoning. For NICE guidance on air pollution and vulnerable groups see recommendation 1.7.7. in NICE guidance NG70.

Tobacco dependence treatment: Following an initial appointment where a quit is initiated, weekly face-to-face appointments with the tobacco dependence adviser should take place for at least four weeks after the quit date is set followed by regular appointments (as required, but as a minimum monthly) throughout the pregnancy. Treatment includes behavioural support and a combination of long and short acting NRT. A recommended delivery model pathway is available on the Prevention Programme's NHS Futures webpages.

Recording data: There should be routine recording of the CO test result and smoking status for each pregnant woman on maternity information systems (MIS), reporting through to the tobacco dependence patient level collection and, where appropriate, the Maternity Service Data Set (MSDS).

Review and act upon local data: Use tools available (for example, the Maternity Services Dashboard's Clinical Quality Improvement Metrics) to review the current situation with smoking and data quality, compare with other nearby or demographically similar Trusts and identify if your Trust is an outlier and/or where improvements can be made.

Vaping: The Royal College of Midwives states that "If a pregnant woman who has been smoking chooses to use an e-cigarette (vaping) and it helps her to quit smoking and stay smokefree, she should be supported to do so". There is also more information available via the Smoking in Pregnancy Challenge Group.

Systemwide action: Action to help pregnant women stop smoking should be supplemented by wider activity across the local system to reduce smoking rates among women, partners and other household or family members. This includes reducing smoking rates in women pre-conception, in addition to working with neonatal care and health visiting services to ensure there are links with local stop smoking services to support quitting postnatally. Local tobacco control networks alongside LMNSs, ICSs and regional teams should be able to support with integrating activity to reduce smoking prevalence in all population groups which can impact on reducing maternal smoking.

Implementation resources

Resources: The NHS Long Term Plan delivery model for smokefree pregnancy provides details of the pathway and treatment programme that should be delivered in this element. This can be found on the FutureNHS webpages with additional resources and shared materials.

Information and links to further resources are also available from the Maternal and Neonatal Health Safety Collaborative. Action on Smoking and Health (ASH) produce annual briefings for Integrated Care Systems showing the impact of smoking, using data at ICS level. The briefings include national data on maternal smoking and other clinical areas broken down to ICS level, and signpost to current resources and information.

The Smoking in Pregnancy Challenge Group produces a range of resources and information for health professionals working to reduce maternal smoking. Those with an interest can also join the Smokefree Pregnancy Information Network administered by ASH, which will provide up to date information throughout the year. For more information contact admin@smokefreeaction.org.uk.

Training - tobacco dependence adviser: Those providing tobacco dependence treatment interventions are specialist advisers and should have successfully completed NCSCT stop smoking practitioner training (or local training to the to the required NCSCT Standard) and a speciality course for smoking in pregnancy (requires registration and log-in) including opportunities to observe good practice; to ensure they have the knowledge and skills to deliver the treatment. Tobacco dependence advisers should receive annual refresher training. NCSCT derived competency frameworks are also available on NHS Futures.

Training - all maternity health professionals: All multidisciplinary staff providing maternity care for pregnant women should receive training on how to use a CO monitor (see CO testing section), the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection). Annual refresher training should align with the Core Competency Framework. Very Brief Advice on smoking in pregnancy training can be accessed via NCSCT e-learning or HEE eLearning for Health Hub.

Element 2: Fetal Growth: Risk assessment, surveillance, and management

Element description
Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).
Interventions
Reduce the risk FGR where possible. 2.1 Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm agreed with the local ICSs. 2.2 Recommend vitamin D supplementation to all pregnant women using an appropriate algorithm agreed with the local ICS. 2.3 Assess smoking status and manage findings as per Element 1. **Monitor and review the risk of FGR throughout pregnancy.** 2.4 Perform a risk assessment for FGR by 14 weeks gestation using an agreed pathway (for example, Appendix D). In multiparous women risk assessment should include the calculation of previous birthweight centiles. The pathway and centile calculator used should be agreed by both the local ICSs and the regional maternity team. 2.5 During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff. No single provider is recommended, but technology platforms should not prevent compliance with Element 2 guidance and should follow national recommendations on the use of fundal height and fetal growth charts. 2.6 As part of the risk assessment for FGR blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy 2.7 Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation. 2.8 The risk of FGR should be reviewed throughout pregnancy and maternity providers should ensure that processes are in place to enable the movement of women between risk pathways dependent on current risk. 2.9 When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care. 2.10 Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation. Measurements should be plotted or recorded on charts by clinicians trained in their use. 2.11 Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement. 2.12 Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. FH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk (e.g., recurrent reduced fetal movements). 2.13 Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery (see RCOG guidance and Appendix D) **Provide the correct surveillance when FGR is suspected and delivery at the right time.**

2.14 When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements (see Element 3) and if required computerised CTG (cCTG). A maternal assessment should be performed at each contact this should include blood pressure measurement using a digital monitor that has been validated for use in pregnancy and a urine dipstick assessment for proteinuria. In the presence of hypertension NICE guidance on the use of PlGF/sflt1 testing should be followed.

2.15 Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks. Maternity care providers caring for women with early FGR identified prior to 34+0 weeks should have an agreed pathway for management which includes fetal medicine network input (for example, through referral or case discussion by phone). Further information is provided in Appendix D.

2.16 When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed with local ICSs following advice from the provider's Clinical Network and/or regional team.

2.17 Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with local ICSs following advice from the provider's Clinical Network

2.18 All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.

2.19 In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks (see 2.20)

2.20 Fetuses who demonstrate declining growth velocity from 32 weeks' gestation are at increased risk of stillbirth from late onset FGR. Declining growth velocity can occur in fetuses with an EFW >10th centile. Evidence to guide practise is limited and guidance (see Appendix D) is currently based on consensus opinion. In fetuses with declining growth velocity and EFW >10th centile the risk of stillbirth from late onset FGR should be balanced against the risk of late preterm delivery. In infants where declining growth velocity meets criteria (see Appendix D) delivery should be planned from 37+0 weeks unless other risk factors are present. Risk factors that should trigger review of timing of birth are: reduced fetal movements, any umbilical artery or middle cerebral artery Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. Opinion on timing of birth for these infants should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability.

Continuous learning

Learning from excellence and error, or incidents

2.21 Trusts should determine and act upon all themes related to FGR that are identified from investigation of incidents, perinatal reviews, and examples of excellence.

2.22 Trusts should provide data to their Boards and share this with their ICS in relation to the following:

a) Percentage of babies born <3rd birthweight centile >37+6 weeks' gestation.
b) Ongoing case-note audit of <3rd birthweight centile babies not detected antenatally and born after 38+0 weeks, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur).
c) Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies.
d) Percentage of babies >3rd birthweight centile born <39+0 weeks gestation

2.23 Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality report and report to their ICS on actions taken to address any deficiencies identified.

2.24 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.

2.25 Individual Trusts should provide data on the distribution of FGR outcomes with relation to maternal reported ethnicity.

2.26 Maternity providers are encouraged to focus improvement in the following areas:

a) Appropriate risk assessment for FGR and other conditions associated with placental dysfunction and robust referral processes to appropriate care pathways following this.
b) Appropriate prescribing of aspirin in line with this risk assessment in women at risk of placental dysfunction.
c) Review of ultrasound measurement quality control. Trusts are encouraged to comply with BMUS guidance on audit and continuous learning with relation third trimester assessment of fetal wellbeing
d) Trusts will share evidence of these improvements with their Trust Board and ICS and demonstrate continuous improvement in relation to process and outcome measures.

Process indicators	Outcome indicators
2a. Percentage of pregnancies where a risk status for FGR is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where an SGA fetus is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital.	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of babies >3rd birthweight centile born <39+0 weeks gestation

2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).	

Rationale

There is strong evidence linking undiagnosed FGR to stillbirth [7,8]. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely birth of the baby.

Update for version 3

The previous versions of this element have made a measurable difference to antenatal detection of FGR across England. The last version resulted in the widespread uptake of uterine artery Doppler screening for the first time outside of tertiary centres in England and a significant improvement in the quality of care provided to pregnant women in all types of maternity setting. By introducing more nuanced risk assessment we have sought to reduce intervention whilst maintaining the focus on delivering babies at risk. In this version we seek to clarify this further so that all members of staff caring for women have clear, practical guidance. Our new title **"Fetal Growth: Risk assessment, surveillance, and management."** reflects this.

Important changes in this update

- Following a review by the Chief Scientific Office only digital measurement of blood pressure is now recommended for risk assessment and monitoring of FGR.
- The previous definition of suboptimal fetal growth of <20g/day in the late third trimester has been too didactically interpreted and has therefore been removed. A prospectively tested method of identifying suboptimal fetal growth in babies >10th centile remains elusive so suggestion for replacement is contained within Appendix D.
- National guidance from RCOG on FH and EFW charts remains awaited so Trusts may continue to use a range of charts. However, charts that are appropriate for plotting EFW and birthweight are recommended for reporting to reduce discrepancies.

The risks and benefits of early term delivery

It is well recognised that preterm birth is associated with both short and long-term sequelae for the infant. The distinction between preterm and term birth is based on the 37+0-week threshold. However, like any threshold on a continuous scale, the separation into two groups is arbitrary. Some of the risks associated with preterm birth are still apparent at 'early term' gestation, defined as 37 and 38 weeks. The

association with short term morbidity can be captured by analysing the risk of admission of the infant to the neonatal unit. Stock et al[9] compared the risk of neonatal unit admission associated with induction of labour at the given week with the comparison group of all women delivered at a later week of gestation.

Figure 3: Neonatal unit admission according to week of gestational age, comparing induction of labour versus expectant management[10].

• **Week of gestational age**	• **Neonatal admission per 1,000**		• **Adjusted odds ratio (95% CI)**
•	• Induction of labour	• Delivered later	•
• **37**	• 176	• 78	• 2.01 (1.80-2.25)
• **38**	• 113	• 74	• 1.53 (1.41-1.67)
• **39**	• 93	• 73	• 1.17 (1.07-1.20)
• **40**	• 80	• 73	• 1.14 (1.09-1.20)
• **41**	• 66	• 84	• 0.99 (0.93-1.05)

Delivery of the baby early prevents the subsequent risk of antepartum stillbirth. As antepartum stillbirth is the major single cause of perinatal death at term, earlier delivery will prevent perinatal death. Stock et al also reported data on the risk of extended perinatal mortality associated with earlier induction.

Figure 4: Extended perinatal mortality according to week of gestational age, comparing induction of labour versus expectant management[11].

• **Week of gestational age**	• **Extended perinatal mortality per 1,000**		• **Adjusted odds ratio (95% CI)**
•	• Induction of labour	• Delivered later	•
• **37**	• 0.9	• 2.3	• 0.15 (0.03-0.68)
• **38**	• 0.8	• 2.0	• 0.23 (0.09-0.58)
• **39**	• 0.6	• 1.9	• 0.26 (0.11-0.62)
• **40**	• 0.8	• 1.8	• 0.39 (0.24-0.63)
• **41**	• 0.7	• 2.2	• 0.31 (0.19-0.49)

Early term delivery reduces the risk of a very rare but serious adverse event (stillbirth or neonatal death) while increasing the risk of much more common but less severe adverse events. Decision-making balances the risks of causing mild harm to relatively large numbers of infants in order to prevent serious harm to a relatively small number. For example, using the data above, at 37 weeks, 10 inductions will lead to one additional baby being admitted for neonatal care, but it will require more than 700 inductions to prevent each perinatal death. Hence, current care is aimed at targeting early term induction to those who are at increased risk of perinatal death.

Implementation

Element 2 recognises that there remains a range of expert opinions on some interventions and allows some flexibility in the choice of pathways. The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed with local ICSs following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.

To implement this element effectively Trusts should:

- ensure that all pregnant women are assessed for their risk of placental dysfunction with the associated potential for FGR in early pregnancy.
- ensure that a robust training programme and competency assessment is included in any processes designed to detect an FGR fetus, for example measurement of FH, use and interpretation of charts, ultrasound scanning for growth and uterine artery Doppler measurement to detect early onset FGR.
- agree which charts will be used antenatally to measure fetal growth and ensure that these charts are based on EFW reference ranges.
- Electronic ultrasound database and MIS suppliers should provide EFW centile charts and birthweight centile charts with reference curves for the 3rd and 10th centiles. Providers using paper EFW centile charts and birthweight centile charts should ensure that the charts have reference curves for the 3rd and 10th centiles. Actual birthweight of the baby should be assessed using the same methodology used antenatally i.e., based on EFW reference, not a birthweight reference scale to ensure consistency.

The RCOG SGA guideline[12] advises that fetal biometry surveillance scans need not be performed more frequently than every three weeks unless potential abnormalities in fetal growth are identified, in which case scans may need to be performed more frequently (see intervention 2.7). Ultrasound surveillance of biometry in at risk fetuses should continue until delivery.

Providers with capacity may wish to use assessment of Middle Cerebral Artery (MCA) Doppler pulsatility indices (PI) in addition to umbilical artery Doppler to help identify and act upon potential fetal compromise in later pregnancy (after 34+0 weeks), but evidence to guide practise is in development.

Version two of the MSDS enables the recording of antenatally detected SGA using local criteria and the recording of fetal biometry, EFW and birthweight. Providers that submit these data via MSDS will be able to compare their performance with peer organisations.

Trusts submitting data to the MSDS will be able to view the percentage of <10th centile and <3rd centile births in each gestational week of the third trimester in their unit annually. These data will allow Trusts to compare outcomes with similar units and to monitor the performance of their SGA and FGR detection programmes over time.

Element 3: Raising awareness of reduced fetal movement.

