UHL Maternity Service Safer Maternity Care Report

Author: Elaine Broughton, Head of Nursing/Midwifery Sponsor: Carolyn Fox, Chief Nurse

Trust Board paper F

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	x
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	Jan 2021	Assurance
Trust Board Committee		
Trust Board		

Executive Summary

Context

This paper is to inform and assure Trust board of the immediate actions taken within UHL Maternity Services in response to the Ockenden Report published on 10th December 2020. In a letter to Trust Chief Executives dated 14th December 2020, there are a number of recommendations and actions that need to be progressed within a limited time. Attached to the report is a self-assessment and assurance framework which the Board are required to review prior to submission to NHSE/I by the 15th January 2021 (Appendix 6) This report aims to provide assurance to the Board that safety in Maternity Services at UHL is crucial in all care provided to the women and babies in LLR, and particularly those who chose to have care provided by UHL Maternity Services.

Questions

1. What is the background of the Ockenden Report
2. What local assurances can Maternity services provide to the EQB
3. What are the risks to delivery

Conclusion

1. Following concerns raised by families regarding the care at Maternity Services at Shrewsbury and Telford Hospitals NHS Trust in 2009 and 2016, Jeremy Hunt former Secretary of State, ordered an independent review of the quality of investigations and implementations of their recommendations of a number of alleged avoidable neonatal and maternal deaths and harm. Since the review commenced a number of families have expressed concern and the number of families has now reached 1,862 cases. The Ockenden Report describes emerging findings from the ongoing review, with the review due to be completed in November 2021.

2. In the appendices of this Report, there is a gap analysis of the all the recommendations in the Ockenden Report, 12 of those recommendations have been thought to be significant enough to warrant immediate action and have been communicated to Provider Trust Chief Executive Officers in a letter from NHSE/I CEO, Chief Nurse and National Medical Director. The 12 immediate recommendations / actions have been added to the attached action plan within the Report.

3. The main risks to delivery and embedding of all the actions (for the majority of Trusts) will be financial risks associated with an increase in staff training, safe staffing, and use of CNST rebate solely for improving safety in Maternity services. The report advises that the Non-Executive Director role within Trusts that act as a Board Level Safety Champion needs to be expanded to incorporate the responsibility for seeking the views of Service Users as part of hearing Women's voices

Input Sought

We would welcome the Trust Board's input regarding the assurance provided by the gap analysis undertaken by the service, the subsequent actions and the assessment and assurance framework provided in the appendices to this document.

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Not applicable]
Improved Cancer pathways	[Not applicable]
Streamlined emergency care	[Not applicable]
Better care pathways	[Yes]
Ward accreditation	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes]
Investment in sustainable Estate and reconfiguration	[Not applicable]
e-Hospital	[Not applicable]
Embedded research, training and education	[Not applicable]
Embed innovation in recovery and renewal	[Not applicable]
Sustainable finances	[Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
- How did the outcome of the EIA influence your Patient and Public Involvement ?
- If an EIA was not carried out, what was the rationale for this decision?

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: [TBC]
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th January 2021**

REPORT BY: **Head of Midwifery and Nursing**

SUBJECT: **UHL Maternity Service response to Ockenden Report**

INTRODUCTION

The Chair of the Independent review into Shrewsbury and Telford Hospitals NHS Trust, Donna Ockenden hopes that the publication of the Ockenden Report will support learning lessons and embedding of meaningful change to take place, not just in Shrewsbury and Telford but across every Maternity Unit in the country. Attached to the report is a self-assessment and assurance framework which the Board are required to review prior to submission to NHSE/I by the 15th January 2021 (Appendix 6) This report aims to provide assurance to the Board that safety in Maternity Services at UHL is crucial in all care provided to the women and babies in LLR, and particularly those who chose to have care provided by UHL Maternity Services.

1. The Ockenden Report is an interim Report following independent review of the Maternity Services at Shrewsbury and Telford Hospital NHS Trust (Appendix 1). The emerging themes and findings were thought to be so significant and adversely affecting safety, it was felt an interim Report needed to be published as serious complications and deaths resulting from maternity care have an everlasting impact on families or loved ones. In 2017 Jeremy Hunt received a letter from bereaved families raising concerns where mothers and babies had died, but also other babies sustaining significant harm, NHS Improvement were instructed to commission an independent review assessing the quality of investigations relating to the newborn, infant and maternal harm. Families who have independently approached the review panel is now over 1800, this will be the largest clinical review relating to a single Service that has been undertaken, as part of an enquiry, in the history of the NHS.

   One of the objectives of publishing an interim Report was to ensure emerging themes and findings i.e. Immediate and essential actions are carefully considered by every Maternity Service in England. These actions were highlighted in a letter to CEO's of Trusts providing maternity services, requesting a response by 21st December 2020 (Appendix 2).

2. Since the publication of the Report, the Service has undertaken a rapid review in the form of a GAP analysis of all the recommendations highlighted in the report (Appendix 3). However, in a letter to the CEO dated 14th December, there are 7 themes highlighting 12 immediate actions for which UHL Maternity Service had to devise an action plan and submit the NHSE/I by 5pm on 21st December 2020 (Appendix 4).

   Our preliminary assessment of the findings of the analysis suggests that for the majority of recommendations identified in the report, UHL is able to demonstrate that the service meets the recommendation or recognises a shortfall and has a plan to implement any actions. The LLR LMNS functions effectively and are keen to take up the challenge to strengthen Governance arrangements and increase their oversight of services. Working with the CCG, UHL are keen to build on learning identified in the Report, it presents the service with an opportunity to challenge the safety and quality, implementing the support toolkits, such as the Perinatal Clinical Quality Surveillance Model.

It is acknowledged UHL have implemented and embedded some of the immediate actions. For example, joint multidisciplinary training was introduced in Maternity in 2011 and is working effectively and more recently monitoring fetal surveillance is becoming stronger month on month since the role of the Fetal Monitoring Midwife was introduced; she leads the way nationally with setting up review meetings, rapid reviews and fetal monitoring training.

In addition to the immediate actions described in the letter from NHSE/I, workforce is discussed in detail, describing developing the Support Worker role, increasing Under Graduate Courses to build the work force for the future. In previous reports the Maternity Service has described the deficit in Midwives and Support Workers through an establishment review using Birth Rate Plus 2 years ago and 4 years ago, another review is due in January 2021, which will continue to show a deficit in the workforce but with a plan on how we intend to increase the workforce in line with national recommendations.

3. The risks to the delivery of the actions relate to financial support from the Trust. The service will need to request the CNST rebates must be used to improve safety in Maternity and funding will be ring-fenced to secure dedicated maternity training.

Summary

This Report is to provide assurance to the Trust that the Maternity Service can provide evidence that the majority of the immediate actions are in place. What will be more of a challenge in 2021 is meeting the strict criteria for implementation and reporting to Board, meeting staffing challenges and gaining dedicated financial support for midwifery staffing and training.
The Maternity Service is committed to improving safety, as always we will rise to the challenge to improve our service and have the evidence to report to our regulators.
Next steps are to submit the attached Assurance and Assessment Tool to NHSE/I by 15th January 2021, have a plan in place for implementation of the Birth Rate Plus recommendations for 31st January 2021.

The benchmarking and action plan attached to the paper describe the position of the service against the recommendations.

Appendix 5 is the CEO response with a deadline of 21st December 2020.

SUPPLEMENTARY REPORTS TO THIS PAPER
Appendix 1 Ockenden Report (2020)
Appendix 2 Letter to CEO
Appendix 3 Gap analysis of recommendations in Ockenden Report
Appendix 4 Action plan submitted to Regional Chief Midwife
Appendix 5 UHL CEO response
Appendix 6 Self Assessment and Assurance tool

Appendix 1

OCKENDEN REPORT

Emerging Findings and Recommendations
from the Independent Review of

MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Our First Report following 250 Clinical Reviews

10 December 2020

OCKENDEN REPORT

Return to an Address of the
Honourable the House of Commons
dated 10 December 2020 for

Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

Our First Report following 250 Clinical Reviews

HC 1081

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

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

10 December 2020

Dear Secretary of State

I publish this emerging findings report at a time when the NHS is facing further challenging months ahead as a result of the Covid 19 pandemic. We are all aware that frontline NHS staff have, day after day, risen to these challenges, demonstrating their commitment to providing excellent care in what are often seen and described as the most difficult of circumstances.

Whilst this year, especially, has been about the pride our country has quite rightly in our NHS, this independent maternity review is about those families who have suffered harm as a result of their NHS care at a time when they had planned for a joyous event. Families have told us of their experiences of pregnancies ending with stillbirth, newborn brain damage and the deaths of both babies and mothers. These families have shared with us their accounts of the overwhelming pain and sadness that never leaves them.

We have met face to face with families who have suffered as a result of the loss of brothers and sisters or, from a young age, have also been carers to profoundly disabled siblings. We have met many parents where there have been breakdowns in relationships as a result of the strain of caring for a severely disabled child, the grief after the death of a baby or resultant complications following childbirth.

Following the review of 250 cases we want to bring to your attention actions which we believe need to be urgently implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning that we recommend be shared and acted on by maternity services across England.

Your predecessor, the former Secretary of State Jeremy Hunt, requested an *'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust'*. When I started work as chair of this review, 23 cases had been identified after considerable efforts by the parents of Kate Stanton Davies and Pippa Griffiths who both died just after their births in 2009 and 2016, respectively. Since the review commenced, the number of families who have directly contacted my team, together with cases provided by the Trust for review, has now reached 1,862. When the review is completed, this is likely to be the largest number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

Understandably, examining the details of 1,862 cases is taking time and we continue to face many challenges which are out of our control, including adapting to new ways of working during the COVID19 pandemic.

Due to the significant increase in numbers, I was asked by the Minister of State for Mental Health, Suicide Prevention and Patient Safety to do my utmost to enable initial learning for The Shrewsbury and Telford Hospital NHS Trust and the wider NHS in this calendar year. Therefore, I publish this first emerging first report arising from the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.

My team and I have also held conversations with more than 800 families who have raised serious concerns about their care. These are in addition to the 250 cases considered in this

report and have also informed our findings in this report. We would like to pay tribute to all the families who have approached us to share their experiences.

We have identified a number of important themes which we believe must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement we are sharing emerging findings and themes, have formed **Local Actions for Learning** and make early recommendations which we see as **Immediate and Essential Actions**. We appeal for these to be implemented at The Shrewsbury and Telford Hospital NHS Trust as soon as practically possible and recommend these for thorough consideration within all maternity units across England.

Secretary of State, through our work to date we have recognised a need for critical oversight of patient safety in maternity units. This oversight must be strengthened by increasing partnerships across trusts within local networks of neighbouring trusts. Neighbouring trusts and their maternity services **must** work together with immediate effect to ensure that local investigations into all serious incidents declared within their maternity services are subject to external oversight by trusts working together. This is essential to ensure that effective learning and impactful change to improve patient safety in maternity services can take effect using a system wide approach and in a timely manner.