Element description
Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.
Interventions
3.1 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet available in multiple languages) on RFM, based on current evidence, best practice and clinical guidelines, to be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact. 3.2 Use provided checklist (on page 33) to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG Green-Top Guideline 57). *
Continuous learning
3.3 Maternity care providers should examine their outcomes in relation to the interventions and trends and themes within their own incidents where the presentation and/or management of RFM is felt to have been a contributory factor. 3.4 Maternity care providers should ensure whether inequalities (particularly relating to ethnicity and deprivation) are being adequately addressed when there are incidents relating to presentation with or management of RFM. 3.5 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 3.6 Maternity providers are encouraged to focus improvement in the following areas: a) Signposting to information regarding RFM to pregnant women by 28+0 weeks of pregnancy. b) Appropriate care according to local guidance in relation to risk stratification and ongoing care for women presenting with RFM. c) Ensuring appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks).

Process indicators	Outcome indicators
3a. Percentage of women who attend with RFM who have a computerised CTG. 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth.	3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation.

Rationale

Enquiries into stillbirth have consistently described a relationship between episodes of RFM and stillbirth, ranging from the 8th CESDI report published in 2001[13] to the MBRRACE-UK reports into antepartum and intrapartum stillbirths respectively[14 15] . In all these case reviews, unrecognised or poorly managed episodes of RFM have been highlighted as contributory factors to avoidable stillbirths. In addition, a growing number of studies, including an individual patient data meta-analysis have confirmed a correlation between episodes of RFM and stillbirth [16 17]. This relationship increases in strength when women have multiple episodes of RFM in late pregnancy (after 28 weeks' gestation). While there is not a nationally agreed definition of what recurrent RFM means; one region has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation*. The relationship between RFM and stillbirth appears to be mediated by placental insufficiency[18,19,20].

This element and its interventions are aligned with the RCOG Green-Top Guideline 57 which is the best evidence summary and set of recommendations to date. A revision of the Green-Top Guideline will be completed in 2023.

Implementation

A systematic review found that interventions for encouraging awareness of fetal movement were associated with a reduction in perinatal death, neonatal intensive care unit admissions and Apgar scores of <7 at 5 minutes of age and were not associated with increases in caesarean births or induction of labour. The effect of encouraging fetal movement awareness or clinical management of RFM on stillbirth is uncertain.

It is possible that altering clinical management after RFM will cause an increase in ultrasound scans and obstetric intervention, such as induction of labour and caesarean birth. The AFFIRM study found that a care package which recommended all women have an ultrasound assessment of fetal biometry, liquor volume and umbilical artery Doppler following presentation with RFM after 26 weeks' gestation and offered induction of labour for recurrent episodes of RFM after 37 weeks' gestation did not significantly reduce stillbirths but was associated with an increase in induction of labour and caesarean births. However, this care pathway reduced the number of SGA babies born at or after 40 weeks' gestation.[21] Other studies found raised awareness of fetal movements, with no mandated management package, did not increase caesarean births.[22 23]

There are no trials of computerised CTG (cCTG) following presentation with RFM. However, cCTG is recommended as this provides an objective assessment of fetal wellbeing and may be completed more quickly than conventional CTG. If a cCTG has been performed and is normal and there are no other indications for an ultrasound

scan, then a scan is not required for a *first* presentation of RFM but should be offered for women reporting recurrent RFM *. Computerised CTGs are recommended over and above visualised CTG due to the potential to reduce the risks of human error.[24] If an appropriate scan has been performed within the previous two weeks and was normal a repeat scan is not required.

Prior to 39 weeks' gestation, induction of labour or caesarean birth is associated with small increases in perinatal morbidity and neurodevelopmental delay. Thus, a recommendation for birth needs to be individualised and based upon evidence of fetal compromise (for example, abnormal CTG, EFW <10th centile or oligohydramnios) or other concerns (for example, concomitant maternal medical disease, such as hypertension or diabetes, or associated symptoms such as antepartum haemorrhage).

At 39 weeks' gestation and beyond, induction of labour is not associated with an increase in caesarean birth, birth with forceps or ventouse, fetal morbidity or admission to the neonatal intensive care unit. Therefore, expediting birth by induction of labour (to women for whom this is not contraindicated) could be discussed (risks, benefits and mother's wishes) with women presenting with a single episode of RFM after 38+6 weeks gestation. The patient decision aid for timing of induction of labour should be used.

It is important that women presenting with recurrent RFM* are additionally informed of the association with an increased risk of stillbirth and given the option of expediting birth (by the most appropriate route for them) for RFM alone after 39+0 weeks. Decision to offer birth should consider the timing as to whether this can be achieved within the safe capacity of the unit.

* While there is not a nationally agreed definition of what recurrent RFM means; one region has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation

Suggested Checklist for the Management of Reduced Fetal Movements (RFM)	
1. Ask	
Confirm there is maternal perception of RFM? How long has there been RFM? Is this the first episode? When were movements last felt?	
2. Act	
Auscultate fetal heart (hand-held Doppler/Pinnard) to confirm fetal viability.	
Assess fetal growth by reviewing growth chart, perform SFH if not performed within last 2 weeks (if not on an ultrasound surveillance pathway already).	
Perform CTG to assess fetal heart rate in accordance with national guidelines (ideally computerised CTG should be used).	
Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler only need to be offered on first presentation of RFM if there is an indication for scan (e.g., the baby is SGA on clinical assessment). Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation. Scans are not required if there has been a growth scan in the previous two weeks.	
In cases of RFM after 38+6 weeks discuss induction of labour with all women and offer birth to women with recurrent RFM after 38+6 weeks.	
3. Advise	
Convey results of investigations to the mother. Mother should be encouraged to re-attend if she has further concerns about RFM.	
IN THE EVENT OF BEING UNABLE TO AUSCULTATE THE FETAL HEART, ARRANGE IMMEDIATE ULTRASOUND ASSESSMENT	

Element 4: Effective fetal monitoring during labour

Element description
Effective fetal monitoring during labour.
Interventions
4.1 All staff who care for women in labour are required to undertake annual training and competency assessment on knowledge and skills required for effective fetal monitoring via Intermittent auscultation (IA) [Midwives] and electronic fetal monitoring [Midwives and Obstetricians]. 4.2 At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review. 4.3 Regular (at least hourly) systematic review of maternal and fetal wellbeing should be agreed and implemented. This should be accompanied by a clear guideline for escalation if concerns are raised using this structured process. All staff to be trained in the review system and escalation protocol. 4.4 A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier. 4.5 Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.
Continuous learning
4.6 Maternity care providers should examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor. 4.7 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 4.8 Maternity providers are encouraged to focus improvement in the following areas: a) Risk assessment of the woman/fetus at the beginning and regularly during labour. b) Interpretation and escalation of concerns over fetal wellbeing in labour.

Process indicators	Outcome indicators
4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed	4d. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[25].

Rationale

As well as reducing stillbirth rates, there is a need to reduce avoidable fetal morbidity related to brain injury causing conditions such as hypoxic-ischemic encephalopathy (HIE) and cerebral palsy. These conditions have a huge emotional and financial impact upon families. They also have significant economic consequences for the health and social care system through the costs of care needed to support those with an avoidable brain injury throughout their lives and litigation understandably brought by families when something goes wrong during labour.

The importance of good fetal monitoring during labour, in achieving birth of a healthy baby, is underlined by data from the RCOG's Each Baby Counts report, showing that fetal monitoring was identified in 74% of babies as a critical contributory factor where improvement in care may have prevented the outcome.

The report identified problems with fetal monitoring using IA, including inappropriate assignment of women to 'low risk', delays in responding to abnormalities and switching to CTG monitoring when appropriate. There was also a failure to follow national guidelines about technique and frequency of IA and a failure to recognise transition between the stages of labour.

In the case of a high-risk labour where continuous monitoring is needed, CTG is the best clinical tool available to carry this out as it is a well-established method of confirming fetal wellbeing and identification of potential fetal hypoxia. However, CTG interpretation is a high-level skill and is susceptible to variation in judgement between clinicians and by the same clinician over time[26] . These variations can lead to inappropriate care planning and subsequently impact on perinatal outcomes[27].

The RCOG's Each Baby Counts report failure to initiate CTG when indicated, failure to record a good-quality CTG, inadequate CTG interpretation and failure to communicate the findings to senior staff in a timely manner. The conclusions resulting from these findings included recommendations for:

- a regular/rolling programme of training in the use of electronic fetal monitoring.
- simple guidelines on the interpretation of electronic fetal monitoring
- clear lines of communication when an abnormal CTG is suspected.
- guidelines on appropriate management in situations where the CTG is abnormal.

Many of the findings and recommendations from the Each Baby Counts report are echoed in the 2017 MBRRACE-UK Perinatal Confidential Enquiry that focused on term, singleton, intrapartum stillbirth and intrapartum-related neonatal death. Recommendations that have now been incorporated into this element of the care bundle include the use of a risk assessment tool on admission and then throughout labour to guide the nature, frequency and interpretation of fetal monitoring, as well as determining the optimal form of training and competency assessment.

In addition, both reports identify that CTG or IA monitoring cannot be used in isolation and are only part of a complex assessment of fetal wellbeing – "*Failure to recognise an evolving problem, or the transition from normal to abnormal, was a common theme. It was rarely due to a single issue, more commonly appearing to arise from a more complex failure of situational awareness and ability to maintain an objective overview of a changing situation*" (MBRRACE-UK Perinatal Confidential Enquiry). There is, therefore, a real need for all staff to undertake multidisciplinary training that includes situational awareness, human factors, and communication. The importance of ensuring situational awareness is present in teams performing complex tasks is also highlighted in the Each Baby Counts report from 2015.

Implementation

Trusts should be able to demonstrate that all qualified staff who care for women in labour are competent to interpret IA [Midwives] and CTG [Midwives and Obstetricians] in relation to the clinical situation, use the Buddy system and escalate accordingly when concerns arise, or risks develop. This includes staff that are brought in to support a busy service from other clinical areas such as the postnatal ward and the community, as well as locum, agency, or bank staff (medical or midwifery)

Intervention 4.1: Owing to a lack of validated packages it is not possible to be prescriptive about the exact nature of either training packages or competency assessment. Principles for training packages are included in Appendix E.

However, it is recommended that all trusts 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, and ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed within the LMNS, (Ockenden, 2022).

Intervention 4.2: The MBRRACE-UK Perinatal Confidential Enquiry report recommended the national development of a standardised risk assessment tool. As this is not yet available the procedure should comply with fetal monitoring guidelines.

Intervention 4.3: The principle underlying this intervention is that fetal wellbeing is assessed regularly (at least hourly) during labour and documented using a structured proforma. This review should be more than recording the fetal heart rate via IA or categorisation of the CTG (Appendix E).

Intervention 4.4: A discussion between the midwife caring for the woman and another midwife or doctor should occur at least 4 hourly when undertaking IA and at least hourly when using CTG monitoring. The discussion should include the FHR (IA or CTG), review of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction, previous caesarean birth; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated (Appendix E).

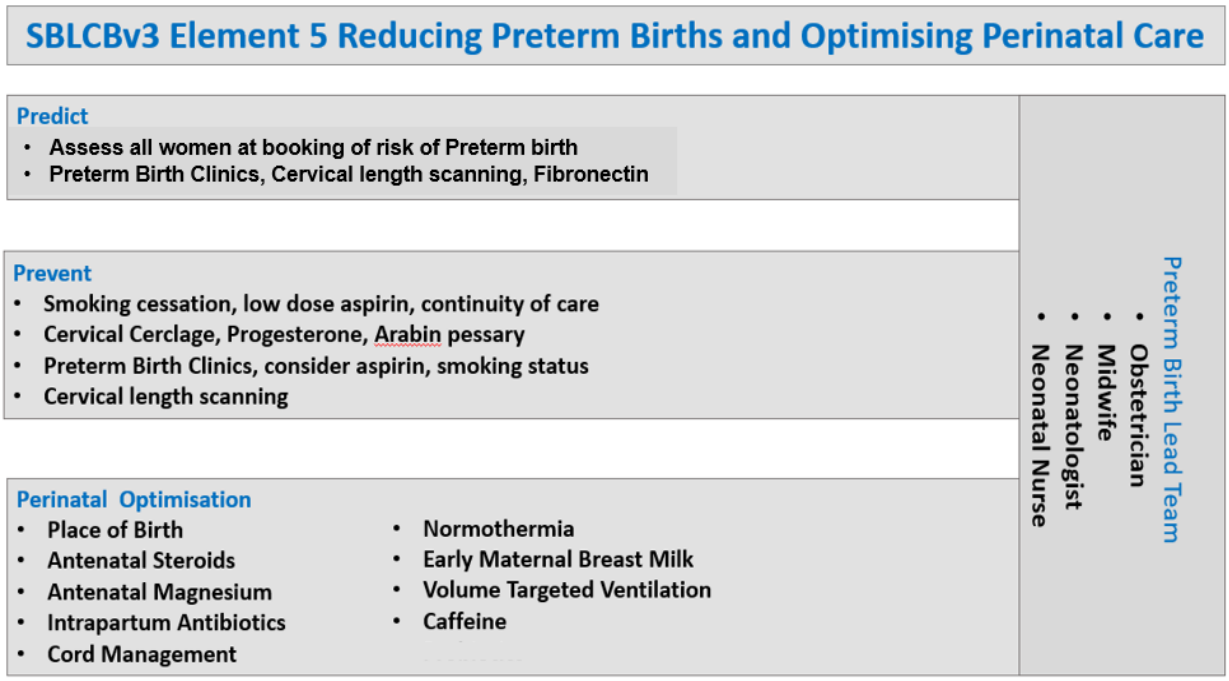
Introduce a Buddy system to pair up more and less experienced midwives during shifts to provide accessible senior advice with protocol for escalation of any concerns.

Intervention 4.5: Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Leads have dedicated time within their remit to support staff working in intrapartum care to provide high quality intrapartum risk assessments and accurate fetal heart rate interpretation using either IA or CTG. The role should contribute to building and sustaining a safety culture in intrapartum care with all staff committed to continuous improvement.

Element 5: Reducing preterm births and optimising perinatal care.

Element description

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.