We have no doubt that, had a similar structure of partnership working been in place, The Shrewsbury and Telford Hospital NHS Trust would have been alerted much earlier for the need to scrutinise its governance processes and learn from its serious incidents.

For this structure to be effective we have identified the need to give increased authority and accountability to Local Maternity Systems (LMS) to ensure safety and quality in the maternity services they represent. They must have knowledge of all serious maternity incidents within their LMS with input to and oversight of these investigations and their resultant outcomes and recommendations. Of significance is that we are convinced that an LMS cannot function effectively when limited to one maternity service only. We also consider it imperative that family voices are strongly and effectively represented in each LMS through the Maternity Voices Partnerships.

This is just one of seven **Immediate and Essential Actions** we outline in this first report. We will add to and strengthen these recommendations in our final report following completion of this review as per the terms of reference. We are certain that these **Local Actions for Learning** and **Immediate and Essential Actions** will improve safety in the maternity service at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England provided that implementation is approached with urgency and determination.

Thank you Secretary of State for your ongoing support.

Yours sincerely,

Donna Ockenden
Chair of the Independent Maternity Review

Acknowledgements

This first report and the work that will follow 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 death in 2009 and Pippa's death in 2016 were avoidable. Their parents' unrelenting commitment to ensuring their daughters' lives were not lost in vain continues to be remarkable. In a void described by the families as 'incomprehensible pain', they undertook their own investigations to highlight the deaths of their newborn daughters, and to insist upon meaningful change in maternity services that would save other lives.

Rhiannon, Richard, Kayleigh and Colin persisted in their call for an independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust; through their tenacity and efforts this review was instigated.

We remain indebted to all the families contributing to this maternity review. Their experiences continue to shape the learning which will transform maternity care for the better. Finally, we convey our sincere gratitude to the many families who tried to raise serious concerns about maternity care and safety at the Trust who have told us they were not listened to.

Why This Report is Important

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones.

The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

CONTENTS

Explanation of Maternity specific terminology used in this report

Throughout the text this report sometimes uses terms and words that may be unfamiliar to some readers. Although use of these are kept to a minimum, on occasions they are essential because this is a report about maternity services. These terms and words are highlighted in ***bold italics*** at the first use with further explanations for them found in the Glossary at the end of this report.

Chapter 1

Introduction

1.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

1.2 The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families. The current terms of reference can be found in Appendix 1.

1.3 Since the commencement of this review many more families have directly approached the review team, voicing similar concerns to those raised by the original cohort of 23 families. Intermittent publicity regarding the work of the review led to a continual increase in families wanting their stories and voices to be heard and their questions and concerns answered. Between June 2018 and the summer of 2020 a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.

1.4 In addition, The Shrewsbury and Telford Hospital NHS Trust , supported by NHS Improvement and NHS England, undertook its own two-stage review of electronic and paper records of cases of ***stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3)*** and ***maternal deaths.*** Through these reviews, known as the 'Open Book', which first occurred in October 2018 as an electronic review and then in July 2020 with paper records included, the review team were notified by NHS Improvement and subsequently the Trust of over 750 cases of poor outcomes across these 4 categories in the period 2000 to the end of 2018. The review team were first able to make contact with these families in April and July 2020.

1.5 Direct contact from families together with the Trust's referrals led to us reporting in July 2020 that the review numbers had increased to encompass 1,862 families. We are aware that a number of families made multiple attempts, sometimes over many years to raise concerns with the Trust, but at this stage we are unable to say whether all of the poor outcomes reported to us occurred as a result of poor care.

1.6 It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019. However, where families contacted us directly with concerns preceding the year 2000, we agreed to review those cases where records exist as per the revised terms of reference. Throughout the review, the care and treatment provided and the quality of any internal reviews, investigations and learning undertaken by the Trust will be considered with reference to the guidance and standards of the day by experienced clinicians who were in clinical practice at the time.

1.7 It is important that we explore the experiences of staff working in the maternity units at The Shrewsbury and Telford Hospital NHS Trust. To do this we will scrutinise staff surveys where available and are working towards a process to hearing from staff directly. In addition we aim to examine past and current governance procedures within maternity services at the Trust that are applicable for the core period of this review.

1.8 To carry out a review of this size and to give each case the attention it deserves will take some time. It is important that expert clinicians lead the process, ensuring that each case is considered carefully and consistently using a standardised methodology. With the review now at 1,862 families, we anticipate a publication date for the second and final report in 2021.

1.9 To date, the review team have already identified emerging themes that should be addressed by the Trust and the wider maternity community across England as soon as possible. Therefore we have decided to publish this first report of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final report, with the full support of NHS England and Improvement, the Department of Health and Social Care and the Secretary of State for Health and Social Care.

1.10 For this first report 250 cases were investigated which are drawn from the entire period of the review and include the original cohort of 23 families. We also refer to in depth conversations and contact with a further 800 families, but we are mindful that these cases have not yet been subject to systematic and independent review by our team.

1.11 Our first objective in publishing these emerging themes and findings and their corresponding **Local Actions for Learning** is to support the improvement work currently underway in the maternity services at the Trust. A second objective is to ensure that these emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** are carefully considered by all maternity services in England. We strongly believe we have identified a need for structural changes which, if implemented nationwide with our recommendations will reduce cases of harm to mothers and babies.

1.12 It is important to note that we would not have been able to identify these objectives without carefully considering the voices of families which underpin this report.

1.13 Over the years, many important recommendations from previous national maternity reviews[1] [2] [3] and local investigations which might have made a significant difference to the safety of mothers and babies receiving care at the Trust have either not been implemented or the implementation has failed to create the intended effect of improving maternity care. From this review of 250 cases we can confirm that we have identified missed opportunities to learn in order to prevent serious harm to mothers and babies. However, we are unable to comment any further on any individual family cases until the full review of all cases is completed.

1.14 Having listened to families we state that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is our call to action. We expect to see real change and improved safety in maternity services as a result of

1 Northwick Park (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557922/ https://www2.harrow.gov.uk/documents/s30776/Maternity%20Review%20Report.pdf

2 Morecambe Bay (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

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

findings from these 250 case reviews and our resultant **Local Actions for Learning** and **Immediate and Essential Actions** whilst we continue to work towards completion of the full and final report.

1.15 Furthermore, we recommend that the **Immediate and Essential Actions** which we have identified should also inform the decision-making of those who lead maternity services at local, regional and national levels.

1.16 Everyone has a part to play. The Shrewsbury and Telford Hospital NHS Trust Board and local commissioners must urgently focus on expediting implementation of the **Local Actions for Learning** and **Immediate and Essential Actions** outlined within this first report. This will ensure that consistently safe maternity care is provided to its local population.

1.17 The NHS England and Improvement regional improvement team must ensure that they give appropriate support and oversight to the Trust. Regulators and professional bodies including the **Care Quality Commission**, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health must strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** in order that they translate into safer maternity care across England. To do nothing is not an option.

1.18 Repeatedly, families have told us of two key wishes. Firstly, they want questions answered in order that they understand what happened during their maternity care. Secondly, they want the system to learn, so as to ensure that any identified failings from their care are not repeated at the Trust or occur at any other maternity service in England. The scale of this review has reinforced their perceptions that their cases were not thoroughly investigated and that there may have been missed opportunities for learning and change and thereby a failure to prevent future harm.

1.19 We owe it to the 1,862 families who are contributing to this review to bring about rapid, positive and sustainable change across the maternity service at The Shrewsbury and Telford Hospital NHS Trust. Implementation of the recommendations from this first report and the final report in 2021 will be their legacy.

Chapter 2:

How we approached this Review

What kind of clinical incident is this review considering?

2.1 This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

2.2 In addition, a small number of earlier cases have emerged where families have raised significant concerns with the review team. These are being reviewed by the independent team wherever medical records are available from which it may then be possible to answer family questions. These earlier cases are those proactively reported to us by families, rather than systematically provided to us by the Trust. In all likelihood these are not the actual number of events. The earlier cases which occurred in the years immediately prior to 2000 are of importance to this review to establish whether there is evidence of embedded learning in subsequent cases.

2.3 The total number of families to be included in the final review and report is 1,862. The original plan was to publish one complete report, when the reviews of all the cases had been completed. However, as numbers of affected families continued to grow, in July 2020 it was agreed with the Minister of State for Mental Health, Suicide Prevention and Patient Safety, that early learning from the review of cases so far be shared with the Trust and the wider maternity services this calendar year. This has led us to publish this first report whilst our work continues towards completion of the remaining cases.

Methodology

2.4 For this first report the care that 250 mothers and their babies received has been reviewed as fully as possible on the evidence available. All clinical reviews have been undertaken by a team of independent expert clinicians. All review team members work outside the Trust and region and have no current or previous association with the Trust.

2.5 All reviews have been undertaken to date with benchmarking and consideration of the standards of care, policies and practice that would have been considered acceptable at the time the incident or concern occurred. The review team have had access to a range of local and national policies and guidance whilst undertaking their work. All the team members reviewing each case are experienced in clinical practice at the time the issue or incident of concern occurred.

2.6 The review team comprises obstetricians, midwives and neonatologists working collaboratively. Where specialist advice is required, for example in obstetric anaesthesia, maternal medicine, or other medical specialities such as adult cardiology or neurology, appropriate clinicians are available in the review team.

Listening to family voices

2.7 Family voices have been heard by the review team, either through face to face individual interviews held in Shrewsbury in a non-NHS location or via telephone or a

videoconferencing platform. Interviews are recorded electronically and typed up using a transcribing service of which a copy of the transcript is then shared with the family. There is a comprehensive support service available to all families in the review following initial assessment with a trained professional. The review team works in collaboration with SANDS, Child Bereavement UK and Bereavement Training International in offering this service. From early 2021 this will be extended to include support from the Midlands Partnership NHS Foundation Trust.

Listening to the views and voices of staff working at the Trust

2.8 Arrangements are under way to ensure that staff voices of current and former employees within the maternity and neonatal services at the Trust will be heard and carefully considered. We will review the information already available about staff views over the years from a number of sources, including staff surveys undertaken by the Care Quality Commission, the ***'Mat Neo' Collaborative***[4] and the NHS annual staff survey[5]. Following analysis of this information we will offer both former and current employees of the Trust the opportunity to speak with members of the review team in confidence.

Review of the Trust's maternity governance processes

2.9 The maternity review team has received a large volume of governance documentation from the Trust that is of importance and is of relevance to the review. It is now believed that the Trust have provided us with all the governance documentation that they have available that refers to the main time period under review. Findings following consideration of this documentation will be included in our final report.

2.10 For the governance documentation considered so far for this report the review team have found inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.

2.11 To date, the review team have also found inconsistent multiprofessional engagement with the investigations of maternity serious incidents at the Trust. There is evidence that when cases were reviewed the process was sometimes cursory. In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care. The review team has also seen correspondence and documentation which often focussed on blaming the mothers rather than considering objectively the systems, structures and processes underpinning maternity services at the Trust.