Interventions

Preterm Birth Lead Team

5.1 Each provider trust should have.

a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimisation

5.2 Each Preterm Birth Lead team should have clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation, and should engage in shared learning and QI with local preterm birth clinical networks, LMNSs and neonatal ODNs.

Prediction

5.3 Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways using the criteria in Appendix F. It is recognised that there are imperfections in the predictability of preterm birth on the basis of history; the use of digital algorithms & tools (for example the Tommy's app) may also be useful to support assessment.

5.4 In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUiPP) to improve predictive accuracy of triage and enable collaborative decision making.

5.5 Networked Trusts should agree on the use of these tools within their ICS/LMNS.

5.6 Multiple pregnancy - risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local network or ICS following advice from the provider's clinical network.

Prevention

All women:

5.7 Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks.

5.8 Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network.

5.9 Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements (and use of decision-assist tools such as the QUiPP and QUIDS apps). The use of TVCS may also be used with or without qfFN. Further advice may be sought from UK Preterm Clinical Network, BAPM, or NICE guidance).

Women at intermediate or high risk (Appendix F):

5.10 Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her.

5.11 Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.

5.12 Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation (Appendix F).

5.13 Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories. This should include access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage. These procedures are performed relatively infrequently and therefore are best provided on a supra-regional basis in order to maintain expertise.

5.14 Midwifery Continuity of Carer (MCoC) models, with a focus on individualised risk assessment and care pathways, may prevent preterm birth and save babies' lives. Ref B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

(england.nhs.uk). Local implementation plans for midwifery CoC models should ensure prioritisation of women from the most deprived groups in line with Core20+5. However, Midwifery CoC must be supported by safe staffing levels to preserve the safety of all pregnant women and families https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

Perinatal Optimisation

5.15 Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur.

5.16 Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.
In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation: *"Conversations with parents should be clearly documented and care taken to ensure that the agreed management plan is communicated between perinatal professionals and staff shifts. Decisions and management should be regularly reviewed before and after birth in conjunction with the parents; plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change."*
https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019

5.17 Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss.

5.18 Acute tocolysis may be used when short term delay is desirable i.e., in utero transfer, and probably to ensure adequate antenatal exposure to corticosteroid/magnesium sulphate (i.e. no longer than 48 hours). There is no evidence that maintenance tocolysis is beneficial when compared with no tocolysis treatment, oxytocin antagonist and calcium channel blockers appear effective in delaying birth for more than 48 hours. In the absence of any contraindications nifedipine is the preferred agent for tocolysis[2].

5.19 **Place of birth** – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth:

a) less than 27 weeks gestational age (in a singleton pregnancy)
b) less than 28 weeks gestational age (in a multiple pregnancy)
c) any gestation with an estimated fetal weight of less than 800g

should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU). Maternity services must operate in close perinatal collaboration with neonatal networks to ensure that babies predicted to require a higher level of neonatal care than can be provided in the local delivery unit are moved in utero whenever possible. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit

5.20 **Antenatal corticosteroids** should be offered to women between 22+0 (where active management is agreed) and 33+6 weeks of pregnancy, optimally at 48 hours prior to birth. A steroid-to-birth interval of greater than seven days should be avoided if possible. and repeat courses of steroids should be avoided where possible. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit

5.21 **Magnesium sulphate** to be offered to women between 22+0 (where active management is agreed) and 29+6 weeks of pregnancy - and considered for women between 30+0 and 33+6 weeks of pregnancy - who are in established labour or are having a planned preterm birth within 24 hours. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit

5.22 **Intrapartum antibiotics** All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis (Benzylpenicillin, where not contraindicated) to prevent early onset neonatal Group B Streptococcal (GBS) infection irrespective of whether they have ruptured amniotic membranes. This excludes planned caesarean births without labour. NB – this intervention should be considered up to 36+6 weeks.

5.23 **Cord Management** Babies born at less than 37 weeks gestational age should have their umbilical cord clamped at or after one minute after birth – this can have benefits for all babies. Perinatal multidisciplinary teams should work together to ensure this can reliably be delivered at all births. https://www.bapm.org/pages/197-optimal-cord-management-toolkit

5.24 **Normothermia** Babies born at less than 37 weeks gestational age should have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. Neonatal normothermia can have benefits for all babies. https://www.bapm.org/pages/105-normothermia-toolkit

5.25 **Early maternal breast milk** (MBM) Babies born below 37 weeks gestational age should receive their own mother's milk, ideally within 6 hours, but aiming always within 24 hours of birth (except in rare situations where there are contraindications to MBM). Perinatal teams should work together to ensure consistent delivery of antenatal advice about MBM, with support (equipment, education, help) for mothers to express within two hours of birth. https://www.bapm.org/pages/196-maternal-breast-milk-toolkit

5.26 **Volume-Targeted Ventilation** For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes.
**NB – For preterm babies who do not need invasive ventilation, consider nasal CPAP or nasal high-flow therapy as the primary mode of respiratory support.*
https://www.nice.org.uk/guidance/qs193/chapter/Quality-statements

https://www.gettingitrightfirsttime.co.uk/medical-specialties/neonatal-intensive-care/

5.27 **Caffeine** For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth
https://www.nice.org.uk/guidance/qs193/chapter/Quality-statements
https://www.gettingitrightfirsttime.co.uk/medical-specialties/neonatal-intensive-care/

Continuous learning & improvement

5.28 All providers are encouraged to draw upon the learning from the four BAPM toolkits and a range of resources from other successful regional current programmes (e.g., PERIPrem resources, MCQIC)

a) https://www.bapm.org/pages/104-qi-toolkits
b) https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/
c) https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-programmes-of-work/maternity-and-children-quality-improvement-collaborative-mcqic/neonatal-care/
d) https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/

5.29 Maternity & Neonatal care providers should determine and act upon all themes related to preterm birth that are identified from investigation of incidents, perinatal reviews and examples of excellence, particularly focusing on prediction, prevention, preparation and perinatal optimisation, including:

a) Risk assessment of women in their first pregnancy for the risk of preterm birth and timely triage to the appropriate care pathway.
b) Management of women at high risk of preterm birth, including appropriate cervical length surveillance and use of cervical cerclage.
c) Implementation of optimisation interventions as a whole **preterm perinatal optimisation** pathway, including measurement and reporting of overall optimisation pathway compliance

5.30 Maternity & Neonatal care providers should demonstrate continuing improvement by regular reassessment of the process and outcome indicators below. These data can be accessed through a number of national and network level data sources including the National Neonatal Audit Programme (NNAP) and Neonatal ODN data. Data completeness via electronic maternity and neonatal record systems is vitally important, and data quality should be monitored frequently. Provider Trusts should seek to support data quality assurance, including support for data clerk or data manager time.

5.31 **Benchmarking:** Maternity & Neonatal care providers should examine their process and outcome indicators in relation to similar provider Trusts to understand variation and inform potential improvements.

5.32 **Sharing learning & improvement:** The preterm birth teams (see 5.1) within each Maternity & Neonatal care provider setting should:

a) Review and share their process and outcome indicator data across the perinatal team on a regular basis (at least quarterly) to drive continual improvement.
b) Share process and outcome indicator data, and evidence of improvement with their Maternity & Neonatal Board level safety champions, LMNS (Local Maternity & Neonatal System) and ICS (Integrated Care System) quality surveillance teams on a quarterly basis.

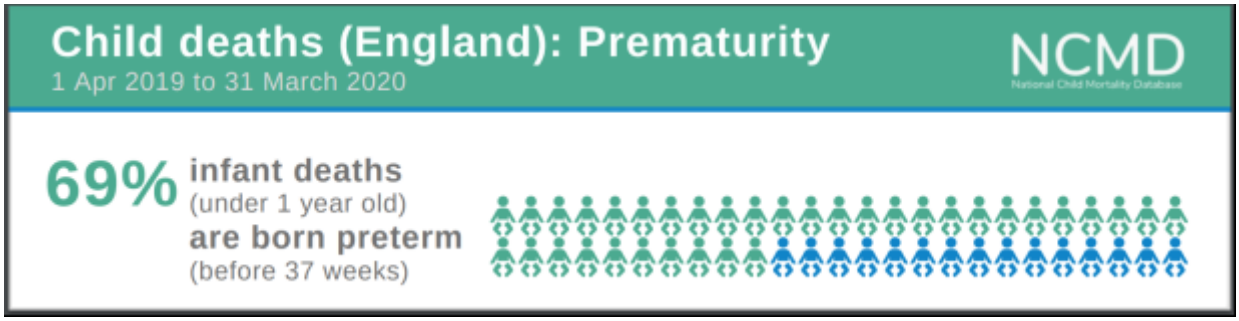
Process indicators	Outcome indicators
5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU) 5b. Percentage of women giving birth before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of women giving birth before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation) *To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section the use of volume targeted*	5i. **Mortality to discharge in very preterm babies** (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner) 5j. **Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: a) Germinal matrix/ intraventricular haemorrhage b) Post haemorrhagic ventricular dilatation. c) Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (from 16+0 to 23+6 weeks). b) preterm (from 24+0 to 36+6 weeks).

Process indicators	Outcome indicators
ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets	

Rationale

- Preterm birth (PTB), defined as birth at less than 37+0 week's gestation, is a common complication of pregnancy, comprising around 8% of births in England and Wales[28]. Prematurity is the most significant cause of mortality in children under five and is associated with significant morbidity in surviving infants. PTB is estimated to cost health services in England and Wales £3.4bn per year[29] .

Figure 5: https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf



- The NHS Long Term Plan has an ambitious goal to reduce stillbirth, neonatal mortality and serious brain injury by 25% by 2020, and 50% by 2025 *NHS Long Term Plan. NHS England January 2019. [available from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf* This has been further developed in *'Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps'* where the Government made it clear that 'we will not achieve the national Maternity Safety Ambition [to halve the rates of stillbirths, neonatal and brain injuries that occur during or soon after birth by 2030] unless the rate of preterm births is reduced' and set an additional ambition to reduce the national rate of preterm births from 8% to 6%. The current scope of NICE preterm guidelines is limited principally to acute presentation[30] [31], and this document specifies those at-risk populations

who should be targeted for additional referral and management to meet this ambition. It is anticipated that the rapidly expanding evidence base in this field will contribute to these evolving guidelines, and the UK Preterm Clinical Network guidance document will be updated periodically and this will be an open access document.

- There are evidence-based perinatal interventions to reduce the risk of preterm mortality or serious brain injury. Perinatal optimisation refers to the process of reliably delivering these evidence-based interventions in the antenatal, intrapartum and neonatal period to improve preterm outcomes.
- UK audit data show there is variable uptake in these interventions with wide variability between units and networks [Ref NNAP 2020 *National Neonatal Audit Programme. 2022. Annual Report on 2020 Data: Royal College for Paediatrics and Child Health; 2022 [Available from: https://www.rcpch.ac.uk/resources/national-neonatal-audit-programme-annual-report-2020*] .
- The British Association of Perinatal Medicine has released a series of QI toolkits to support implementation of this perinatal optimisation pathway. *https://www.bapm.org/pages/104-qi-toolkits*

Implementation

All the elements within SBLCBv3 address iatrogenic preterm and early term birth, recognising the need to ensure that any decision for birth is based on evidence of maternal and/or fetal compromise. This element focuses on reducing spontaneous preterm birth via prediction, prevention, and preparation. This will need to be done in the context of a strong perinatal team including neonatology, obstetrics, and midwifery. https://www.bapm.org/resources/building-successful-perinatal-teams-doc

- The Preterm Birth Lead Team (see 5.1) should provide leadership and oversight of the implementation of Element 5 of SBLCBv3.

- Providers should have provision for care for women at risk of preterm birth ideally within a preterm birth prevention clinic with midwifery support and access to risk assessment tests, including transvaginal cervix scanning and quantitative fetal fibronectin and potential interventions, for example, cervical cerclage, pessary, and progesterone. Where preterm birth prevention clinics are not available providers should ensure that women are able to access care that guarantees that they are given evidence-based information, access to risk assessment tests and interventions as appropriate and can actively

participate in decisions regarding their management.

- Providers should have access to supra-regional prevention services within their care pathways and networks, which include access to high vaginal and transabdominal cerclage.

Further guidance regarding the implementation of this Element, and care of women and their babies at risk of preterm birth can be found at:

- https://www.bapm.org/pages/104-qi-toolkits
- https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/
- https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-programmes-of-work/maternity-and-children-quality-improvement-collaborative-mcqic/neonatal-care/
- https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/
- https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019.
- NICE Guideline NG25 'Preterm labour and birth'
- NICE Diagnostics Guidance DG33 'Biomarker tests to help diagnose preterm labour in women with intact membranes'
- Ockenden Report (2022) Element 9 accessible at https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions
- UK Preterm Clinical Network 'Reducing Preterm Birth: Guidelines for Commissioners and Providers'

Appendix F includes a suggested risk assessment and management algorithm that providers may wish to adopt.

Element 6: Management of Pre-existing Diabetes in Pregnancy

Background and rationale for introducing management of Diabetes in pregnancy into the SBLCB.

Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. Contemporary annual data from the mandatory National Pregnancy in Diabetes audit (NHS Digital) (Lancet D&E 2021) in England & Wales shows that perinatal loss in diabetes is 4-5 times higher than the background population: In women with Type 1 diabetes, stillbirth occurs in 10.4 per 1000 livebirths and stillbirths, with neonatal death occurring in 7.4 per 1000 livebirths; In women with Type 2 diabetes it is even higher – stillbirth occurs in 13.5 per 1000 livebirths and stillbirths, with neonatal death occurring in 11.2 per 1000 livebirths. The risk of perinatal mortality is highest in women who are the most socioeconomically deprived (increased 2-fold) and those who have suboptimal glucose control in the third trimester (increased 3 fold). As women with diabetes are more socioeconomically deprived and more likely to be of South Asian and Black ethnicity than pregnant women without diabetes, there is an urgent need to address these inequalities.

Introducing management of Diabetes into the SBLCB allows us to do this in two key ways:

- Ensuring there are standard pathways of care for MDT management of these women throughout pregnancy, with increased access to expert and 'joined-up' support for their complex care needs.
- Improving management of glucose control during pregnancy by focusing support on high-risk women who are not achieving safe pregnancy glycaemic targets and by ensuring consistent and high levels of uptake of digital glucose monitoring technology to facilitate this.

The recent Ockenden report has highlighted the need for continuity of experienced staff within Diabetes in Pregnancy teams to reduce poor outcomes in women with diabetes.

The recent MBBRACE report has highlighted the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA).

Element description

Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (e.g., continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Interventions

6.1 Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.

6.2 Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) and be provided with appropriate education and support to use this.

6.3 Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved.

6.4 Women with diabetes should have an HbA1c measured at the start of the third trimester and those with an HbA1c above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.

Green	HbA1c 43 mmol/mol or less	Continue current care
Amber	HbA1c 44-48 mmol/mol	Consider additional input to improve glucose management
Red	HbA1c more than 48 mmol/mol	MDT discussion required. Offer additional input to improve glucose management including alternative methods of monitoring treatment. Offer increased fetal surveillance, and re-discuss increased risk of stillbirth, birth and neonatal complications.

6.5	Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e., PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic. In circumstances where regular travel to a tertiary clinic is not possible, ongoing care should be planned via regular (4-6 weekly) MDT discussion with the MMC centre throughout the pregnancy.
6.6	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.
Continuous learning	
6.7	Maternity care providers involved in the care of women with type 1 and type 2 diabetes should examine their outcomes in relation to all themes related to these women. These include risk assessment and management in the antenatal and intrapartum period.
6.8	Maternity care providers who look after women with type 1 and type 2 diabetes in pregnancy should submit data to the NPID audit, review their submissions and develop an action plan to address ongoing challenges.
6.9	Individual Trusts should examine their outcomes in relation to other Trusts caring for women in pregnancy with type 1 and type 2 diabetes and engage with wider regional and national Diabetes Clinical networks to share examples of good practice and work collaboratively to address challenges.
6.10	Individual Trusts should actively gather feedback from service users about their care, and co-produce guidance and proposed care pathways with Maternity Voices Partnerships (MVP) members with ‘lived experience’.
6.11	All cases of perinatal death in women with diabetes, or where diabetes is considered to be a possible contributory factor, should be reviewed by a multidisciplinary team which includes members with expertise in the care of women with diabetes in pregnancy. Learning from these case reviews should be disseminated as appropriate and an action plan developed to reduce the risk of recurrence.
6.12	Any pregnancies where CGM or HbA1C was not offered in line with the recommendations should be subject to case review to determine service-level issues which could be addressed.

Process indicators	Outcome indicators
6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. 6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with CGM training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise.	6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the NPID dashboard (aiming for >95% of women) 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women) *Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.*

Reducing perinatal mortality in pregnancies complicated by diabetes.

This element provides a practical approach to reducing perinatal mortality in pregnancy affected by Type 1 or Type 2 diabetes, by implementing multidisciplinary team pathways and an intensified focus on glucose management within maternity settings in line with the NHS Long Term Plan and NICE guidance. It focuses on demonstrating clear multidisciplinary pathways to provide a dedicated, integrated service for addressing complex needs (and thereby mitigate risk for poor pregnancy outcome). Furthermore, as glucose is the most significant modifiable risk factor for poor pregnancy outcome in pregnancies complicated by diabetes, the element includes: clear documentation of assessing glucose control digitally; using HbA1c to risk stratify and provide additional support/surveillance (National Diabetes Audit data); and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control (NICE and NHS plan).

Appendix A: Acknowledgments

NHS England would like to thank the following contributors to the development of the elements of this care bundle:

Saving Babies' Lives Care Bundle Steering Group

Name	Organisation
Matthew Jolly (chair)	NHS England
Tony Kelly	NHS England
Donald Peebles	University College London/NHS England
Gordon Smith	University of Cambridge
Katie Morris	British Maternal & Fetal Medicine Society
Basky Thilaganathan	St George's, University of London and Royal College of Obstetricians and Gynaecologists
Jo Locker	Office of Health Improvement and Disparities
Martyn Willmore	Office of Health Improvement and Disparities
Julia Robson	Office of Health Improvement and Disparities
Alex Heazell	University of Manchester
Tim Draycott	Royal College of Obstetricians
Nigel Simpson	University of Leeds and Leeds Teaching Hospital NHS Trust
Sarah Bates	BAPM (British Association Perinatal Medicine)
Basky Thilaganathan	Royal College of Obstetricians and Gynaecologists
Chris Binnie	Service User Representative
Jane Sandal	NHS England
Charlie Podschies	NHS England
Karen Thirsk	NHS England
Sarah Winfield	The Mid-Yorkshire NHS Trust
Jenny Myers	University of Manchester
Eleanor Scott	University of Leeds and Leeds Teaching Hospital NHS Trust
Prof Helen Murphy	Professor of Medicine (Diabetes and Antenatal Care), University of East Anglia, Norwich, UK

Element 1: Reducing smoking in pregnancy.

Name	Organisation
Jo Locker (Lead)	Office of Health Improvement and Disparities
Martyn Willmore	Office of Health Improvement and Disparities
Julia Robson	Office of Health Improvement and Disparities
Matthew Jolly	NHS England
Misha Moore (Lead)	NHS England
Paul Cilia La Corte (Lead)	NHS England
Jayne Coyne	NHS England
Hannah Ellison	NHS England
Karen Thirsk	NHS England

Element 2: Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction

Name	Organisation
Ed Johnstone (lead)	University of Manchester and Manchester Academic Health Science Centre
Matthew Jolly	NHS England
Katie Morris	British Maternal & Fetal Medicine Society
Donald Peebles	University College London/NHS England
Gordon Smith	University of Cambridge
Jane Sandall	NHS England
Basky Thilaganathan	Royal College of Obstetricians and Gynaecologists

Element 3: Raising awareness of reduced fetal movement (acknowledgments TBC)

Name	Organisation
Alex Heazell (lead)	University of Manchester
Charlotte Bevan	Sands
Jane Brewin	Tommy's
Anita Dougall	Royal College of Obstetricians and Gynaecologists
Hannah Hague	Cheshire & Merseyside Strategic Clinical Network
Elizabeth Hutton	Kicks Count
Matthew Jolly	NHS England
Tony Kelly	NHS England
Katie Morris	British Society of Maternal and Fetal Medicine
Jane Munro	Royal College of Midwives
Donald Peebles	University College London/NHS England

Devender Roberts	Cheshire & Merseyside Strategic Clinical Network
Gordon Smith	University of Cambridge
Cara Taylor	Central Manchester University NHS Foundation Trust
Basky Thilaganathan	Royal College of Obstetricians and Gynaecologists

Element 4: Effective fetal monitoring during labour

Name	Organisation
Donald Peebles (lead)	University College London/NHS England
Matthew Jolly	NHS England
Tony Kelly	NHS England
Katie Morris	British Maternal & Fetal Medicine Society
Gordon Smith	University of Cambridge
Wendy Randall	West Hertfordshire Hospitals NHS Trust

Element 5: Reducing preterm births.

Name	Organisation
Anna David	University College London
Dr Elizabeth Bonney	Leeds Teaching Hospital NHS Trust
Devender Roberts (TBC)	
Katherine Simpson	Head of Midwifery & Neonatal Services, Great Western Hospital, Swindon
Sarah Bates (Lead)	BAPM (British Association Perinatal Medicine)
Andrew Shennan	Kings College London
Nigel Simpson (Lead)	University of Leeds
Matthew Jolly	NHS England
Tony Kelly	NHS England
Katie Morris	British Maternal & Fetal Medicine Society

Element 6: Management of Diabetes in pregnancy

Name	Organisation
Sarah Winfield (Lead)	The Mid-Yorkshire NHS Trust
Jenny Myers (Lead)	University of Manchester
Eleanor Scott (Lead)	University of Leeds and Leeds Teaching Hospital NHS Trust
Matthew Jolly	NHS England

Prof Helen Murphy (Lead)	Professor of Medicine (Diabetes and Antenatal Care), University of East Anglia, Norwich, UK

With additional thanks to the Maternity Transformation Programme Stakeholder Council and the Maternity Clinical Networks for their comments and feedback.

This document was produced by the NHS England National team, with particular thanks to Karen Thirsk, Rachel Vollans and Charlie Podschies.

Appendix B: Detailed safe and healthy pregnancy messages

There are numerous causes of stillbirth, many of which are poorly understood. *MBRRACE-UK* highlights that stillbirth and neonatal mortality rates are higher in women from Black, Asian and minority ethnic backgrounds, those living in areas of deprivation and twin pregnancies. Almost three-quarters of both stillbirths and neonatal deaths occur preterm therefore maternity advice and care should be focused on mitigating risk. Other at-risk groups are women with pre-existing medical conditions especially cardio-vascular disorders; diabetes, psychiatric disorders and maternal age (teenage and older women) and women living with obesity. Health professionals should consider these risk factors (as well as smoking, drinking, recreational drug-taking, oral hygiene and diet) and take appropriate action for individual women. Providing information as 'safe and healthy pregnancy' messages for all women presents an opportunity to raise awareness of pre-term birth as well as stillbirth as an uncommon but possible outcome.

This section looks at how women can help themselves and their baby. It also includes some pre-pregnancy advice, and a note on whooping cough and Covid 19 vaccination.

Background

It is unhelpful to make women feel unnecessarily anxious or judged. Key messages need to be shared sensitively with women to enable them to know what they can do to help themselves and their baby stay safer in pregnancy.

For women who are at increased risk of stillbirth, communication may be a barrier. It is important to provide information in a format and/or language that is easily accessible and understood. For non-English speaking women, it is imperative that an interpreter/translation service is utilised and family members and/or friends are not used as an alternative.

Safer Pregnancy is a website developed by Sands that carries safer pregnancy messages with links to national guidance and further information.

Safe and healthy pregnancy messages

The section below contains additional information which may support conversations with women around these safe and healthy pregnancy messages.

Pre-pregnancy

Advice point: Choose when to start or grow your family by using contraception.
Why is this important? Worse outcomes are linked to unplanned pregnancies. Also, getting pregnant again after a baby is born can happen sooner than many people realise, and too short a gap between babies is known to cause problems. Planning your pregnancy facilitates accessing pregnancy care at the right time and early booking is associated with better outcomes.
Tip: Encourage women to speak to a health professional about the range of contraception options available. Some maternity services are now offering contraception from birth (IUCD at caesarean birth) and/or on the postnatal wards.

Advice point: Consult with your GP if taking medication for long-term conditions (e.g., diabetes, hypertension, epilepsy)
Why is this important? Some medications may have to change prior to pregnancy e.g. Sodium Valporate is not recommended in pregnancy as it can cause birth defects as well as problems with baby's learning and behaviour. Outcomes are better if conditions such as diabetes; epilepsy; hypertension for example are optimised prior to conception.
Tip: GPs to ensure women of childbearing age are aware of their personal status regarding medications and pregnancy as part of medication review appointments.

Advice point: Eat healthily and be physically active to enter pregnancy at a healthy weight and maintain a healthy weight while pregnant.
Why is this important? Women who are overweight or obese before they conceive have an increased risk of complications during pregnancy and birth including an increased risk that their baby will be stillborn.
Tips: Encourage women who are overweight or have obesity to:

- speak to a health professional about how to lose weight and sustain the weight loss to enter pregnancy at a healthy weight.
- eat a balanced diet, control portion sizes and swap unhealthy food for healthier options (the Eatwell Guide may be helpful)
- be fit and healthy, try to be active daily and do at least 150 minutes of weekly physical activity, including both aerobic and strength exercises.

Advice point: Take a daily supplement of 400 micrograms (400 µg) folic acid before conception and until the 12th week of pregnancy (some women will require a higher dose of 5mg as advised by a healthcare professional).
Why is this important? Folic acid (also known as vitamin B9) is very important for the development of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida. A high proportion of women are still unaware of the recommendation to take folic acid and do not take supplements.
Tips: Encourage women to take folic acid in preparation for pregnancy

Advice point: Before pregnancy, ensure that you are protected from measles, rubella, Coronavirus (Covid 19) and Flu. Check you are vaccinated if you're thinking of becoming pregnant.

Why is this important? Maternal rubella and maternal measles infection in pregnancy may result in fetal loss or congenital rubella syndrome. Coronavirus in pregnancy is associated with a 2-3 times greater risk of pre-term birth and increased risk of stillbirth therefore vaccinations in preparation for pregnancy are strongly recommended. Coronavirus and Flu are also associated with severe illness in pregnant women causing hospital admission.

Tips: Encourage women to check with their GP that they have had two documented doses of MMR vaccine. If not, they can catch up on missing doses before becoming pregnant but should take steps to avoid pregnancy for one month following the MMR vaccination. Coronavirus vaccinations can be given at the same time as seasonal flu vaccines. There are no published studies that demonstrate an increased risk of miscarriage or problems with fertility associated with COVID-19 vaccinations.

Advice point: Find out about screening if you think you or your partner could be a carrier for a genetic disorder.

Why is this important? Some disorders can be passed from parents to their children through their genes, and these can be more common in some groups of people.

Tip: Encourage women to speak to their GP to see if they and/or their partners should be screened before becoming pregnant. Women at risk should be referred for pre-pregnancy counselling with genetic specialist.

Advice point: Stop smoking and/or exposure to second hand smoke.

Why is this important? Smoking and second-hand smoke can impact on fertility. It can take time to stop smoking so leaving it until pregnancy will be less immediate and can be less successful thus exposing the baby to greater risk. Tobacco smoke contains thousands of chemicals, and many are toxic. They can pass through the placenta to the baby and affect their development. A small baby who doesn't grow healthily has an increased chance of being stillborn. Smoking or exposure to second hand smoke also increases the likelihood of a baby being born prematurely, and that they will have health and development problems in childhood and later life.