2.12 Further, whilst the action plans and recommendations that the review team have seen so far provide some limited evidence of feedback to staff, we have found clear examples of failure to learn lessons and implement changes in practice. This is notable in the selection of, or advice around, place of birth for mothers, the management of labour overall, the injudicious use of oxytocin, the failure to escalate concerns in care to senior levels when problems became apparent, with continuing errors in the assessment of fetal wellbeing.

2.13 This indicates that opportunities for valuable learning to improve care and the prevention of similar occurrences in the future were lost. The frequency with which particular issues have re-occurred, even within the limited group of cases reviewed so far, is entirely consistent with that conclusion. In the sections below we have provided anonymised

4 https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/

5 From 2003 to 2019 and provided by the Trust to the review team 10.11.20

vignettes of some of the mothers' and babies' stories; these are illustrative of the types of incidents which have occurred, and which might have been avoided had lessons been learned from previous events and changes in practice been implemented accordingly.

2.14 Within the 250 cases reviewed to date, we have also found that a number of the earlier cases of significant concern were not investigated at the time, although this appears to improve over the period under review. The Trust underwent external review and scrutiny by the CQC in 2015, 2018 and 2020[6], and by The Royal College of Obstetricians and Gynaecologists (RCOG)[7] in 2017. However, even within this later timeframe, there is evidence that some serious incidents were not investigated using a systematic and multiprofessional approach, and evidence is lacking that lessons were learned and applied in practice to improve care.

6 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report 2015

7 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/

Chapter 3

Trust Board oversight and External Reviews

3.1 As we have progressed with this review a number of apparent themes have emerged in the 250 cases and family interviews considered to date. These themes will be further scrutinised as we review the remaining cases, but the following are noted by the maternity review team at this early stage:

Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory

3.2 We understand from documents supplied to us by the Trust that there have been ten Chief Executive Officers (CEOs) from 2000 to early 2020, with eight in post between 2010 and the current day. Four of those eight were employed as interim CEOs[8]. Since 2000 there have been ten Executive Board Chairs. There has also been considerable Board level turnover amongst both Executive and Non-Executive Directors since the year 2000.

3.3 We have concluded that, it is probable that this lack of continuity at Board level has resulted in a loss of organisational memory. As new CEOs started at the Trust there was a tendency, until at least 2019, to regard problems at the Trust as *'historical'* or as a *'legacy'* from previous years. Indeed, one of the groups of cases of potentially significant concern submitted to the review team by the Trust, ranging from between 1998 and 2017 and therefore, includes some relatively recent cases, was titled *'The Legacy'* cohort by the Trust.

What the Care Quality Commission (CQC) said about the Trust

CQC Reports

3.4 The CQC reports in 2015[9], 2018[10] and 2020[11] vary considerably. We note that the two later reports are critical of leadership at the Trust. The 2015 CQC report graded the maternity and gynaecology services *'good'* across all five domains of safe, effective, caring, responsive and well led, with an overall rating of *'good'*. (CQC 2015, page 21). Oswestry, Ludlow and Bridgnorth Midwifery Led Units (MLUs) were also rated *'good'* across all 5 domains. The 2015 report noted that *'The Trust had recently opened the new Shropshire Women and Children's Centre at the Princess Royal [hospital] site. This had seen all consultant led maternity services and inpatient paediatrics move across from the Royal Shrewsbury [hospital] site. We found that this had had a positive impact on these services.'* (CQC 2015, page 2)

The CQC reports in 2018 and 2020

3.5 We note that in the 2018 and 2020 reports the Trust's overall rating of the domain *'well led'* was *'inadequate'*. The 2020 report states that there is a lack of stability in the Executive team. Overall, the CQC told the Trust they must *'ensure that there are effective governance systems and processes in place to effectively assess, monitor and improve the quality and safety of services'.* (CQC 2020, page 6).

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

9 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report January 2015

10 https://www.cqc.org.uk/provider/RXW CQC report 29th November 2018

11 https://www.cqc.org.uk/provider/RXW CQC report January 2020

3.6 In respect of maternity services at the Princess Royal Hospital, the CQC advised that the Trust must:

- *Ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults*
- *Ensure high risk women are reviewed in the appropriate environment by the correct member of staff*
- *Ensure grading of incidents reflects the level of harm, to make sure the duty of candour is carried out as soon as reasonably practical*
- *Ensure all women receive one to one care when in established labour*
(CQC 2020, page 8)

The review team will further consider these CQC reports of the maternity service and the Trust's responses to them in its final report.

MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)

Overview of MBRRACE reports: perinatal mortality rates at the Trust 2013-2017

3.7 Stillbirths, neonatal deaths and perinatal mortality rates for the UK are published by MBRRACE-UK in Perinatal Mortality Surveillance Reports[12]. These reports publish stabilised and adjusted mortality rates to adjust for chance variation due to small numbers and for key factors known to increase the risk of perinatal mortality such as mother's age, socio-economic deprivation, baby's ethnicity, baby's sex, multiple births and gestational age at birth (for neonatal deaths only).

3.8 MBRRACE issues individual reports to NHS Trusts indicating the local perinatal mortality rates. These Trust-specific reports recommend that Trusts should review existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care have been implemented.

3.9 MBRRACE reports show that for the years 2013-2016 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were up to or more than 10% higher than comparable UK NHS Trusts. For the year 2017 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were reported as up to 5% higher or up to 5% lower than the UK average (suggesting roughly comparable rates with other UK Trusts). Perinatal mortality rates for 2018 were not published at the time of writing this report.

Clinical Commissioning Group (CCG) oversight of the Trust

3.10 There are two CCGs in the local area, Telford and Wrekin CCG and Shropshire CCG. They were formally established in April 2013 and from 2019 have engaged in *'bringing their decision-making processes closer together'*[13].

12 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

13 https://www.healthwatchtelfordandwrekin.co.uk/news/new-board-members-join-shropshire-ccg-and-telford-and-wrekin-ccg/

3.11 The Maternity review team will have the opportunity to consider a range of maternity specific documentation from the two CCGs. As commissioners, the interactions with the Trust and the CCGs and the ***Primary Care Trusts (PCTs)*** before them, will provide valuable insight into the local external oversight the Trust's maternity services received during the timespan of the maternity review.

3.12 We note that during the inaugural Telford and Wrekin CCG Board meeting in April 2013[14] there appeared to have been some concerns raised about maternity services at the Trust, leading to the CCG intending to write to the Trust *'with regards to concerns with Midwifery numbers.'* (page 4).

3.13 In June 2013 the Telford and Wrekin CCG Quality and Safety report[15] describes that, following concerns raised by both CCGs, a 'Risk Summit' led by the NHS England Area Team had been held in May 2013. Concerns specific to maternity services were: *'Maternity services model and the number of SIs reported (in particular 1 high profile case and coroner's inquest and a 2nd SI...'* (page 5). In July 2013 a CCG led review of maternity services at the Trust[16] was commenced with the stated *'Lack of improvement in maternity services'* recorded as a 'risk' as follows:

'Risk 3 - Lack of Improvement in Maternity Services
External review of maternity services across the local health economy has now formally commenced and will report to Boards by September 2013.' (page 4)

3.14 The resulting report[17] published jointly by both CCGs in October 2013 will be considered more fully in the final report, as will further documentation received from the CCGs.

The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust

3.15 Prior to its demise in 2017 the purpose of statutory supervision of midwives was to protect the public by ensuring a safe standard of midwifery practice through enhanced quality and safety.

3.16 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by supervisors of midwives at the Trust. The review team will continue to consider all available supervisory governance documentation relating to any individual cases in this maternity review.

14 See Telford and Wrekin CCG, Minutes of Governing Board Meeting 090413 –page 4
https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/may-3/444-03-ccg-board-minutes-9th-april-2013-v1/file

15 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/june-3/542-10-5-twccg-board-quality-and-safety-june-2013-report/file

16 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/july-3/585-11-3-ccg-board-quality-and-safety-report-9th-july-2013/file

17 https://shropshireccg.nhs.uk/media/1197/maternity-services-review-msr-report-281013.pdf

Review of Maternity Services 2007- 2017

3.17 In June 2017 the Trust conducted an internal review of maternity services[18]. It considered the history of maternity services between 2007 and 2017, focussing on issues of patient safety, learning, and engagement with bereaved parents. The report concluded that '*all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service.*' 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.*' (2017, page 28.)

18 https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

Chapter 4

Multidisciplinary Review: Our findings following review of 250 cases

Midwifery and Obstetric issues identified in the review of 250 cases at the Trust

The roles of midwives and obstetricians in the multidisciplinary maternity team

4.1 Midwives and obstetricians work closely together providing maternity care. Midwives are specialists in the provision of normal pregnancy care throughout the pregnancy pathway. Obstetricians are the lead clinicians providing care for complex pregnancies and births in an obstetric unit working in collaboration with midwives and other health care professionals including obstetric anaesthetists. The following is a reflection of emerging themes identified from the 250 cases reviewed to date by the independent review team.

4.2 The midwifery and obstetric issues identified from these cases are merged for the purposes of this report, which recognises the close working relationship that is required between midwives and obstetricians for the benefit of mothers and babies within their collective care.

Compassion and kindness

4.3 One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust. Healthcare professionals are in a privileged position caring for women and their families at a pivotal time in their lives. Many of the cases reviewed have tragic outcomes where kindness and compassion is even more essential. The fact that this has found to be lacking on many occasions is unacceptable and deeply concerning.

4.4 Evidence for this theme was found in the women's medical records, in documentation provided by the Trust and families, in letters sent to families by the Trust and from through the families' voices heard through the interviews with the review team. Inappropriate language had been used at times causing distress. There have been cases where women were blamed for their loss and this further compounded their grief. There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.

4.5 *Follow up letter sent after discharge which states: 'If you would like to come and have a chat with me about the death of your baby…' There were no words of condolences or sympathy within the body of the letter. (2001)*

4.6 *A woman was in agony but told that it was 'nothing'; staff were dismissive and made her feel 'pathetic'. This was further compounded by the obstetrician using flippant and abrupt language and calling her 'lazy' at one point. (2011)*

4.7 *A woman was in great pain after delivery and left screaming for hours before it was identified that there were problems that needed intervention. The attitude of some of the midwives also made the situation worse. (2013)*

4.8 There are several examples from the cases reviewed to date indicating that minimal learning has occurred and that this lack of compassion and kindness has persisted. There are some examples of midwives and doctors who have made a huge difference to the women and families due to the care they provided and kindness they showed. However, kind and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team.

Place of birth: Assessment of risk

4.9 At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth. This can be at home, a midwifery led unit or an obstetric-led unit. Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate. In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth. There is evidence from interviews with women and their families, that it was not explained to them in case of a complication during childbirth, what the anticipated transfer time to the obstetric-led unit might be.

4.10 *A woman was considered appropriate for birth in a remote stand-alone birth centre despite developing known risk factors in the weeks leading up to her delivery. There were then errors in the fetal monitoring in labour. After birth the baby was not monitored appropriately despite clear warning signs, and was transferred, too late, to a specialist unit where the baby died. (2009)*

4.11 *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)*

4.12 *A woman who delivered in a stand alone birth centre suffered a catastrophic haemorrhage requiring transfer to the consultant unit, where she died. Her family stated that there had not been an explanation of the risks of birth in a midwifery led unit, nor information on the need for transfer if complications arose. (2017)*

Clinical care and competency: management of the complex woman

4.13 At the point of registration a midwife will have achieved competency in the required academic and clinical subject areas and therefore qualify for entry to the Nursing and Midwifery Council register. In a significant number of cases the review team found evidence that the clinical care and decision making of the midwives did not demonstrate the appropriate level of competence, with consequences for the mothers and babies in their care. One aspect is failure to recognise deviation from the norm and so failure to escalate appropriately.

4.14 In some cases the review team has found evidence of poor consultant oversight of mothers with high-risk pregnancies; they either remained under midwifery-led care or were managed by obstetricians in training without appropriate and timely escalation.

4.15 *A woman in the early third trimester of her pregnancy was admitted to the antenatal ward with severe pre-eclampsia, characterised by new onset hypertension and proteinuria. Shortly after her discharge home she had an eclamptic seizure and was taken to a neighbouring unit, where she delivered. (2011)*

4.16 *A woman developed severe high blood pressure and was managed on the labour ward. There was a delay in treating her high blood pressure and, following delivery, there was a further delay in seeking senior clinical advice. She subsequently died in another hospital. (2011)*

4.17 *A pregnant woman who was known to have large uterine fibroids had midwifery led care and was not referred to an obstetrician as her condition should have required. There were errors in the interpretation of the baby's growth and an obstetric opinion or ultrasound scan was not obtained. The baby was delivered around ten weeks early, was growth restricted and died the same day from a severe hypoxic birth injury. (2016)*

Escalation of concerns

4.18 In the cases reviewed so far, concerns regarding escalation have evolved as an overarching theme. The cases show repeated failures to escalate for further opinion and review. This is a key element of the role of the midwife and an integral part of safe practice. There is also evidence that when concerns were escalated they were not then acted upon appropriately or escalated further to the appropriate level. This may indicate a lack of multidisciplinary communication and collaboration and/or senior clinical supervision, both of which are key to providing safe care.

4.19 The reviewers found a significant number of instances both of failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants. From the 250 cases reviewed to date these problems appear to continue across the review period, suggesting a failure to learn from other previous serious incidents which had resulted in stillborn or severely brain damaged babies.

4.20 *A woman was induced for raised blood pressure at 37 weeks. The fetal heart rate was normal on arrival on labour ward. After artificial rupture of the membranes there was a failure by the midwife to record the fetal heart rate or escalate any concern and the baby was subsequently stillborn. The family did not feel that they were involved in the investigation and did not receive an apology. (2015)*

4.21 *A woman who was admitted with contractions and early signs of infection late in her second trimester of pregnancy was seen by a junior doctor and discharged without higher level assessment. Her management was not subsequently discussed with a senior colleague. Several hours later she was re-admitted and delivered a premature baby. (2015)*

Management of labour: monitoring of fetal wellbeing, use of oxytocin

4.22 Fetal heart rate (FHR) monitoring is an essential component of the safe management of labour. When labour is managed in a midwife-led setting the FHR is monitored using intermittent auscultation (IA). On the labour ward setting the FHR is usually monitored continuously with the ***cardiotocograph*** (CTG). The review team found significant problems with the conduct of intermittent auscultation and in the interpretation of CTG traces.

4.23 Oxytocin is an intravenous infusion commonly used in obstetric labour wards to increase the frequency, strength and length of uterine contractions. There are guidelines for its use and it should be used carefully and reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns. 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.

4.24 Long labour exacerbated by use of oxytocin can result in an obstructed labour leading to fetal distress and also difficult caesarean delivery because the fetal head is deeply in the pelvis. Long labours can also increase the risks of infection and excessive haemorrhage after birth. The review team noted many examples where oxytocin was used injudiciously; these cases occurred across the time period of the 250 cases reviewed, which suggests a failure to learn from previous cases where the outcome was poor.

4.25 *A woman who had a previous caesarean section was induced and had a long labour using oxytocin. The baby's head was in the occiput posterior position and this made the delivery by caesarean section difficult. The mother said afterwards that she had the impression that the Trust were trying to keep the caesarean section rate low. (2000)*

4.26 *A mother, admitted in labour with a breech presentation, had inappropriate use of oxytocin for her long labour with CTG concerns. Standard obstetric teaching is to avoid the use of oxytocin in breech labour and especially in this case, where there was the added complication of FHR abnormalities. Her baby was born in very poor condition and died a few days later. (2006)*

4.27 *A woman presented in labour at 39 weeks. There were CTG abnormalities in labour, which were not escalated. Oxytocin was used despite an abnormal CTG. The baby was delivered normally but developed a hypoxic brain injury and cerebral palsy. (2006)*

4.28 *A woman had a prolonged labour at a birth centre despite earlier concerns over abnormal CTG tracings during the antenatal period. She was transferred to the labour ward but her baby was stillborn shortly afterwards. Despite the failure to adequately monitor both the mother and the baby there was no investigation or learning. The mother and father did not receive an apology. (2007)*

4.29 *A woman was in labour and there were fetal heart rate concerns. Despite the abnormal CTG oxytocin use was continued throughout the labour. At the caesarean section there was evidence that there had been an obstructed labour. The baby suffered from hypoxic brain injury and died some months after birth. (2009)*

4.30 *A woman had oxytocin commenced in the later stage of delivery with CTG abnormalities. There was a ventouse delivery and the baby was delivered in poor condition and developed a hypoxic brain injury. (2010)*

4.31 *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 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 clinical practice in future. (2014)*

4.32 *A woman had a previous caesarean section followed by a normal delivery. The following pregnancy she was induced at term. Oxytocin was used in the presence of CTG*

abnormalities and there was excessive uterine action (hyper stimulation). There was also a failure to monitor the fetal heart during siting of epidural. An emergency caesarean section was performed and the baby was delivered in a poor condition. The investigation did not address the management of labour and CTG interpretation or the injudicious use of oxytocin. (2014)

4.33 *A woman was admitted in normal labour. There were CTG abnormalities in the second stage, which were not recognised and later it was also not recognised that the maternal heart rate was being recorded rather than the fetal heart. The baby was born in poor condition, developed hypoxic brain injury, and died several months later. (2015)*

4.34 *A woman had a failed ventouse delivery and emergency caesarean section in a previous pregnancy. In the next pregnancy the baby was found to be macrosomic (large) on scan at 36 weeks. The woman was admitted in labour and despite requests for a caesarean section she was persuaded to attempt a vaginal birth. This was complicated by a pathological CTG in labour with inappropriate use of oxytocin and shoulder dystocia. The baby died a few days later from hypoxic brain injury and complications of the shoulder dystocia. The family were dissatisfied with the investigation. The investig*ation failed to acknowledge omissions in care, which prevented future learning. (2015)

4.35 *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 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, and said during a meeting with the Review Chair that they had been 'put off, fobbed off and had obstacles put in our way'. (2016)*

Traumatic birth

4.36 Some cases involving long labour with injudicious use of oxytocin resulted in women becoming fully dilated and consequently being assessed for instrumental vaginal delivery. The review team found evidence in a number of cases of repeated attempts at vaginal delivery with forceps, sometimes using excessive force; all with traumatic consequences. There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.

4.37 *A woman laboured and had repeated attempts at forceps delivery. The baby sustained multiple skull fractures and subsequently died. (2007)*

4.38 *A woman who was known to have a big baby was refused her request for a caesarean section and encouraged to labour. She had a forceps delivery and the baby had* **shoulder dystocia** *with a resulting fractured* ***humerus****. In her letter to the Trust afterwards the mother wrote that she felt her request for a caesarean section was refused because the Trust wanted to keep their caesarean section rates low. There was no incident form or investigation. (2012)*

4.39 *A baby died following a traumatic forceps delivery. There were repeated attempts by two doctors to deliver the baby with forceps. (2013)*

4.40 *A woman had repeated attempts to deliver the baby using forceps. The baby was found to have skull fractures after birth and subsequently developed cerebral palsy. There was no investigation. The family were very dissatisfied with the Trust's response to their concerns. (2017)*

4.41 The reviews of these and other cases indicate that efforts to ensure a vaginal delivery either should not have been attempted or should have been abandoned and the baby delivered by caesarean section. Some of these deliveries were undertaken by consultant obstetricians, which was particularly concerning.

Caesarean section rates at The Shrewsbury and Telford Hospital NHS Trust

4.42 Caesarean section rates have risen in the UK over the two decades of this review. It is notable that for this period the caesarean section rate at The Shrewsbury and Telford Hospital NHS Trust has consistently been 8%-12% below the England average and those of its neighbouring units (Table 1). Over the years this has been positively reported in the local press with it widely known in the local community.

Table 1. Comparison of Caesarean section rates between The Shrewsbury and Telford Hospital NHS Trust, neighbouring Hospital Trusts, and the rates in England.

	The Shrewsbury and Telford Hospitals NHS Trust	University Hospitals of North Midlands NHST	Royal Wolverhampton Hospitals Trust	NHS Hospitals England
2006-2007	11.8%	24.3%	25.5%	24.2%
2007-2008	15.5%	23.5%	26.1%	24.6%
2008-2009	16.8%	24.1%	25.0%	24.6%
2009-2010	15.8%	25.6%	24.9%	24.8%
2010-2011	No data	-	-	-
2011-2012	14.9%	26.3%	25.9%	24.4%
2012-2013	16.3%	25.4%	25.4%	24.8%
2013-2014	16.3%	27.6%	27.9%	26.2%
2014-2015	16.3%	26.0%	28.0%	26.5%
2015-2016	19.5%	29.0%	28.2%	27.1%
2016-2017	20.8%	29.8%	26.6%	27.3%
2017-2018	21.0%	30.0%	28.0%	29.0%

(Data from NHS Maternity Statistics NHS Digital)

4.43 The review team came across many cases where women said that they had been aware The Shrewsbury and Telford Hospital NHS Trust wished to keep caesarean section rates low. A typical quote during interviews was that *'they didn't like to do caesarean sections'*. The review team observed that women who accessed the Trust's maternity service appeared to have little or no freedom to express a preference for caesarean section or exercise any choice on their mode of delivery.

4.44 The review team have the clear impression that there was a culture within The Shrewsbury and Telford Hospital NHS Trust to keep caesarean section rates low, because this was perceived as the essence of good maternity care in the unit. Whereas it is not possible to correlate this culture with overall poor obstetric outcomes, the previous vignettes show that in some individual cases earlier recourse to a caesarean delivery would have avoided death and injury.