Tips: The best thing a woman who smokes can do is stop. Find out about local stop smoking support available for women and families in your area and adopt an opt out approach to smoking cessation.

Advice point: Reduce/stop alcohol consumption in preparation for pregnancy.

Why is this important? Drinking to excess can be associated with unplanned pregnancy. Alcohol passes from the mother's blood across the placenta to the developing baby. Alcohol in the baby's blood has a direct effect on the baby and can lead to birth defects, reduced growth and effects on brain and nervous system with long-term learning and behaviour problems. It can also affect the placenta and interfere with the baby's oxygen and nutrient supply. Stillbirths are also more common in women who drink heavily. Drinking alcohol at critical times in the baby's development, heavy ('binge') drinking and frequent drinking increase the likelihood that the baby will be affected.

Tips: The simplest and safest advice for women is not to drink alcohol at all while planning to become pregnant. There are free and confidential helplines for people concerned about their, or a relative's, drinking. Drinkline 0300 123 1110. NHS UK (formerly NHS Choices) has additional options.

During Pregnancy

Advice point: Continue to take Folic Acid until the 12th week of pregnancy.
Why is this important? Folic acid (also known as vitamin B9) is very important for the development of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida. A high proportion of women are still unaware of the recommendation to take folic acid and do not take supplements.
Tips: Encourage women to continue to take folic acid until the 12th week of pregnancy

Advice point: Pregnant women should take 10µg of Vitamin D a day.
Why is this important? Pregnant women (and all adults, including breastfeeding women) are also recommended to have 10 µg of vitamin D a day. Vitamin D regulates the amount of calcium and phosphate in the body, which keeps bones, teeth, and muscles healthy. Women with BMI >25 have decreased bioavailability of vitamin D which makes these women and their babies at greater risk. Some women are more likely to need vitamin D than others, those who rarely go outside; always cover their skin; use high-factor sun block; have darker skin; have a BMI above 25.
Tips: Encourage women to take Vitamin D in pregnancy; particularly women with a greater risk of a deficiency, as above

Advice point: You may be advised to take aspirin from 12 weeks of pregnancy.
Why is this important? Low dose aspirin (150mg) from 12 weeks of pregnancy is recommended for women who are at high risk of pre-eclampsia. Aspirin is a cyclooxygenase inhibitor with anti-inflammatory and antiplatelet properties. There is no increased risk of adverse fetal or neonatal effects associated with low-dose aspirin exposure.
Tips: An accurate risk assessment is required at booking to identify women at increased risk of pre-eclampsia and ensure Aspirin prescribed from 12th Week of pregnancy.

Advice point: The safest way to ensure baby is not damaged by alcohol is not to drink while pregnant. Advice about alcohol in pregnancy can get confusing – the simplest line is to not drink alcohol at all when pregnant.
Why is this important? Alcohol passes from the mother's blood across the placenta to the developing baby. Alcohol in the baby's blood has a direct effect on the baby and can lead to birth defects, reduced growth and effects on brain and nervous system with long-term learning and behaviour problems. It can also affect the placenta and interfere with the baby's oxygen and nutrient supply. Stillbirths are also more common in women who drink heavily. Drinking alcohol at critical times in the baby's development, heavy ('binge') drinking and frequent drinking increase the likelihood that the baby will be affected.

Tips: The simplest and safest advice for women is not to drink alcohol at all while pregnant. There are free and confidential helplines for people concerned about their, or a relative's, drinking. Drinkline is a national advice line and can be contacted on 0300 123 1110.

Advice point: Stop smoking and/or exposure to second hand smoke. NHS UK (formerly NHS Choices) has additional options.

Why is this important? Smoking and exposure to second hand smoke affects the development of the baby and is associated with complications in pregnancy and poor outcomes. Smoking or exposure to second hand smoke also increases the likelihood of a baby being born prematurely. Also, smoking in pregnancy increases the risk of Sudden Infant Death (SID) https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/sleep-and-night-time-resources/co-sleeping-and-sids/ .Tobacco smoke contains thousands of chemicals, and many are toxic. They can pass through the placenta to the baby and affect their development. A small baby who doesn't grow healthily has an increased chance of being stillborn or having health and development problems in childhood and later life.

Tips: The best way for women to protect themselves and their baby is to stop smoking completely and/or reduce/stop exposure to second hand smoke. Stopping at any time in pregnancy will help, although the sooner the better as it may contribute to a low-birth weight baby. Stopping smoking early in pregnancy can almost entirely prevent any damage to the baby. Stopping smoking in early pregnancy, prior to 15 weeks, can reverse the risk of some adverse perinatal outcomes. If her partner or other household members smoke, they can support her by making efforts to give up smoking too and have a smoke-free home. Find out about local stop smoking support available for women and families in your area and adopt an opt-out approach to smoking cessation.

Advice point: If you currently use or have used illegal street drugs or other substances, it is important to tell your midwife.

Why is this important? Street drugs and other substances can be harmful to the baby during pregnancy.

Tips: A woman may be worried about sharing this information – reassure her that it will be treated in strict confidence and will only be shared with relevant health professionals if that's in the best interest of the baby. Women can contact FRANK for friendly and confidential drugs advice, including information on the different types of help available. The FRANK helpline 0300 123 6600 is open every day, 24 hours a day or Text 82111 and FRANK will text back. Healthcare professionals should support and manage the care of pregnant women who use drugs, alcohol or other substances in conjunction with referral to specialist teams (drug and alcohol) where required.

Advice point: Eat healthily and be physically active to maintain a healthy weight while pregnant.

Why is this important? Women who are overweight or are living with obesity have an increased risk of complications during pregnancy and birth including an increased risk that their baby will be stillborn. Due to the increased risks associated with obesity, birth is recommended in an obstetric unit which affects choice regarding place of birth.

Tips: While pregnancy isn't the time for a weight-loss diet, it is a good time to adopt a healthy diet, so encourage women to swap unhealthy foods for healthier options and try to keep active. Reassure women that, even during the last few months of pregnancy, they only need an extra 200 calories a day (for example, two slices of wholemeal toast or an apple and a banana). Also encourage women to do 30 minutes or more of moderate physical activity, such as walking, every day right up until the baby is born. If they are not used to exercise, then they can build up to daily exercise. If there are health reasons why they shouldn't exercise, advise them to talk to their midwife or GP.

Advice point: Maintain oral hygiene.
Why is this important? Hormone changes can increase blood flow to gum tissues, causing sensitivity, bleeding or swollen gums. This is known as pregnancy gingivitis, which has been linked to poor pregnancy outcomes, including pre-term birth and low birth weight babies.
Tips: Free dental care is available to all pregnant women and up to a year after the birth

Advice point: Have the seasonal Flu vaccination, it's safe, effective and free of charge to pregnant women.
Why is this important? Influenza is more likely to cause severe illness in pregnant women than in women of reproductive age who are not pregnant. Changes to the immune system, heart, and lungs during pregnancy make women more susceptible to influenza severe enough to cause hospitalisation throughout pregnancy and up to two weeks postpartum. A common influenza symptom, e.g., fever, may be associated with neural tube defects and other adverse outcomes for a developing baby such as perinatal mortality, prematurity, and lower birth weight. Parental vaccination also can help protect a baby from influenza after birth (because antibodies are passed to a developing baby during pregnancy)
Tips: Getting an influenza (flu) vaccine is the first and most important step in protecting against flu. Vaccination has been shown to reduce the risk of flu-associated acute respiratory infection in pregnant women by up to one-half and reduces a pregnant person's risk of being hospitalized with flu by an average of 40 percent. Pregnant women who get a flu vaccine also are helping to protect their babies from flu illness for the first several months after their birth, when they are too young to get vaccinated. Reassure women and their families that Flu vaccinations have been given to millions of people over many years with an excellent safety record.

Advice point: Have the pertussis (whooping cough) vaccination.
Why is this important? It's safe, effective, and free of charge to pregnant women. Pertussis can lead to the death of a young baby. Pregnant women can have a pertussis vaccine from 16 weeks gestation – the best time is at 16 to 32 weeks. Women may still be immunised after week 32 of pregnancy but this may not offer as high a level of passive protection to the baby. The aim of the maternal pertussis immunisation programme is to provide the baby with passive immunity to pertussis until the baby starts routine immunisations from 8 weeks of age.

Tips: You can be reassuring that vaccine containing pertussis can be safely given to pregnant women from 16 weeks gestation. It gives 90% protection against the disease and is 97% effective in preventing death from pertussis in babies less than 3 months. The mother's antibodies that are generated in response to the vaccine help protect the baby until they have their immunisations from 8 weeks of age. The baby should also complete their routine childhood immunisations on time at 8, 12 and 16 weeks of age.

Advice point: Have the Coronavirus (COVID-19 vaccination/booster

Why is this important? Women who are pregnant or were recently pregnant, are more likely to get severely ill from COVID-19 compared to people who are not pregnant. Pregnancy causes changes in the body that can make it easier to get very sick leading to increase hospital admissions, the need for ventilation in intensive care units and the requirement of extracorporeal membrane oxygenation (ECMO). There is also a higher rate of stillbirth in infected women and an increase in babies born pre-term with its associated complications. Other factors can further increase the risk of getting very sick with COVID-19: women from Black Asian and Mixed Ethnic Groups with underlying medical conditions; being older than 25 years; and living/working in communities with high numbers of COVID-19 cases/low levels of COVID-19 vaccination.

Tips: Getting a COVID-19 vaccination/ booster is the first and most important step in protecting against COVID-19. Vaccination has been shown to reduce the risk to babies born to vaccinated women of admission to neonatal units and intrauterine fetal death. There are no published studies that demonstrate an increased risk of miscarriage or problems with fertility.

Advice point: Always check with your pharmacist, midwife of doctor about medicines and therapies used in pregnancy, even if you have taken them for a long time on prescription or think they are harmless.

Why is this important? A medicine or therapy may have different effects on your body if you're pregnant. As a result, familiar medicines and therapies may not always be safe for pregnant women or their developing baby.

Tips: If medications are via prescription they should be checked by the pharmacists or doctor who prescribed it. If they are over-the-counter medications, then they should be checked with the pharmacist or midwife. If it's a complimentary or alternative therapy, check with the therapist. Not all therapies are considered safe in pregnancy e.g., some essential oils are not recommended for use while pregnant.

Advice point: Wherever possible, avoid contact with people who have infectious illnesses, including diarrhoea, sickness and childhood illnesses, such as chickenpox or parvovirus (slapped cheek) or any rash-like illness.

Why is this important? The immune system becomes weaker in pregnancy, so pregnant women are more at risk of infections. Some infections can increase the risk of stillbirth and/or maternal and perinatal complications.

Tips: Encourage women to:

- be strict about good hygiene – washing hands before and after handling food, after going to the toilet and after sneezing and blowing their nose.
- know which foods to avoid
- urgently seek advice from their GP or midwife if they have been in contact with someone who has rash-like illnesses, or if they develop a rash-like illness themselves.

Advice point: Reduce the risk of CMV (cytomegalovirus) and Toxoplasmosis infections.

Why is this important? CMV is a common virus, similar to the herpes virus that causes cold sores and chickenpox. Infection can be dangerous during pregnancy as it can cause problems for unborn babies, such as hearing loss, visual impairment or blindness, learning difficulties and epilepsy. CMV is particularly dangerous to the baby if the pregnant mother has not had the infection before. Toxoplasmosis is a common infection that is usually harmless. However, if pregnant women get toxoplasmosis for the first time when they are pregnant, or a few months before they conceive, there's a small risk the infections could cause miscarriage or stillbirth.

Tips: it is not always possible to prevent a CMV infection, but you can reduce the risk by:

- washing your hands regularly with soap and hot water, particularly if you have been changing nappies, or work in a nursery or day care centre.
- not kissing young children on the face – it is better to kiss them on the head or give them a hug.
- regularly wash toys or other items that get young children's saliva or urine on them.
- not sharing food or cutlery with young children, and not drinking from the same glass as them.

These precautions are particularly important if you have a job that brings you into close contact with young children. In this case, you can have a blood test to find out whether you have previously been infected with CMV. Find out more about CMV on the CMV Action website.

To prevent toxoplasmosis, it is recommended that gloves are worn during gardening and when emptying cat litter trays/dealing with excrement.

Advice point: Attend all antenatal appointments.

Why is this important? Some of the tests and measurements have to be done at specific times, and the midwife needs to share information as the pregnancy progresses.

Tips: The first midwife appointment (sometimes called 'booking appointment') should happen before 10 weeks. Make sure women know where the dates and times of appointments are written and what to do if they miss an appointment or can't attend.

There's an animation that describes antenatal and newborn screening for pregnant women, new mums and their families on the government website https://youtu.be/_afr5oIlpTM** and there are leaflets also available in 12 languages

http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Tip: Maternity services are staffed 24/7, and there is always someone who can speak to women on the phone.

Advice point: Contact the maternity service promptly if you are worried. Don't wait!

Tip: Maternity services are staffed 24/7, and there is always someone who can speak to women on the phone

Leaflets are also available in 12 languages
http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Why is this important? Timely action is sometimes needed (see below). Women should be aware of who to contact/when if they have concerns as it may be an acute issue that requires a prompt response for the wellbeing of the woman and/or baby. Leaflets are also available in 12 languages
http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Reasons to get in touch promptly include:

- Baby's movements have reduced, slowed down or changed.
- Bleeding from the vagina
- Watery, clear or coloured discharge from the vagina which seems different to usual.
- Signs of pre-eclampsia, such as obvious swelling, especially affecting the hands and face or upper body; severe headache that won't go away, sometimes with vomiting; problems with vision (blurring, flashing lights or spots, difficulty in focusing); and severe pain just below the ribs in the middle of the abdomen.
- Itching, particularly on the hands and feet, can be a sign of the liver disorder called intrahepatic cholestasis of pregnancy (ICP); women should contact a midwife within 24 hours if they experience itching.