Overall there did not seem to be a consideration of whether this culture contributed to unnecessary harm.

Bereavement care

4.45 It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a significant effect on the wellbeing of parents and their families in the time immediately following the loss and in the longer term.

4.46 The Stillbirth and Neonatal Death Society (SANDS)[19] states that high quality bereavement care involves a recognition of parenthood using sensitive and effective communication, whilst enabling informed choice in all aspects of care and decision making. This may be decision making with regards to delivery, seeing their baby, funerals and post mortem, to name a few aspects. Midwives and obstetricians need to have an awareness of these key issues and also an awareness of the grief and trauma that families may be going through. Compassion and kindness in care and communication by midwives, obstetricians and all members of the maternity team parents may encounter is essential. Such compassion can have a positive and long lasting influence on the experience families have at this time.

4.47 Whilst there is some limited evidence that parents were supported to spend time with their baby after death and to create memories from the very limited time they were able to spend together, there is also little evidence of follow up support being provided as would be expected and recommended. There are several instances where the bereavement care was either inadequate or non-existent, which had a negative impact on the wellbeing of the parents and their overall experiences.

4.48 Not only was bereavement care poor in a number of the 250 cases reviewed to date, there are also examples of completely inappropriate comments made to some family members after the loss of their baby. There are several examples where mothers say that they were made to feel responsible by Trust staff for the loss of their babies.

4.49 *One mother complained about the consultant obstetrician's attitude when seen on the neonatal ward. She described the consultant as being rude and completely dismissive of the family's concerns. She also complained about postnatal care saying that the staff were not aware of the issues and she had to keep explaining distressing details at every shift change. There was no investigation or learning. (2009*)

4.50 *A woman whose baby died after a particularly traumatic delivery was seen by the consultant afterwards. The consultant was described as having 'no compassion or understanding of the trauma experienced'. (2013)*

4.51 *The family had received limited bereavement support on Day 17 after birth. The family found this unhelpful and unprofessional. …….bereavement care was lacking to the point of being completely inadequate. The Trust's bereavement service should have made contact much sooner. There is no record that any follow up support and advice was given. (2016)*

4.52 *A mother experienced a neonatal death at 17 hours of age. She and her partner described the bereavement service 'as offering no support, lacking in compassion and actually making it so many times worse'. (2016)*

19 https://nbcpathway.org.uk/about-nbcp/national-bereavement-care-pathway-background-project

4.53 *A woman had an apparently uncomplicated homebirth. Later the same day and overnight she repeatedly rang the midwifery unit to say that she was concerned that the baby wasn't feeding properly. She was reassured but the baby collapsed and died the next day. The family felt they had to 'push for an investigation' and that the Trust did not listen to them. They believed that the bereavement care they received was inadequate. (2016)*

LOCAL ACTIONS FOR LEARNING: MATERNITY 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.

- **4.54** A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.

- **4.55** All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.

- **4.56** The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.

- **4.57** These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2[20] (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.

- **4.58** Staff must use NICE Guidance (2017)[21] on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.

- **4.59** The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.

- **4.60** The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse

20 https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

21 https://www.nice.org.uk/guidance/cg190

outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015[22].

- **4.61** Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.

- **4.62** There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training[23].

- **4.63** Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.

- **4.64** The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.

- **4.65** The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.

- **4.66** The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

Maternal Deaths

4.67 Between the years 2000 and 2019, there were 13 maternal deaths at The Shrewsbury and Telford Hospital NHS Trust. The review team were also contacted by two families who had experienced the death of their mothers whilst under maternity care at the Trust before 2000. These will be reviewed if clinical records become available.

4.68 The review team identified recurrent themes in the care of some mothers who died, which present opportunities for important learning from the initial evaluation of these occurrences.

4.69 In the cases reviewed from 2000 onwards there appears to have been a lack of antenatal multidisciplinary team planning for women with significant pre-existing comorbidities and/or other medical risk factors. Whilst the women appear to have been correctly identified as 'high risk' at booking, the review team were unable to identify the lead clinician with overall responsibility for the care of the woman in the majority of cases. Whilst pathways seem to have existed for referral to other medical specialities, once referred for specialist care, the resultant assessments were frequently conducted by junior doctors. There appear to have been no joint clinics and multidisciplinary care planning for antenatal monitoring, labour, delivery or postnatal care.

22 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

23 https://www.hsib.org.uk/documents/261/HSIB_Delays_to_intrapartum_intervention_once_fetal_compromise_is_suspected_Report.pdf

4.70 In some cases there was poor completion of the ***maternal early warning score (MEWS)*** which might have prompted escalation if completed appropriately, and there was frequently a failure to recognise the deteriorating patient. High risk and significantly sick women on the delivery suite were reviewed by junior medical staff without involvement of consultant obstetricians or consultant obstetric anaesthetists for lengthy time periods. There were delays in initiating appropriate investigations and treatment which also led to delayed escalation. These delays impacted on timely transfers to a higher level facility such as high dependency or intensive care.

4.71 The review team is further concerned about the rigour and quality of investigations after serious incidents such as a maternal death. In some cases no investigation was initiated. Some cases were investigated internally by a small governance team, no learning appears to have been identified and the cases were subsequently closed with it deemed that no further action was required. A number of investigations lacked visibility and input from the wider multidisciplinary team, resulting in missed opportunities for important learning.

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.

- **4.72** The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.

- **4.73** Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.

- **4.74** There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.

Obstetric Anaesthesia

4.75 Obstetric anaesthetists are an integral part of the labour ward team. Over 60 % of all women entering the labour ward require anaesthetic interventions, and many more are assessed by an obstetric anaesthetist in the antenatal or postnatal period[24]. The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work[25].

24 RCoA Guidelines for the Provision of Anaesthesia Services (GPAS); Chapter 9: Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020 "Raising the Standards", RCoA Quality Improvement Compendium, 4th Edition, May 2020, page 241-268; www.rcoa.ac.uk

25 OAA/AABGI Guidelines for Obstetric Anaesthesia Services 2013

4.76 The number of women requiring advanced levels of medical and anaesthetic care from maternity services has risen over the last 20 years, due to a number of factors including increasing levels of maternal obesity and its associated co-morbidities such as Type 2 diabetes, high blood pressure and cardiac disease. More women conceive with pre-existing medical problems and/or are delaying motherhood until they are older and may therefore have developed more underlying medical conditions[26].

4.77 The trend towards an older obstetric population with increasing morbidities and significant levels of maternal obesity means obstetric anaesthetists are increasingly required to take on the role of peri-partum physician dealing with the management of these underlying medical conditions in labour and in acute settings, as well as providing their traditional services such as pain relief in labour and anaesthesia for operative delivery or immediate surgery postpartum. The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability 'around the clock', as maternity is a 24 hours a day and 7 days a week service.

4.78 In considering the cases for this first report, the review team have identified several areas of concern relating to obstetric anaesthesia practice. The reviewers found a tendency towards simple task focus, e.g. siting an epidural, or administering anaesthesia, without a holistic assessment of the patient and appreciation of the wider clinical picture.

Poor obstetric anaesthesia practice

4.79 *A woman with severe and rapidly progressive pre-eclampsia and uncontrolled blood pressure (BP) was taken to theatre for an emergency caesarean section. The labour ward team failed to control her blood pressure and the duty anaesthetist compounded the issue when inducing general anaesthesia without administration of any drugs to attenuate the potential BP rise during intubation. This failure exposed the woman to an increased risk of cerebrovascular accident (CVA) or a stroke. (2011)*

4.80 *A woman requested epidural analgesia in labour. She had frequent contractions and felt the urge to push, although diagnosed as being in the first stage of labour. There were significant concerns about fetal wellbeing on the basis of the cardiotocograph (CTG). Despite this, the CTG was discontinued for a significant time to site the epidural. When the CTG was recommenced immediately after siting of the epidural, the fetal heart rate was difficult to obtain and an emergency caesarean section was indicated. The anaesthetist did not seek clarification on the CTG and possible urgency of delivery before siting the epidural. The baby was born in poor condition, requiring neonatal resuscitation. (2014)*

Lack of escalation to, and involvement of, senior anaesthetists

4.81 We also found several examples of lack of senior involvement from the consultant anaesthetists on call. Even in periods of high workload there was limited support by the consultant anaesthetist responsible for the delivery suite out-of-hours. Complex obstetric complications, for example severe sepsis or pre-eclampsia, or women with significant pre-existing underlying co-morbidities, were treated by very junior staff for extended periods of time even when the complexity of work clearly required senior input. There were some cases where there was an evident delay in escalating to the

26 Knight M et al on behalf of MBRRACE-UK. Saving Lives, Improving Mother's Care- Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013 – 2015. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017

consultant anaesthetist on call. However, when requested by junior doctors, we also found instances where the consultant anaesthetist failed to attend in a timely manner.

4.82 *A woman who had an epidural for pain relief in childbirth developed a significant headache and unspecific neurological symptoms after birth. She was seen over several days by a junior doctor. Only one review was documented in the notes. There was a significant delay requesting further diagnostic tests and involving the consultant anaesthetist. Subsequent imaging showed significant pathology that should have been detected earlier. The delay put the woman at significant risk for further complications. (2012)*

Limited consultant anaesthetist representation in incident investigation and multidisciplinary team meetings after significant incidents

4.83 The review team found instances of maternal deaths or cases of severe complications, where the obstetric anaesthesia team was requested by the obstetric risk management team to 'perform their own incident investigation' and not participate in any wider investigation or contribute recommendations to prevent such occurrences in future. Sometimes only junior anaesthetic staff attended initial root cause analysis meetings or obstetric anaesthetists were not represented at all in investigation panels or team meetings. This undermines the concept of multidisciplinary team working and indicates to the external review team that obstetric anaesthetists were not perceived as an integral part of the maternity team.

4.84 As late as 2016 the review team saw serious incident investigations without input from obstetric anaesthetists or relevant other sub-specialities. The lack of a well-functioning multidisciplinary team represented a significant weakness in the structure of the Trust's maternity services with a significant impact on wider learning from adverse events and ultimately a detrimental impact on patient safety.

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.

- **4.85** Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.

- **4.86** Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.

- **4.87** Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.

Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.

- **4.88** Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.

- **4.89** The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice' [27].

- **4.90** The Trust must ensure appropriately trained and appropriately senior/ experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.

- **4.91** The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

Neonatology

4.92 From our review of patient clinical records in 250 cases to date, for most babies the quality of neonatal care at the Trust appears to have been satisfactory or good and at times excellent. The period 2000 - 2019 includes the time when services across England and Wales were moving from a situation where many units delivered intensive care to one where all units became part of networks within which certain units were designated intensive care units and others were not.

4.93 Prior to 2006, the neonatal unit at the Royal Shrewsbury Hospital regularly delivered neonatal intensive care, as was appropriate at that time. From 2009 the unit was designated as a Local Neonatal Unit (LNU). LNUs are not expected to deliver ongoing neonatal intensive care. It appears that there was a period between 2006 and 2011 when the local network was transitioning from one model of neonatal care to another.