Advice point: In later pregnancy (after 28 weeks), it is safer to go to sleep on your side than on your back.

Why is this important? For pregnant women, the blood flow going to the baby may be reduced or interrupted if they spend a long time lying on their back. Research has linked this with an increased risk of stillbirth.

Tips: Encourage women to settle on their side when they go to sleep or have a day-time nap, rather than on their back. A woman who wakes up on her back shouldn't worry but should settle to sleep again on her side. Find out more information about sleep positions on the Tommy's website.

Advice point: Talk to your midwife about the benefits of breastfeeding.

Why is this important? There is overwhelming evidence on the benefits of breastfeeding for babies for a wide range of different health outcomes. https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/breastfeeding-resources/off-to-the-best-start/

Tips: Maternity services have specially trained staff to provide you with advice and support with any questions, there is always someone to talk to

Appendix C: Medication to reduce the risk of pregnancy complications.

All women should take a daily supplement of 400 micrograms (400 µg) folic acid before conception and until the 12th week of pregnancy (some women will require a higher dose as advised by a healthcare professional). Women (and all adults, including breastfeeding women) are also recommended to have 10 µg of vitamin D a day.

Elements 2 and 5 of this care bundle include the assessment of pregnant women for treatment with aspirin. NICE recommends Aspirin[c] reduces the risk of pregnancy complications related to placental dysfunction, particularly preeclampsia[32]. Thus, it is important to take a full history from pregnant women who have had a previous baby with FGR and/or a preterm birth to determine whether placental dysfunction was a contributory factor. Aspirin as a preventative medication appears to be safe in pregnancy and therefore there is a substantial net benefit of daily aspirin use to reduce the risk for preeclampsia and associated preterm birth. Aspirin is therefore recommended from the first to the third trimester of pregnancy in women, following risk assessment at their pregnancy booking visit.

Dosage

There is evidence from randomised controlled trials that the dose of aspirin should be 150mg[33] from 12 weeks' gestation and may be more effective if taken at night[34]. In some circumstances this may not be appropriate and lower doses (60-75mg) may be used (for example, pregnant women with hepatic or renal disease).

[c] Although this use is common in UK clinical practice, at the time of publication, aspirin did not have a UK marketing authorisation for this indication. Community pharmacies cannot legally sell aspirin as a Pharmacy Only Medicine for prevention of pre-eclampsia in pregnancy in England. Aspirin for this indication must be prescribed. The prescriber should see the Summary of Product Characteristics for the manufacturer's advice on use in pregnancy. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

Predictive algorithms that combine a variety of risk factors to identify pregnant women at risk for preeclampsia are available. Providers should use an algorithm such as the one included in Table 1 which is based on the NICE pregnancy hypertension guideline[35]. Any other algorithm must be agreed with local commissioners (ICBs) following advice from the provider's Clinical Network.

Table 1: Clinical risk assessment for preeclampsia as indications for aspirin in pregnancy

Risk level	Risk factors	Recommendation
High	• Hypertensive disease during a previous pregnancy • Chronic kidney disease • Autoimmune disease such as systemic lupus erythematosus or antiphospholipid syndrome • Type 1 or type 2 diabetes • Chronic hypertension • Placental histology confirming placental dysfunction in a previous pregnancy	Recommend low dosage aspirin if the woman has ≥1 of these high-risk factors
Moderate	• First pregnancy • Are 40 years or older at booking. • Pregnancy interval of more than 10 years • Body mass index (BMI) of 35kg/m² or more at first visit • Family history of preeclampsia in a first degree relative • Multiple pregnancy	Consider aspirin if the woman has two or more moderate risk factors

There are a few absolute contraindications to aspirin therapy[36]. Pregnant Women with a history of aspirin allergy (for example, urticaria) or hypersensitivity to other salicylates are at risk of anaphylaxis and should not receive aspirin. There is significant cross-sensitivity between aspirin and other nonsteroidal (NSAIDS) drugs, thus aspirin is contraindicated in pregnant women with known hypersensitivity to NSAIDs. Relative contraindications to aspirin include a history of gastrointestinal bleeding, active peptic ulcer disease, other sources of gastrointestinal or genitourinary bleeding, and severe hepatic dysfunction. The decision to continue aspirin in the presence of obstetric bleeding or risk factors for obstetric bleeding should be considered on a case-by-case basis.

Appendix D: Risk assessment, surveillance pathway and management of FGR

This appendix describes a risk assessment and surveillance pathway for pregnant women at increased risk of FGR and a management pathway when a fetus has been found to be growth restricted, recognising that prior to 34 weeks this will require input from fetal medicine services. It has been designed to optimise effectiveness and minimise the scan burden on providers and recognise the potential harm caused by increased intervention in infants at only marginally increased risk of stillbirth. Trusts may wish to follow other pathways, but these should be agreed with their local ICSs and for some deviations specified in the guidance the regional maternity team.

Definition of FGR within SBLCBv3
FGR is difficult to diagnose representing those fetuses that have failed to reach their growth potential. A Delphi consensus-based definition has been used in research for both early (defined in the Delphi consensus as <32 weeks) and late onset FGR[37], but has not yet been shown to be useful in improving outcomes through intervention. Diagnosing FGR in a current pregnancy and risk assessing whether FGR existed in a previous pregnancy also present different challenge.

The following definitions are suggested to address these challenges and remain practical for most providers. It highlights that absent or reversed end diastolic flow in the umbilical artery is a feature of early onset FGR, importantly even in the absence of this feature (for example, a normal umbilical artery Doppler) after 32 weeks of gestation does not exclude growth restricted or fetal compromise.

Definition of FGR in a previous pregnancy as a risk factor: defined as any of the following:

- birthweight <3rd centile
- early onset placental dysfunction necessitating birth <34 weeks.
- birthweight <10th centile with evidence of placental dysfunction as defined below for current pregnancy.

Definition of FGR in a current pregnancy: defined as either of the following:

- EFW or abdominal circumference (AC) <3rd centile
- EFW or AC <10th centile with evidence of placental dysfunction (either):
- Abnormal uterine artery Doppler (mean pulsatility index >95th centile[38]) earlier in pregnancy (20 – 24 weeks) and/or
- Abnormal umbilical artery Doppler (absent or reversed end diastolic flow or pulsatility index >95th centile).

Suboptimal fetal growth:

- EFW or AC crossing declining by >50 centiles between two scans 14-21 days apart, >/=34 weeks gestation.

Risk assessment and screening

Early onset FGR is rare (~0.5%[73]). Most cases are associated with abnormal uterine artery Doppler indices or already present estimated fetal weight (EFW) <10th centile in the early third trimester. Thus, uterine artery Doppler can be used in the second trimester (18+0 – 24+0 weeks) to facilitate determining the risk of placental dysfunction and risk of hypertensive disorders or early onset FGR.

For pregnant women with a normal uterine artery Doppler pulsatility index (mean measurement ≤95th centile) the risk of these disorders is low and thus serial scanning for fetal biometry can be routinely planned from 32 weeks gestation.

Pregnant Women at moderate risk of FGR do not require uterine artery Doppler assessment but are still at risk of later onset FGR so require serial ultrasound assessment of fetal growth from 32 weeks.

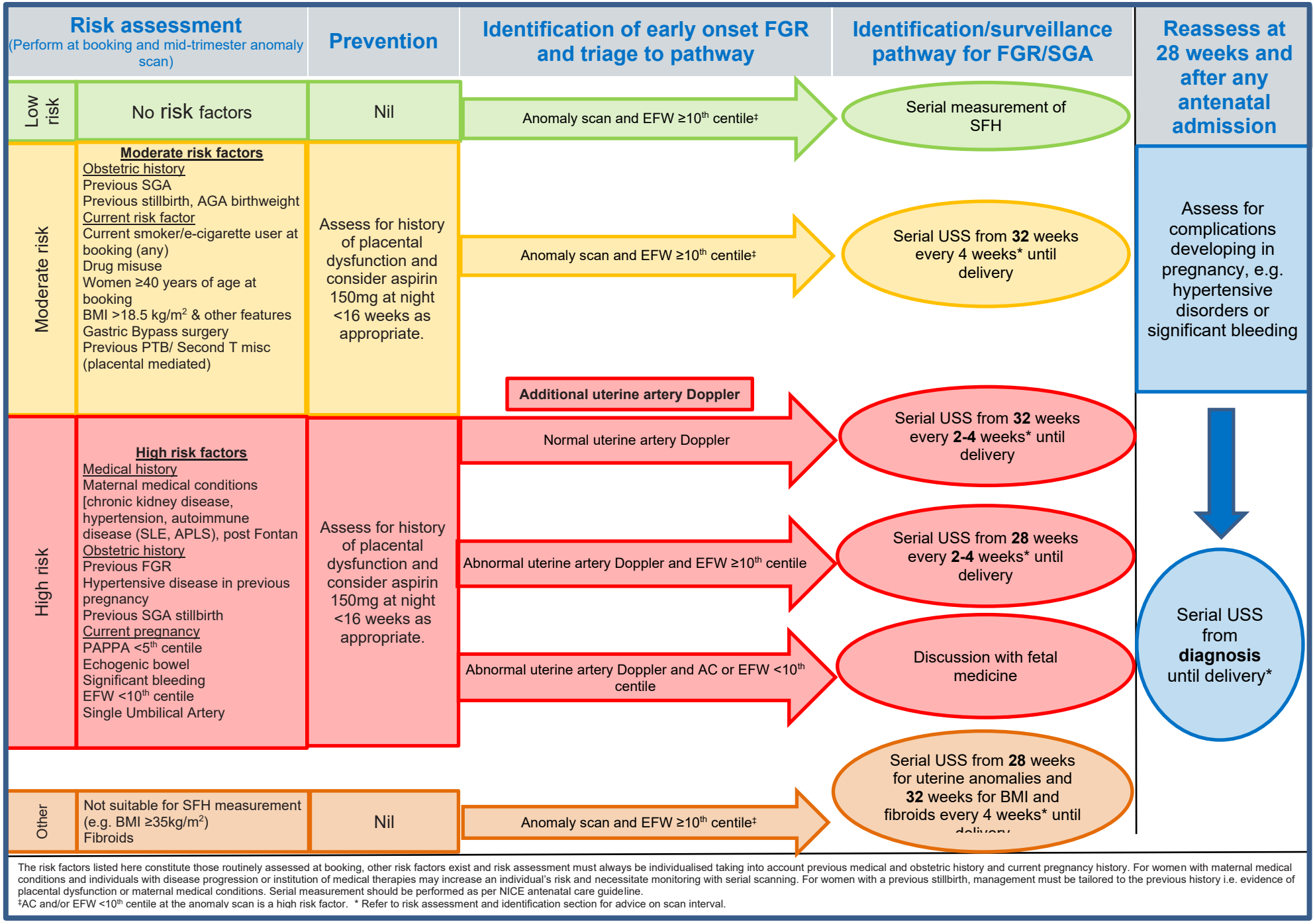
Ongoing surveillance of fetal growth should be performed at intervals between 21 – 28 days whilst fetal growth remains >10th centile. For many pregnancies in the moderate risk category or in those unsuitable for SFH measurements, an interval of four weeks is appropriate. For pregnant women in the high-risk category the scan interval should be confirmed following the first assessment for fetal growth, but routine growth assessment should not occur <14 days.

Trusts are encouraged to invest in training of Ultra sonographers to perform uterine artery Doppler alongside the fetal anomaly scan with the opportunity to reduce the number of serial scans for growth that a woman would require during the pregnancy.

It should be noted that there are reference ranges available for uterine artery Doppler PI throughout pregnancy[39] and thus while offering at the time of the fetal anomaly scan is appropriate (for resource use and convenience), the measurement may be performed at any time during pregnancy [40].

Figure 6 provides an algorithm for using uterine artery Doppler as a screening tool for risk of early onset FGR. Note the use of <10th centile EFW calculated at the time of the routine anomaly scan is preferred over <10th centile AC.

Figure 6: Algorithm for using uterine artery Doppler as a screening tool for risk of early onset FGR.



The risk factors listed here constitute those routinely assessed at booking, other risk factors exist and risk assessment must always be individualised taking into account previous medical and obstetric history and current pregnancy history. For women with maternal medical conditions and individuals with disease progression or institution of medical therapies may increase an individual's risk and necessitate monitoring with serial scanning. For women with a previous stillbirth, management must be tailored to the previous history i.e. evidence of placental dysfunction or maternal medical conditions. Serial measurement should be performed as per NICE antenatal care guideline.

‡AC and/or EFW <10th centile at the anomaly scan is a high risk factor. * Refer to risk assessment and identification section for advice on scan interval.

Management of FGR

The RCOG[41] provides detailed recommendations for the monitoring of SGA when EFW is <10th centile and Trusts should either follow this guidance or a similar protocol which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network as to whether the variation is acceptable.

This appendix describes further recommendations for management of fetuses with FGR supported by randomised controlled trial evidence and highlights important features for management:

- Absent or reversed end diastolic flow in the umbilical artery is a feature of FGR prior to 32 weeks.
- Ductus venosus (DV) Doppler is less predictive after 32 weeks in the management of the FGR fetus.
- A normal umbilical artery Doppler after 32 weeks of gestation does not mean that the fetus is not growth restricted, nor that there is no evidence of fetal compromise.
- After 34 weeks providers with capacity may wish to use assessment of Middle Cerebral Artery (MCA) Doppler pulsatility indices (PI) to help identify and act upon potential fetal compromise in later pregnancy.

FGR diagnosed before 34 weeks' gestation.

Prior to 34+0 weeks, management of the FGR fetus requires regional network specialist fetal medicine input to determine the most appropriate monitoring for fetal wellbeing and timing of birth where fetal compromise is demonstrated.

Trusts caring for such pregnant women should have access to personnel who can carry out DV Doppler assessment and computerised CTG. If Trusts do not have access to DV Doppler or access that is intermittent (i.e., not 365 days/year), then computerised CTG must be provided for monitoring and a pre-established referral pathway should be present to enable assessment of pregnant women by a specialist fetal medicine service within 72 hours.