4.94 We have found a small number of cases where the neonatal care was substandard. However, these were very much the exception and we have to date found no evidence of systemic poor practice or lack of care in the neonatal service.

4.95 It appears from the majority of the 250 medical records reviewed to date 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.

27 http://www.csen.com/GPAS.pdf

4.96 Review of the medical records show that advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. It appears that their practice has been sound and likely to have contributed to the maintenance of good standards of neonatal practice within the Trust.

LOCAL ACTIONS FOR LEARNING: NEONATAL SERVICE

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 neonatal services.

- **4.97** Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.

- **4.98** There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.

- **4.99** The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.

- **4.100** There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

Chapter 5

Immediate and Essential Actions to Improve Care and Safety in Maternity Services

We include these **Immediate and Essential Actions** because the Minister of State for Mental Health, Suicide Prevention and Patient Safety has expressly asked us, as part of this first report, to make recommendations which will help to improve safety in maternity services across England. We are aware that to date, there has been a mixed approach to implementing change from national safety reports and reviews into maternity services triggered by concerns relating to safety, such as this review.

Recommendations are of limited use if they are not implemented; indeed, had earlier recommendations been followed at The Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes we are investigating might not have occurred. Relying on the strength of our collective clinical experience we have named our conclusions as **Immediate and Essential Actions** – i.e. these are things which we say must be implemented now if not already done so.

As a team of clinicians we are engaged in practice across eleven Trusts in London and the South East and South West of England. In addition to clinical practice, our current roles, or those we have held in the recent past include midwifery, clinical and divisional director roles, consultant midwives, leads for governance, labour ward coordinators, clinical matrons and educational leads. Many of us have been active in leading and supporting regional and national maternity safety initiatives and have published their expertise in maternal and child health on a national and international level[28].

Many of our **Immediate and Essential Actions** are not newly developed; they are largely formed from recommendations made in previous reports and publications, to which we have referred below. We have formed our 'musts' from recurrent themes we have identified from investigating the selected 250 cases of concern referred to in this first report, with the objective being to positively impact safety in all maternity services across England.

28 http://www.ockendenmaternityreview.org.uk/

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.

Our Ongoing Work

I am grateful to my Independent Review Team who continue to support me with this review. We have taken these initial steps, through the publication of this first report, towards making a significant difference in helping to improve safety in maternity services. This review of 250 cases at the Trust can now impact positively on the maternity care provision for women and their families in Shropshire with the Trust working with their commissioners to ensure this happens.

As our work continues, we implore maternity services across England to also carefully consider this first report, and to make ambitious plans to ensure timely implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** takes place.

Donna Ockenden

Appendix 1: Terms of Reference

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?

Key Principles

14. The review will be expected to:

a. Engage widely, openly and transparently with all relevant parties participating in the review process;

b. Be respectful when dealing with individuals who have been impacted by the incidents being investigated;

c. Adopt an evidence-based approach;

d. Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and babies;

e. Consider links to national policy and best practice in relation to midwifery, maternity, neonatal and obstetric care and investigation management that were relevant at the time; and

f. Consider the challenge of implementing proposals, including the workforce.

g. Handle data and information with care and in accordance with good information governance practice

15. For families who have contacted the Chair of the Secretary of State commissioned Independent Review directly, and whose cases were originally investigated by the Trust, the investigations of these cases will be reviewed. The review process will consider the investigations and associated action plans from each incident investigation to ensure these appropriately addressed the relevant concerns and were implemented by the Trust at the time.

16. All cases will be reviewed in relation to Trust policy and national guidance that was relevant at the time.

17. In 2018 NHS Improvement commissioned an 'Open Book' review of Trust records. Shrewsbury and Telford Hospital NHS Trust was requested to 'open its books' in relation to specific maternity data held by the organisation from 1 January 1998, when national incident reporting on the Strategic Executive Information System (STEIS) began, to 27 September 2018. The scope included patients from England and Wales (Powys).

18. The purpose of the review was to determine as far as reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to:

a. Maternal deaths

b. Stillbirths

c. Neonatal deaths

d. Babies diagnosed with hypoxic ischemic encephalopathy (Grade 2 & 3)

19. This has identified over 300 cases which don't appear to overlap with many other cases known to the review team. The independent review will now consider how to incorporate these cases, and any others which arise through the investigation, into its scope to assess whether their outcomes were the result of failings.

Resources

20. Resource requirements will be agreed between the Chair of the review, NHS Improvement and NHS England and the Department of Health and Social Care to ensure the review is adequately supported.

Timeframe

21. The overall timeline will be agreed between the Chair of the review, NHS Improvement and NHS England and Department of Health and Social Care, in light of the extended scope of the review.

22. The final review report and proposals should be available within one month of the review being completed.

Appendix 2: Glossary

Definitions and Medical and Midwifery terms used throughout this Report

Glossary of terms used

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
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
Clinical Commissioning Groups (CCG)	Groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anesthetists. They have a neonatal unit staffed by neonatologists and nurses
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
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
HSIB	The Healthcare Safety Investigation Branch. They investigate incidents that meet the Each baby Counts criteria and their defined criteria for maternal deaths https://www.hsib.org.uk/maternity/what-we-investigate/

Hypoxic ischaemic encephalopathy (HIE)	A newborn brain injury caused by oxygen deprivation to the brain. Graded into HIE grades 1-3 depending on severity
Humerus	The long bone in the arm
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
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
Maternal Death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
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
MatNeo 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
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'
MBRRACE-UK	(Mothers and Babies: Reducing Risk though 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
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 liveborn baby who died before 7 completed days after birth - Late neonatal death – a liveborn baby who died after 7 completed days but before 28 completed days after birth
Non Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation

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
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Perinatal death	A stillbirth or early neonatal death
Pre-eclampsia	A disease of high blood pressure, proteinuria and organ dysfunction occurring in pregnancy
Primary Care Trust or 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 or CCGs.
Shrewsbury and Telford Hospital NHS Trust or the Trust	
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal

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OCKENDEN REPORT

Appendix 2

Skipton House
80 London Road
London
SE1 6LH

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11th December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21st December 2020**. The priorities are:

1) **Enhanced Safety**
   a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
   b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
   b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) **Staff Training and working together**
   a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
   b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
   c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) **Managing complex pregnancy**
   a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
   b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) **Risk Assessment throughout pregnancy**
   a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) Monitoring Fetal Wellbeing
   a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) Informed Consent
   a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, by 21 December. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which will be published shortly and draws together elements including:

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) compliance against the CNST safety actions, and
4) a current workforce gap analysis

Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15th January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely

Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

Ruth May
Chief Nursing Officer, England

Professor Steve Powis

National Medical Director

NHS England and NHS Improvement

Recommendations from Ockenden Report into Maternity Services at Shrewbury and Telford Hospital NHS Trust					
No.	**Review Recommendations**	**Evidence required**	**UHL & LLR LMNS Compliance**	**Gap analysis**	**Actions**
1	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. A plan to implement the Perinatal Clinical Quality Surveillance Model.	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.	Regional clinical network approach to fetal monitoring guideline Launch of regional Intra Uterine transfer policy Awaiting Regional dashboard reporting MSDS Information LLR LMNS review UHL maternity dashboard monthly and discusses new monitoring outcomes annually Good attendance from UHL and CCG's at clinical network meetings	UHL is engaged and proactive in joining regional initiatives and promoting safety, it is evident through attendance at the regional clinical network and other regional meetings	Review maternity dashboard to consider clinical indicators that would highlight problems so care could be improved, or areas of improvement so the learning can be shared
		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.	Occasional external specialist asked to review cases. Internally a Chair from the Trust Exec team leads the RCA investigation	No regular external expert on RCA panel, although a regional approach is in prgress	Engage with midlands clinical network and Chief Midwife to create a pool of clinical experts
		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.	Excellent engagement and attendance at the LMNS from all health care providers working with maternity services.	Support the LMNS to to provide quality assurance to the CCG Board regarding implementation of the recommendations from this report	
		An LMS cannot function as one maternity service only.	The LLR LMNS only hosts one maternity service because of the extensive area it covers	Review of LLR LMNS and the maternity service it represents	Refer to chief Midwife and discuss with SRO for LMNS
		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.	The LMNS Chair/SRO does not currently have CCG Board membership, in recent recommendations the Maternity service was advised the Chair must be from the provider Trust and is therefore the clinical director for Womens and Childrens services at UHL	Chair does not currently have CCG board membership	Discuss with CCG Executive director of integration and Transformation
		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.	The maternity SI reports are sent to the Quality and safety CCG team for sign off, but not to the LMNS or Trust Board. The Trust has an adverse events committee where there is a Trust overview of all SI reports and key issues and these can be feed into Trust Board	No oversight of SI's and Key Issues at LMNS	Discuss with chair to add as an agenda item
		Quarterly Board review of perinatal safety, with formalised perinatal Governance processes to Board level Non exec safety Champion in post, developing a relationship with the LMS, include a Regional Chief Midwife and Lead obstetrician who have oversoght of perinatal quality and surveillance	Awaiting an update on the model of surveillance, UHL hold a quarterly perinatal oversight group with LMNS membership and Trust oversight, this feeds into the Trust Mortality Board. Non exec safety champion in place, however not involved in the LMNS Regional Chief Midwife in post	The non exec safety champion role is expanding, discussion with Trust Board to explore the extent of this The maternity safety champion role is to be reviewed nationally, awaith the outcome of this, although UHL has a robust process for the safety champions to feed into Trust board	Implement the Perinatal clinical Surveillance Model following recepit of guidance
2	Maternity services must ensure that women and their families are listened to with their voices heard.	Evidence of a robust mechanism for collecting feedback from service user's Evidence that the service engages with the MVP to seek feedback	Results of FFT including comments Review and reporting of themes from complaints report on annual CQC report and action plan to Improve feedback Review MVP minutes as eviidence of seeking there advice and support to improve feedback	Engage more community groups to assist in co-production of maternity services	Obtain information from partners of hard to reach groups and local communities interested in influencing maternity services
		Ensure there is an executive director in place with specific responsibility for maternity services	The Chief Nurse in UHL is the exec lead for maternity services	UHL meets the recommendation	No action required

		is there evidence of an independent senior advocate role that reports to both the Trust and LMNS Board and available to families attending follow up meetings where concerns have been expressed about care	Recognised advocate role embedded within the Trust	There is no advocate role currently to fulfill this recommendation	Discuss the role within the Trust and LMNS board
		Each Trust Board must identify a nonexecutive 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.	There is a non exec director allocated as Board level safety champion in UHL who has been in place for 18 months, the non exec director fulfills the role as describe in the safety champion brief	The non exec director does not have specific responsibility for ensuring the womens Voice is heard	The role needs consideration and review and the expectation of this role is expanding
		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.	Maternity services are engaged with the MVP, members of the MVP are invited to interview panels, reconfiguration board, to comment on information going to women and feedback comments from the Women thye engage with	The service encourages womens voices to be heard but may	Maternity services to collate evidence of womens voices been heard, to enable the service to provide the CQC with this evidence
3	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.	Multi disciplinary has taken place in UHL for 10 years, the evidence Is presented on the dashboard and collected on the electronic training system There are names of clinicians who attend available in the education team which can be validated as proof of multidisiplnary attendanc	This is embedded in UHL Maternity service	Implement reporting of multidisciplinary training reporting to the LMNS 3 times a year as recommended
		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	Twice daily ward rounds occur in both delivery suites with the consultant, junior doctors, aneasthetist and co-ordinating midwife except at weekends where I occurs once a day at times	The ward rounds are embedded the service	Review frequency of multidisciplinary ward rounds on a weekend/bank holidays
		Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	There has been no maternity safety training funding in 2019/2020. In previous years UHL has used this money to embed and enhance training, UHL has a robust record of bids and has presented previously regarding the use of safety money	No access to safety money in 2019/20	
4	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.	Consultant Obstetricans have specialist interest and lead on complexities in pregnancy, when women are identified as having complex needs they are referred to the consultant lead	Women with multiple co-morbidities/complexities should not attend mulple clinics with no lead conultant in charge of the overall care	Review the process within the service, to ensure one consultant is the lead where mulple complexities are present in pregnancy Complete audit profrma to assess compliance with this recommendation
		Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	Women are referred to a specialist clinic from booking if complications are present at that time. If the pregnancy becomes complicated later in pregnancy the referral occurs at that		Include in the above audit, compliance with completion of birth plans for complex women
		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.	UHL have applied to be a maternal medicine centre, currently on hold due to the pandemic, although currently accepting referrals from DGH maternity services	UHL have the specialist consultants and capacity to be a maternal medicine hub	
		This must also include regional integration of maternal mental health services.	The regional clinical network for mental health has recently joined with the overall regional clinical network, enabling mental health service issues to be discussed at a regional level, The clinical regional reference group previously met just as a mental health network but a regional approach has been in place for many years	LLR mental health service has recently been accpted as an early implementer in providing a mental health service for women suffering birth trauma. The bidding process showed excellent working between the maternity service, mental health service and public health and the CCG's	

5	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.	Women are risk assessed at booking and the notes reviewed again on submission to the Hospital where the midwives in the antenatal service review the noted to ensure the correct appointments are sent	Although women are checked at every antenatal visit and referred in to a consultant clinic if complications occur there is no formal risk assessment at every appointment	Review how midwives can evidence that they have risk assessed women at every contact Clarify with national/regional team what the expectation is of risk assessment
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	All women booked on a low risk pathway to deliver at home or in a stand alone unit have a 36 week risk assessment to assess if the place of birth in a low rsik setting is still appropriate and if not they are advised to have their babies in a consultant unit	High risk women who chose not to birth in a consultant unit are informed of the risks and reiewed by an obstetrician, this information should be documented in the womens notes	Add to audit programme, an audit to review the 36 week risk assessment for place of birth, include women who birth at home against advice
6	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.	There is a fetal monitoring midwife in post to comply with saving babies lives care bundle and a lead obstetrician. The midwife is a band 7 0.8WTE covering all areas within the maternity service. The lead fetal monitoring clinicians support staff in the role out of the regional guidance, work with the education team on the training package, assessment and delivery of the training. They are also members of the regional fetal monitoring group which review cases at each meeting to encourage shared learning. As part of the MatNeo project a new intrapartum risk assessment was devised which is completed on admission to ensure women have appropriate montioring throughout labour. This risk assessment is completed regularly throughout labout Fetal monitoring lead midwife at UHL set up national network meeting for fetal monitoring leads. The meetings facilitate shared learning, current challenges and the opportunity to share innovative practice. This meeting is not formally minuted but has meeting notes which reflects attendees and matters arrising.	There is no gap in this recommendation, although the funding is temporary for the fetal monitoring midwife The fetal monitroing lead can produce evidence of proactive up to date learning form the fetal monitoring network she started There is a robust training and review process in place	Work with the senior team to secure funding to make this post permanent Review thr process of learning and development from CTG meetings, monitoring and reporting attendance Fetal monitoring lead to present to LMNS AND Quality group the work the Trust have completed in rlation to fetal monitoring
		The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	There are twice weekly Fetal montiroing meetings via teams, which run for 30 minutes each and a different case is discussed each time. This has multi-disciplinary engagement and is well attended. Half fetal monitoring study days have been running since April 2019 and became full study day in April 2020. Due to covid it has ben reduced recently to half a day online with the completency assessment in place. Fetal monitoring competency assessments have been in place at UHL since 2011 and were part of the fetal monitoring session on mandatory training. There is a clear pathway for when staff fail their competence assessment with a different pathway for each staf group. Competency assessments are for continuous fetal monitoring as well as intermittent auscultation assessment. Fetal monitoring leads involved with staff support when there is adverse outcome and are members of the perinatal risk group where such cases are reviewed.	UHL can produce all the evidence of training, competency package and fetal monitoring meetings. Uhl are compliant with this recommendation	Produce an ongoing trajectory of compliance with training and review by LMNS quarterly

		The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines. This must include the introduction of a second fetal monitoring lead	UHL were successful in implementing SBLV1 and were on track to implement all elements of SBLV2 prior to covid. Due to covid there has been alterations in the GROW pathway and the CO monitoring, this was national guidance. We are beginning to reinstate the pre covid elements. There has been a fetal monitoring lead obstetrician for 18 months when the working party for the region developed the fetal monitoring regional guideline The lead fufills the role described in the recommendations	Due to CO testing stopping for 6 months, audit data is not complete. The monitoring has recommenced and audits are improving now as the reintroduction increases UHL has a fetal monitoring obstetric lead who works closely with the fetal monitoring midwife	UHL monitors SBLCB2 and reports quarterly to the NHSE, and bi monthly to the LMNS, continue surveillance and reporting
7	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	All women at booking are given a choice of intended place of birth. They are offered LRI, LGH, SMBC or homebirth. Women have access to UHL information leaflets on yourhealth.leicestershospitals.nhs.uk And the information is on www.leicestermaternity.nhs.uk	There is good quality information available in leaflet form and on the Leicester maternity website	Review the information avaialble with the LMNS to assess if there are any ways the service can improve promoting the pathways
		Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Women are supported in their choice of mode of birth including maternal choice for caesarean section and are referred to an obstetrician for a discussion.	The Trust has evidence of supporting women with their choices, any discussion should be documented in the notes with personalised care plan	Discuss with LMNS how to review and audit this recommendation
		Women's choices following a shared and informed decision making process must be respected.	Women's choices are respected within the service. Where women have not felt this was the case the commuity midwife has referred the woman to the intrapartum matron for further support and discussion.	Women are informed or risks but also supported to achieve the birth they wish.	Discuss with LMNS how to review and audit this recommendation
8	Workfore Review - it is clear the safe delivery of maternity services is dependent on a multidisciplinary team approach.	Recent birthrate plus assessment, including reporting the deficit in maternity support workers.	UHL last birthrate plus assessment was reported in March 2019, with an assessment 2 years prior to that. UHL have just applied for another refresh of birth rate plus Business case in 2018 approved for increase of 15 midwives and in 2020 for 20 midwives but 10 MSW's not approved	The last assessment highlighted a deficit of 55 wte midwives and 20 MSW's	Trust Boards to confirm that they have a plan in place to meet the birthrate plus standard by 31st January 2021, confirming the timescales for implementation.
		Work with HEE on the expansion of the midwifery undergraduate numbers, including a review of maternity placements.	2 years ago the second University in Leicester commenced and undergraduate Midwifery course which has increased intake of student midwives year on year since There is good recruitment from the local university out turn with all students wishing to stay in Leicester offered a pos	Development is needed within the support worker workforce and a pathway for support workers to move onto midwifery training	develop a business case to improve support worker numbers to support the midwifery workforce

Ockenden Review of Maternity services – Urgent Action

Action plan for UHL Maternity services for Immediate Action

DATE COMMENCED:	DATE OF LATEST REVIEW:	DATE OF NEXT REVIEW:	MONITORING COMMITTEE:
December 2020	18.12.20	14.01.21	W&C CMG Quality & Safety Board UHL Maternity safety champions LMNS
EXECUTIVE LEAD: Carolyn Fox			**OPERATIONAL LEAD:** Elaine Broughton and Kerry Williams

Ref	Standards	Action to be taken	Risks to Delivery	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment
1.	**Enhanced Safety**						
a.	A plan to implement the perinatal Clinical Quality Surveillance Model (further guidance to be published)	Engage with clinical network and regional team to have a robust process of inviting external reviewers on Incident panels. Await guidance of surveillance model	None	HOM, Clinical Director	21.12.20	1.	Awaiting further instruction, there is no detail of the model in the report or letter
b.	All Maternity SI's are shared with Trust Boards and LMS at least monthly, in	Add maternity SI's and HSIB reports with safety recommendations to Exec quality Board, Quality	None	HOM/ CMG lead for safety and risk	21.12.20	4	Trust Patient Safety highlight report details all incidents SI's and Never Events currently.

Status key:	5	Complete	4	On track	3	Some delay-expect to complete as planned or implemented but not consistently delivering	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	Standards	Action to be taken	Risks to Delivery	Lead for Action	Action Completion Deadline	Progress RAG	Progress update/comment
	addition to HSIB reporting	Outcomes Committee, the Trust board and LMS Agenda					This is shared with Quality Outcomes Committee and Executive Quality Board. Plan is to review the current Maternity Safety Report to expand the information from SI's and HSIB investigations.
2	**Listening to women and their families**						
a.	Evidence of robust mechanism for gathering service user feedback and working with MVP to coproduce local maternity services	Continue to push FFT and increase footfall. Continue with quarterly reports to CMG quality and safety board and LMS regarding themes from complaints Continue with annual reporting on CQC national maternity survey to Trust patient Experience committee	None	HOM/DHOM	21.12.20	5	Robust mechanism in place for seeking feedback already in situ via FFT and through the MVP Themes and feedback will be added to agenda's from the next meetings Work will continue to improve how feedback is used.
		Review the current approach to how the service uses the comments from FFT to improve care to ensure learning is maximised. Review Womens Patient experience Board to invite user rep	None	HoM/DHoM	Jan 2021		