Pregnant women with early onset FGR should give birth in a unit with neonatal facilities able to deal with the increased risks of FGR preterm infants. Timing should be determined in collaboration with neonatal colleagues, sub-speciality fetal medicine input, steroid administration and magnesium sulphate administration and be guided by current RCOG guidance and findings from the Truffle 2 study [42]

FGR diagnosed after 34 weeks' gestation.

For fetuses with an EFW <3rd centile diagnosed later in pregnancy birth should be initiated at 37+0 weeks' gestation. If other risk factors are present, then involvement of a specialist fetal growth service or fetal medicine service is required to plan birth.

In fetuses with an EFW between the 3rd and <10th centile, other risk factors must be present for birth to be recommended prior to 39 weeks. These are reduced fetal movements, any umbilical artery or MCA Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. If FGR cannot be excluded, then birth after 37 weeks should be discussed with the mother and an ongoing management plan individualised.

For all fetuses with an EFW or AC <10th centile, birth or the initiation of induction of labour should be offered at 39+0 weeks after discussion with the mother.

Evidence on the use of MCA Doppler in the management of late onset FGR is awaited and this is not mandated for use in the management of FGR in this version of SBLCB.

For pregnant women who decline induction of labour or birth after 39+0 weeks, counselling must include a discussion regarding evidence that there is no increase in risk for the baby or for the mother from birth/induction at this gestation and that there is no evidence to determine how fetuses with SGA/FGR should be monitored if pregnancy continues.

Appendix E: Risk assessment at the onset of labour

4.1 Multidisciplinary Training – Principles:
Include multidisciplinary and scenario-based training – this should involve all medical and midwifery staff who care for pregnant women in birth settings.
All staff to be competent in the use of fetal monitoring equipment.
Teaching about fetal responses to labour including changes in fetal heart rate (FHR). In addition, the impact of factors antenatal risk factors such as fetal growth restriction and intrapartum risk factors such as maternal pyrexia.
Effective fetal monitoring in low-risk pregnancies using IA, the role of IA in initial assessment, in established labour and indications for changing from IA to CTG.
Interpretation of CTG including:

- normal FHR parameters
- impact of intrapartum fetal hypoxia on the FHR
- classification of CTG
- holistic interpretation of fetal monitoring in specific clinical circumstances (such as previous caesarean births, breech and multiple pregnancy).

Channels of communication to follow in response to a deteriorating CTG trace, and escalation.
Application of local fetal monitoring guideline (NICE, FIGO or Physiological)
Multi-disciplinary training must integrate the local handover tool (such as SBAR) into teaching programme at all trusts (IEA 7, Ockenden Report)
Provision of adequate training is a Trust priority – as a minimum all staff should receive a full day of multidisciplinary training (including the principles outlined above) each year with reinforcement from regular attendance at fetal monitoring review events.
The training and assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network.

Competency assessment: all staff will have to pass an annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. The assessment should include demonstrating a clear understanding of the areas covered in training (see principles above). Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment.
No member of staff should care for pregnant women in a birth setting without evidence of training and assessment within the last year.

4.2 Start of labour risk assessment.
All pregnant women should undergo a full clinical assessment when presenting in early or established labour. This should include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. This assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network and reflect fetal monitoring guidelines. This should be shared with woman and her birth partner to enable an informed decision re place of birth.

4.3 Ongoing labour risk assessments
To include: start of labour risk assessment; intrapartum risk factors; consideration of fetal heart rate parameters when using Intermittent auscultation (IA) or cardiotocograph (CTG),

and whether the woman and her birth partner have any concerns. This information is used to inform the whole clinical picture and inform care and escalation if required.

4.4 Buddy system/Fresh Eyes

There is no evidence to inform the optimal frequency of a buddy system for IA or CTG and/or its effectiveness. However, the concept was introduced to enable a fresh eyes perspective of maternal and fetal wellbeing therefore has the potential to be beneficial and supportive.

IA is predominantly used in low-risk labours where the incidence of hypoxia is very low and therefore an hourly fresh eyes process can be distracting from care in labour without conferring benefit. A four hourly review may be more beneficial*

CTG is predominantly used in labour where there are risk factors and therefore the risk of sepsis and fetal hypoxia is greater; therefore, fresh eyes review at least hourly may be more beneficial*

*Timeframe for Fresh Eyes should be decided within maternity services should be agreed with local commissioners (CCG) based on the advice of the Clinical Network.

4.5 Fetal monitoring expertise

The dedicated hours for midwifery and obstetric fetal monitoring leads will be dependent on the size of the maternity unit and agreed with local commissioners (CCG) based on the advice of the Clinical Network.

Appendix F: Risk assessment, surveillance pathway and management of women at risk of preterm birth

This appendix describes a risk assessment, surveillance and management pathway for pregnant women at risk of preterm birth. It has been designed with reference to NICE guidance[43] and the UK Preterm Clinical Network guidance. It does not address administration of corticosteroids, magnesium sulphate and use of tocolytics for which there is evidence based guidance[44 45 46]

Prevention

All pregnant women should be assessed at booking for risk factors for preterm birth. This assessment should include modification of population-based risk factors acknowledging that the majority of preterm births occur in pregnant women not appropriate for care in a preterm prevention clinic.

Smoking cessation: Smoking doubles the risk of preterm birth[47] and therefore all pregnant women should be asked about smoking, and cessation advice and/or referral should be provided. Women who have experienced a previous preterm birth, who stopped smoking early in the pregnancy, modify their risk back to that of a non-smoker. If smoking cessation is delayed until the third trimester this modifiable benefit is lost. The importance of promoting smoking cessation is therefore one of the most important prevention strategies to implement (see Element 1 for more detail).

Maternal age: Young women (<18 years) have an increased risk of preterm birth[48]. Appropriate referral to teenage pregnancy teams should be offered to provide adequate support and advice throughout the pregnancy and may help prevent preterm birth.

Domestic violence: Women experiencing domestic violence and/or other social pressure should be directly counselled and referred for specific support through local pathways.

Urinary tract infection (UTI): A midstream urine sample (MSU) should be taken and sent for culture and sensitivity in all high or intermediate risk pregnant women at booking. Culture positive samples, even in symptom-free pregnant women (asymptomatic bacteriuria), should be promptly treated. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended. Those who have a recurrent episode require review in secondary care.

Vaginal infection: Pathogens such as *Neisseria Gonorrhoeae* and *Chlamydia Trachomatis* are associated with preterm birth, and screening should be offered to at-risk pregnant women. In particular, healthcare professionals should inform pregnant women under the age of 25 years about the high prevalence of chlamydial infection in their age group and give details of their local National Chlamydia Screening Programme.

The role of organisms found in bacterial vaginosis (BV) remains controversial; the presence of BV is linked with preterm birth, but the varying methods used to ascertain its presence, and the timing and means of treatment in several studies have meant that no consensus currently exists as to its identification and treatment in at-risk pregnant women. The presence of Group B Streptococci in a vaginal swab is not an indication to treat until in labour unless also isolated from a midstream urine specimen.

Risk assessment

The risk assessment should identify a group of high-risk pregnant women who require management in a preterm birth prevention clinic where further tests may be offered as part of the surveillance pathway. This assessment should take place at the booking appointment with referral by 12 weeks.

Table 2 is a suggested risk assessment and management tool.

Table 2: Risk assessment and management tool for pregnant women at risk of preterm birth

Risk factor	Pathway
High risk • Previous preterm birth or mid-trimester loss (16 to 34 weeks gestation). • Previous preterm prelabour rupture of membranes <34/40. • Previous use of cervical cerclage. • Known uterine variant (i.e., unicornuate, bicornuate uterus or uterine septum). • Intrauterine adhesions (Ashermann's syndrome). • History of trachelectomy (for cervical cancer).	**Surveillance** 1. Referral to local or tertiary Preterm Prevention (PP) clinic by 12 weeks. 2. Further risk assessment based on history +/- examination as appropriate in secondary care with identification of pregnant women needing referral to tertiary services. 3. All pregnant women to be offered transvaginal cervix scanning every 2-4 weeks between 16 and 24 weeks as a secondary test to more accurately quantify the risk of preterm birth. 4. Additional use of quantitative fetal fibronectin in asymptomatic pregnant women may be considered where centres have this expertise. **Management** 5. Interventions should be offered to pregnant women as appropriate, based on either history or additional risk assessment tests by clinicians able to discuss the relevant risks and benefits according to up to date evidence and

Risk factor	Pathway
	relevant guidance, for example, UK Preterm Clinical Network guidance and NICE[49] guidance. These interventions should include cervical cerclage, pessary and progesterone as appropriate.
Intermediate risk • Previous birth by caesarean section at full dilatation. • History of significant cervical excisional event i.e., LLETZ where >15mm depth removed, or >1 LLETZ procedure carried out or cone biopsy (knife or laser, typically carried out under general anaesthetic).	**Surveillance** 1) Refer to preterm birth prevention clinic by 12 weeks. 2) Further risk assessment based on history +/- examination as appropriate in secondary care with discussion of option of additional risk assessment tests, including: a) A single transvaginal cervix scan between 18-22 weeks as a minimum. b) Additional use of quantitative fetal fibronectin in asymptomatic pregnant women can be considered where centres have this expertise. **Management** 3) Interventions should be discussed with pregnant women as appropriate based on either history or additional risk assessment tests by clinicians able to discuss the relevant risks and benefits according to up-to-date evidence and relevant guidance. These interventions should include cervical cerclage, pessary and progesterone as appropriate. 4) Pregnant women at intermediate risk should be reassessed at 24 weeks for consideration of transfer back to a low-risk pathway.

Risk assessment

Pregnant women with any of the additional high-risk factors should be reviewed in a preterm birth prevention clinic where a detailed history should be obtained and an individualised plan made. Additional tests for ascertaining risk should be offered; as a minimum this should include transvaginal cervix scan between 18 and 22 weeks. Some providers may wish to schedule this as part of the anomaly scan. Additional cervical length scans should be performed at the discretion of the lead clinician and are likely to be more frequent than the minimum outlined above.

The addition of a second risk assessment tool, quantitative fetal fibronectin, is currently being evaluated in symptomatic pregnant women in clinical studies. In asymptomatic pregnant women, this additional tool may be used from 18 weeks to ascertain risk of second trimester miscarriage or preterm birth in conjunction with cervical length measurement and support discussions of potential interventions with pregnant women. It can also be used in high-risk pregnant women in late second/early third trimester to determine timing of preparation for preterm birth, for example, administration of steroids and magnesium sulphate. In current clinical practice the use of additional risk assessment tools in asymptomatic pregnant women should be at the discretion of the lead clinicians and where there is expertise and clear guidance for use.

The use of other near-patient tests, such as placental alpha macroglobulin-1 (PAMG-1, PartoSure) and insulin-like growth factor binding protein-1 (IGFBP-1, Actim Partus), has recently been examined by NICE and these are currently not recommended for routine use outside research settings[50].

Prevention
After assessment within the preterm birth prevention clinic, pregnant women on the basis of history and/or additional risk assessment tools should be offered treatment to prevent second trimester miscarriage and preterm birth.

Several interventions have been assessed for pregnant women at high risk of preterm birth: cervical cerclage, progesterone and pessaries. Cervical cerclage is an established procedure, progesterone is recommended in certain situations by NICE, and there are randomised trials suggesting benefit in the use of Arabin pessaries in at-risk pregnant women [51]. At present the evidence base cannot determine precisely in which pregnant women, and in what circumstances, each intervention will be most effective. Care should, therefore, always be individualised, taking into account the pregnant women's wishes, and following a discussion with a clinician able to discuss the potential risks and benefits of each intervention. The following evidence and guidance should be discussed:
Pregnant women with a history of spontaneous preterm birth or late miscarriage (16-34 weeks):

- Offer a history-indicated (planned, prophylactic, elective) cervical cerclage or transvaginal ultrasound surveillance of the cervix within the second trimester.
- History-indicated cerclage should be placed by the end of the first trimester where possible, however often it may be prudent to wait until after the dating scan and aneuploidy screening has been performed, so that significant fetal malformations can be excluded.
- For pregnant women having ultrasound surveillance, discuss intervention when cervix is <25mm, either cervical cerclage[52], Arabin pessary or prophylactic progesterone (vaginal or intramuscular).
- **Pregnant women with a previous failed transvaginal suture**:
- The circumstances of the failed suture and other clinical factors should be

considered prior to placement, and appropriately experienced clinicians should be involved in the decision making and surgery. High vaginal or transabdominal cerclage may be considered. Transabdominal placement during pregnancy should be undertaken prior to 14 weeks. Guidelines regarding laparoscopic placement have previously been published by NICE[53].

- **Pregnant Women with no history of spontaneous preterm birth or midtrimester loss in whom a transvaginal cervix scan has been carried out between 16+0 and 26+0 weeks of pregnancy and the cervix is less than 25mm***:*
- Care for these pregnant women should be individualised. Counselling should include options of continued surveillance or intervention with clinicians able to discuss the relevant risks and benefits according to up to date evidence and relevant guidance. These interventions should include cervical cerclage, pessary and progesterone as appropriate.

Pregnant women with an intervention (cerclage, pessary or progesterone) should remain under the care of the preterm birth prevention clinic until birth. Pregnant women undergoing transvaginal cervix scanning risk assessment should continue this until 24 weeks, when this monitoring pathway is complete and if no intervention is recommended, pregnant women may be transferred to routine pathways of care. Midwifery-led care is appropriate if no other additional risk factors are identified.

Abbreviations

AC – Abdominal circumference
BME – Black and Minority Ethnic
CI – Confidence interval
CO – Carbon monoxide
CTG – Cardiotocograph
DV – Ductus venosus
EFW – Estimated fetal weight.
FGR – Fetal growth restriction
FHR – Fetal heart rate
FH – Fundal Height
HCP – Healthcare professional
HEE – Health Education England
IA – Intermittent auscultation
ICB – Integrated care board
ICS – Integrated care systems
LLETZ - Large loop excision of the transformation zone
LTP – NHS Long Term Plan
LMNS – Local maternity and neonatal system
MCA – Middle Cerebral Artery
MIS – Maternity information system
MSDS – Maternity services data set
MSU – Midstream urine
MSW – Maternity Support Worker
NSAIDS – Nonsteroidal anti-inflammatory drugs
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
ODN – Operational delivery networks
ONS – Office for National Statistics
PI – Pulsatility index
PMRT – Perinatal mortality review tool
PHE – Public Health England
RCM – Royal College of Midwives
RCOG – Royal College of Obstetricians and Gynaecologists
RFM – Reduced fetal movements.
SBLCB – Saving Babies' Lives Care Bundle
SEN – Special educational needs
SFH – Symphysis fundal height
SGA – Small for gestational age
SIDS – sudden infant death syndrome
TVCS – Transvaginal cervix scanning
VBA – Very brief advice
WHO – World Health Organisation

References

1. Sandall, J., Soltani, H., Gates, S., Shennan, A. & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5. . Midwife-led continuity models versus other models of care for childbearing women - Sandall, J - 2016 | Cochrane Library
2. NHS England (2016). National Maternity Review: Better Births – Improving outcomes of maternity services in England – A Five Year Forward View for maternity care. Available from: https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/ [Information accessed 11 May 2023]
3. Homer, C., Leap, N., Edwards, N. and Sandall, J. (2017). Midwifery continuity of carer in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009). Midwifery. 48, 1-10. Available from: https://doi.org/10.1016/j.midw.2017.02.009 [Information accessed 25 January 2019].
4. MacKay DF, Smith GCS, Dobbie R, Pell JP (2010). Gestational Age at Delivery and Special Educational Need: Retrospective Cohort Study of 407,503 Schoolchildren. PLoS Med 7(6): e1000289. Available from: https://doi.org/10.1371/journal.pmed.1000289 [Information accessed 11 May 2023].
5. MacKay DF, Smith GCS, Dobbie R, Pell JP (2010). Gestational Age at Delivery and Special Educational Need: Retrospective Cohort Study of 407,503 Schoolchildren. PLoS Med 7(6): e1000289. Available from: https://doi.org/10.1371/journal.pmed.1000289 [Information accessed 11 May 2023].
6. Grobman WA. (2018). A randomized trial of elective induction of labor at 39 weeks compared with expectant management of low-risk nulliparous women. American Journal of Obstetrics and Gynecology; 218: S601.
7. Gardosi J, Madurasinghe V, Williams M, Malik A, Francis A. Maternal and fetal risk factors for stillbirth: population based study. BMJ. 2013;346(January): f108. Available from: http://www.bmj.com/content/346/bmj.f108 [Information accessed 11 May 2023].
8. Blencowe H, Cousens S, Jassir FB, Say L, Chou D, Mathers C, Hogan D, Shiekh S, Qureshi ZU, You D, Lawn JE (2016). National regional and worldwide estimates of stillbirth rates in 2015, with trends from 2000: a systematic analysis. The Lancet Global Health 2016;4(2):e98-e108

9. Stock SJ, Ferguson E, Duffy A, Ford I, Chalmers J, Norman JE (2012). Outcomes of elective induction of labour compared with expectant management: population based study. BMJ: 344: e2838.
10. Stock SJ, Ferguson E, Duffy A, Ford I, Chalmers J, Norman JE (2012). Outcomes of elective induction of labour compared with expectant management: population based study. BMJ: 344: e2838
11. Stock SJ, Ferguson E, Duffy A, Ford I, Chalmers J, Norman JE (2012). Outcomes of elective induction of labour compared with expectant management: population based study. BMJ: 344: e2838.
12. Royal College of Obstetricians and Gynaecologists (2013). RCOG Green-Top Guideline 31: The Investigation and Management of the Small for Gestational Age Fetus. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/ [Information accessed 26 April 2023].
13. Maternal and Child Health Research Consortium. 8th Annual Report. Confidential Enquiry into Stillbirths and Deaths in Infancy. London: Maternal and Child Health Research Consortium, 2001
14. Draper ES, Kurinczuk JJ, Kenyon S. (Eds.) on behalf of MBRRACE-UK. MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2015.
15. Draper ES, Kurinczuk JJ, Kenyon S (Eds.) on behalf of MBRRACE-UK. MBRRACE-UK 2017 Perinatal Confidential Enquiry: Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death. The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester: Leicester, 2017
16. Scala C, Bhide A, Familiari A, Pagani G, Khalil A, Papageorghiou A, Thilaganathan B. (2015). Number of episodes of reduced fetal movement at term: association with adverse perinatal outcome. American Journal of Obstetrics and Gynaecology: 213(5):678 e1-6. doi: 10.1016/j.ajog.2015.07.015
17. Thompson JMD, Wilson J, Bradford BF, Li M, Cronin RS, Gordon A, Raynes-Greenow CH, Stacey T, Cullling VM, Askie LM, O'Brien LM, Mitchell EA, McCowan LME, Heazell AEP. A better understanding of the association between maternal perception of foetal movements and late stillbirth-findings from an individual participant data meta-analysis. BMC Med. 2021 Nov 15;19(1):267.
18. Warrander LK, Batra G, Bernatavicius G, Greenwood SL, Dutton P, Jones RL, Sibley CP, Heazell AE. Maternal perception of reduced fetal movements is associated with altered placental structure and function. PLoS One. 2012;7(4):e34851. doi: 10.1371/journal.pone.0034851.
19. Brita Askeland Winje, Borghild Roald, Nina Petrov Kristensen, J Frederik Frøen. Placental pathology in pregnancies with maternally perceived

decreased fetal movement--a population-based nested case-cohort study PLoS One 2012;7(6):e39259. doi: 10.1371/journal.pone.0039259

20. Michal Levy, Michal Kovo, Yakira Izaik, Isca Luwisch Cohen, Letizia Schreiber, Hadas Ganer Herman, Giulia Barda, Jacob Bar, Eran Weiner. Reduced fetal movements at term in singleton low risk pregnancies-Is there an association with placental histopathological findings? Acta Obstet Gynecol Scand . 2020 Jul;99(7):884-890. doi: 10.1111/aogs.13810
21. Norman J, Heazell AEP, Rodriguez A, Weir CJ, Stock SJE and Calderwood CJ (2018). Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM): a stepped wedge, cluster-randomised trial. Lancet: Sep 27. pii: S0140-6736(18)31543-5. doi: 10.1016/S0140-6736(18)31543-5.
22. include references for (MBAM) PMID 34555257 and (Mindfetalness) PMID 31971325
23. Flenady V, Gardener G, Ellwood D, Coory M, Weller M, Warrilow KA, Middleton PF, Wojcieszek AM, Groom KM, Boyle FM, East C, Lawford H, Callander E, Said JM, Walker SP, Mahomed K, Andrews C, Gordon A, Norman JE, Crowther C. My Baby's Movements: a stepped-wedge cluster-randomised controlled trial of a fetal movement awareness intervention to reduce stillbirths. BJOG. 2022 Jan;129(1):29-41. doi: 10.1111/1471-0528.16944
24. Baker H, Pilarski N, Hodgetts-Morton VA, Morris RK. Comparison of visual and computerised antenatal cardiotocography in the prevention of perinatal morbidity and mortality. A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 2021 Aug;263:33-43. doi: 10.1016/j.ejogrb.2021.05.048
25. Gale C, Statnikov Y, Jawad S, Uthaya SN, Modi N (Brain Injuries expert working group) (2018). Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database. Archives of Disease in Childhood Fetal and Neonatal Edition: Jul;103(4): F301-F306.
26. Alfirevic Z, Devane D and Gyte GML (2013). Continuous Cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour (Review). The Cochrane Collaboration. John Wiley & Sons Ltd.
27. Murphy KW, Johnson P, Moorcraft P, Pattinson R, Russel V, Turnball A (1990). Birth asphyxia and the intrapartum cardiotocograph. British Journal of Obstetrics and Gynaecology: 97: 470-479.
28. National Institute for Health and Care Excellence (2015). Preterm Labour and birth (NICE Guideline 25). Available from: https://www.nice.org.uk/guidance/ng25 [Information accessed 11 may 2023].
29. National Institute for Health and Care Excellence (2015). Preterm Labour and birth (NICE Guideline 25). Available from: https://www.nice.org.uk/guidance/ng25 [Information accessed 11 May 2023].

30. National Institute for Health and Care Excellence (2015). Preterm labour and birth (NICE Guideline 25). Available from: https://www.nice.org.uk/guidance/ng25 [Information accessed 11 May 2023].
31. National Institute for Health and Care Excellence (2018). Biomarker tests to help diagnose preterm labour in women with intact membranes (Diagnostics guidance 33). Available from: https://www.nice.org.uk/guidance/dg33 [Information accessed 11 May 2023].
32. National Institute for Health and Care Excellence (2011). Hypertension in pregnancy: diagnosis and management (Clinical Guideline 107). Available from: https://www.nice.org.uk/guidance/cg107 [Information accessed 11 May 2023].
33. Rolnik DL, Wright D, Poon LC, O'Gorman N, Syngelaki A, de Paco Matallana C, Akolekar R, Cicero S, Janga D, Singh M, Molina FS, Persico N, Jani JC, Plasencia W, Papaioannou G, Tenenbaum-Gavish K, Meiri H, Gizurarson S, Maclagan K, Nicolaides KH (2017). Aspirin versus Placebo in Pregnancies at High Risk for Preterm Preeclampsia. New England Journal of Medicine, 377(7):613-622
34. Ayala DE, Ucieda R and Hermida RC (2012). Chronotherapy with Low-Dose Aspirin for Prevention of Complications in Pregnancy. Chronobiology International, 30:1-2, 260-279
35. National Institute for Health and Care Excellence (2011). Hypertension in pregnancy: diagnosis and management (Clinical Guideline 107). Available from: https://www.nice.org.uk/guidance/cg107 [Information accessed 11 May 2023].
36. Elsevier. Clinical pharmacology [database online]. Available at: http://www.clinicalpharmacology.com/. Retrieved March 20, 2018
37. Gordijn SJ, Beune, IM, Thilaganathan B, Papageorghiou A, Baschat AA, Baker PN, Silver RM, Wynia K and Ganzevoort W (2016). Consensus definition of fetal growth restriction: a Delphi procedure. Ultrasound in Obstetrics and Gynecology: 48: 333-339. doi:10.1002/uog.15884
38. Gómez O, Figueras F, Fernández S, Bennasar M, Martínez JM, Puerto B (2008). Reference ranges for uterine artery mean pulsatility index at 11-41 weeks of gestation. Ultrasound in Obstetrics and Gynecology: 32(2):128–32. Available from: http://doi.wiley.com/10.1002/uog.5315 [Information accessed 11 May 2023].
39. Gómez O, Figueras F, Fernández S, Bennasar M, Martínez JM, Puerto B (2008). Reference ranges for uterine artery mean pulsatility index at 11-41 weeks of gestation. Ultrasound in Obstetrics and Gynecology: 32(2):128–32. Available from: http://doi.wiley.com/10.1002/uog.5315 [Information accessed 28 April 2023

40. Royal College of Obstetricians and Gynaecologists (2013). RCOG Green-Top Guideline 31: The Investigation and Management of the Small for Gestational Age Fetus. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/ [Information accessed: 28 April 23].
41. Royal College of Obstetricians and Gynaecologists (2013). RCOG Green-Top Guideline 31: The Investigation and Management of the Small for Gestational Age Fetus. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/ [Information accessed: 28/04/23]
42. Ref bottom of page 79 Truffle 2 study
43. National Institute for Health and Care Excellence (2015). Preterm labour and birth (NICE Guideline 25). Available from: https://www.nice.org.uk/guidance/ng25 [Information accessed 28/04/23].
44. Roberts D, Brown J, Medley N, Dalziel SR (2017). Antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth. Cochrane Database of Systematic Reviews: Issue 3. Art. No.: CD004454. DOI: 10.1002/14651858.CD004454.pub3
45. Crowther CA, McKinlay CJ, Middleton P, Harding JE (2015). Repeat doses of prenatal corticosteroids for women at risk of preterm birth for improving neonatal health outcomes. Cochrane Database Systematic Reviews: Jul 5;(7):CD003935. doi: 10.1002/14651858.CD003935.pub4
46. Chang E (2015). Preterm birth and the role of neuroprotection. BMJ: 350: p. g6661.
47. Andres RL, Day MC (2000). Perinatal complications associated with maternal tobacco use. Seminars in Neonatology: **5**(3): 231 – 41.
48. UK Preterm Clinical Network (2018). Reducing preterm birth: Guidelines for Commissioners and Providers. UK: Preterm Clinical Network
49. National Institute for Health and Care Excellence (2015). Preterm labour and birth (NICE Guideline 25). Available from: https://www.nice.org.uk/guidance/ng109 [Information accessed 28 April 2023].
50. National Institute for Health and Care Excellence (2018). Biomarker tests to help diagnose preterm labour in women with intact membranes (Diagnostics guidance 33). Available from: https://www.nice.org.uk/guidance/dg33 [Information accessed 11 May 2023].
51. UK Preterm Clinical Network (2018). Reducing preterm birth: Guidelines for Commissioners and Providers. UK: Preterm Clinical Network
52. Berghella V. and Mackeen AD (2011). Cervical length screening with ultrasound-indicated cerclage compared with history-indicated cerclage for prevention of preterm birth: a meta-analysis. Obstetrics and Gynecology: 118(1): p. 148-55.

53. National Institute for Health and Care Excellence (2007). Laparoscopic cerclage for prevention of recurrent pregnancy loss due to cervical incompetence (Interventional Procedures Guidance 228). Available from: https://www.nice.org.uk/guidance/ipg228 [Information accessed 28 April 2023].

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: enquiries@england.nhs.uk

This publication can be made available in a number of alternative formats on request.