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b.	Identification of exec director and non exec director with specific responsibility for maternity services to bring independent challenge to oversight of maternity and neonatal services, ensuring voices of service users and staff are heard	Non Exec director and Exec Director identified	None	Chief nurse	21.12.20	5	There is an identified accountable Exec Director and non-exec Director for Maternity Services, who work with staff to listen to safety concerns.
		Non exec director and safety champion to seek the views of the service users	Time constraint	Chief nurse	Jan 2021	4	These roles will be expanded to include the additional action of working with service users
3	**Staff training and working together**						
a.	Implement Consultant led labour ward rounds twice daily (over 24hrs) 7 days a week	Review frequency of consultant led ward rounds Review what is required to ensure twice a day rounds 24/7	Review of consultant job plans	CD/HOS	21.12.20	4	Currently ward rounds on delivery suite occur at least twice a day Mon-Fri and once a day on weekends.
b.	Joint multidisciplinary training is vital. Assurance to LMNS that this occurs	See comments, this is in place and embedded in the service. Await guidance to enable service to review if there are any changes required	None	CD, HOM, Education Lead	21.12.20	5	Multidisciplinary training has happened since 2011. Currently undertaking the following multi-disciplinary training; - Saving babies lives study day (skills drills) - Fetal monitoring study day

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c.	Confirmation that funding allocated for maternity staff training is ring fenced Any CNST Maternity Incentive scheme refund is used for improving maternity safety	There has been no allocation of National maternity safety money in 2020/21, however prepare bids for when safety training money next becomes available nationally	National monies being available	HOM/DHOM Education Team	04.01.21	3	2018/2019 and 2019/2020 UHL maternity service submitted successful business cases for safety training money. There has been no national money available in 2020/21 Business case will be drafted for when national money becomes available.
		Submit a paper to financial recovery Board highlighting the need to use this financial support for improving maternity safety	Trust in financial special measures			3	The Trust is in financial special measures, it is therefore imperative that this process follows best practice for financial governance and therefore until a paper has been discussed at Financial Recovery Board this action cannot be completed.
4	**Managing complex pregnancy**						
a.	All women with complex pregnancy has a named consultant lead and mechanisms to regularly audit compliance in place	Named consultant in place and mechanisms for audit established	none	HOS DHOM	21/12/20	5	Women with complex needs have a named consultant.
		to commence audit in the next month by 7th January 2021		HOS DHOM	7.01.21	4	Audit to be undertaken to provide assurance and identify any areas of improvement
b	Understand what further steps are required by UHL to	Enquire from NHS England when a decision will be made regarding the proposals for	None	HOS,CD	21.12.20	5	UHL have submitted a proposal working together as a regional HUB with two other Trusts to

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	support the development of maternal medicine hub	Hubs in the East Midlands					provide this service awaiting NHSE response
5	**Risk assessment throughout pregnancy**						
a.	A risk assessment must be completed and recorded at every contact. To include ongoing review and discussion of intended place of birth. (key element of personalised care and support plan)	Seek clarity as to requirement from regional chief midwife Review documentation of discussion of intended place of birth to ensure this happens every contact Complete audit proforma to audit compliance with plans of care and discussions	Completing a specific form for risk assessment and place of birth discussion every visit will require more staff as it will take a lot more time to see each woman	HOM/community matron/HOS	21.12.20	4	Risk assessments completed on admission in labour to ascertain suitability for intermittent or continuous monitoring. Risk assessments for HIE repeated throughout labour 2hrly. PPH risk assessments also completed on admission/at start of labour and reassessed throughout labour 4hrly. Currently planning audit to monitor compliance with both risk assessments.
6	**Monitoring Fetal Wellbeing**						
a.	Implement SBLCB-Element 4 states there needs to be one fetal monitoring lead. The recommendation is there are two-a midwife and obstetrician each site to lead best practice, training sessions, review cases and ensure compliance	Confirm obstetric leads with HOS Business case to secure permanent funding for fetal monitoring midwife	The midwife lead is funded from external money which finishes March 2021,	HOS/HOM/DHOM	21.12.20	5	The fetal monitoring midwife completes all these elements and the delivery suite leads, lead on fetal monitoring which just needs to be confirmed

Status key:	**5**	Complete	**4**	On track	**3**	Some delay-expect to complete as planned or implemented but not consistently delivering	**2**	Significant delay – unlikely to be completed as planned	**1**	Not yet commenced	**0**	Objective Revised

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	with guidelines						
7	**Informed consent**						
a.	Every Trust should have pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website	Review best practice of Chelsea and Westminster and adjust the www.leicestermaternity.nhs.uk website if needed	none	DHOM/matrons	21/12/20	5	There is robust information on the maternity website and access to on line leaflets for many pathways

Status key:	**5**	Complete	**4**	On track	**3**	Some delay-expect to complete as planned or implemented but not consistently delivering	**2**	Significant delay – unlikely to be completed as planned	**1**	Not yet commenced	**0**	Objective Revised

University Hospitals of Leicester NHS Trust

Caring at its best

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18 December 2020

By email to: janet.driver3@nhs.net
Janet Driver
Regional Chief Midwife for the Midlands
NHSE I

Dear Janet

Re Ockenden Review of Maternity Services – Urgent Action

Please find attached, as requested, the response from University Hospitals of Leicester (UHL) to the letter dated 14th December in relation to the Ockenden Review of Maternity Services.

As you will see from the document attached our Trust is on track to have completed all the Immediate and Essential Actions by the required date of the 21st of December, with the exception of action 3c.

This action relates to the "Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety".

As you will be aware UHL is currently in Financial Special Measures and as such, would not be in a position to confirm this funding allocation outside of our normal financial governance procedures. A paper will be presented to the next available Financial Recovery Board in January and the decision will be communicated to you immediately thereafter.

Please be assured of our commitment to act without delay to make the required improvements to deliver the best care to our women and families.

With best wishes.

Yours sincerely

Rebecca Brown
Acting Chief Executive

Enc. Action Plan

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

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.

- 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

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

The maternity dashboard is presented at the LMNS every meeting	Any deviations above or below normal reporting are reviewed and if felt necessary further scrutiny by way of a review submitted to the LMNS The dashboard is reviewed with the CCG annually to add any clinical indicators or alter thresholds according to national trends An example of this is a rise in third and fourth degree tears for which a deep dive was carried out and OASI training introduced A further example was a higher than national average PPH rate for which a PPH risk assessment tool was introduced	Monitoring of the outcomes on the dashboard. Any review on clinical outcomes that is presented to the Trust is reviewed at the LMNS				
All summaries of SI's are available to Trust Board All Maternity SI's reported to the CCG and reviewed when complete by the CCG			All Summaries of maternity SI's to be added to the LMNS agenda	HOM to request adding to February agenda	None required	No risk, the CCG's sign off the SI reports,there fore they are seen externally

External regional review for the defined criteria above, is achieved on request. There is an executive chair on every SI panel All cases of the defined criteria are referred to HSIB, reported to Each Baby Counts and to MBRRACE	An action plan is developed from the learning of incidents and completion monitored Learning bulletins are sent to all staff via email and closed social media pages and discussed at CMG Board Necessary changes are made to guidelines and disseminated to staff	Monitor outcomes via the dashboard, perinatal risk group, perinatal review group, perinatal oversight group. Review of national reporting through MBRRACE and Each Baby counts which compares the service outcomes to other Trusts Local Audit	Raise with the regional team that there is no robust process for regional clinical oversight More robust audit of changes in practice and embedding of QI processes	Regional Chief midwife Audit leads/HOM 31.01.21	Regional clinical oversight process Funding for midwifery audit lead will require a business case to FRB	The risk is mitigated by having CCG review and executive chair on an incident panel The Trust is in special financial measures. The mitigation will be support from the senior midwifery team
CNST SAFETY ACTIONS **Safety Action 1**-UHL compliant with reporting on perinatal review tool **Safety Action 2-** currently reporting the majority of data required on MSDS, on track to achieve required standard Safety Action10-UHL achieved this in CNST Year 2, however it has been on hold throughout the pandemic	Evidence can be reviewed nationally as it is a national tool The evidence is checked nationally The evidence is checked nationally					

Immediate and essential action 2: Listening to Women and Families
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.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

There is a non-executive director responsible for maternity services working collaboratively with the safety champion	The non-exec director is in attendance at the maternity safety meetings-the minutes of the meetings show evidence of this. Together with the safety champion she holds safety sessions monthly with maternity and neonatal staff	Feedback from staff and Women Staff survey Patient experience feedback	The non exec directors role is to be extended to incorporate listening to Womens voices	Chief Nurse/Trust Board 31.01.21	Time	Currently the HOM, DHOM and safety champion are involved with the MVP
The senior independent Advocate is a new role which NHS England have reportedly taken the lead on employing a number of them to work with Trusts and fulfil the recommendations	This post is not in place	Not Applicable	Work with regional and national teams to develop the role	HOM/ Regional Chief Midwife	?	There is no independent advocate, however the bereavement midwife liaises with families as do the investigators from HSIB. The professional Midwifery advocates could support
SAFETY ACTIONS **Safety Action1-**UHL are compliant with reporting on the perinatal review tool **Safety Action 7**-UHL can provide evidence of working with users and co-production through the minutes of the MVP and LMNS meetings	This evidence is reviewed nationally LMNS minutes MVP minutes					

Safety Action 9-the UHL maternity safety champions meet bi monthly,	This is evidenced by the minutes of the meetings					

Immediate and essential action 3: Staff Training and Working Together

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.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**

Multidisciplinary training has been in place in UHL since 2011.	The data for training is collated by the education team as evidence, the proof can be validated by reviewing names and job roles of attendees	The compliance figures are reported monthly the CMG Quality and performance board, LMNS, and performance review meetings	Increase compliance-since mandatory was stopped during COVID pandemic the training figures have not yet reached compliance	HOS, CD, HOM and DHOM March 2021	Releasing time to train (this is difficult at the moment due to increasing hospital admissions due to COVID)	Compliance is increasing and extra on-line training is been made available
There are multidisciplinary ward rounds on delivery suite twice a day	The consultant led ward rounds occur twice a day, however there is no process to document them	The compliance will be monitored at CMG Quality and Performance Board and LMNS	Introduce a recording tool	CD, HOS 02.01.21	None	There is no risk
The maternity service submits bids for training monies and has to justify to HEE and NHSE how it has been spent	The last round of bids for maternity safety money, UHL presented at a national conference how it was spent.	CMG Quality and Performance Board LMNS	Ensure further maternity safety money is procured in a timely manner	HOM/DHOM/ LMNS	Financial resource for maternity safety	The service is providing as much training as possible with the limited resource
SAFETY ACTIONS **Safety Action 4** Workforce is reviewed using birth rate plus and RCOG guidance **Safety Action 8** In December 2019, midwives training achieved 90%, training was 85% for obstetricians 90% was achieved in Jan 2020.						

Immediate and essential action 4: Managing Complex Pregnancy
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

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Women identified with complex pregnancy at booking are referred to a specialist clinic and should be allocated a named consultant	Audit of the records to ensure each woman with a complex pregnancy has a named consultant	Audits are recorded by the Trust audit group and presented at the quarterly CMG audit groups, the actions from an audit are followed up by the CMG and Trust Audit leads	Develop a quarterly report to the CMG quality and performance board to report results of spot check audits	Intrapartum Matrons February 2021 CMG Board	Clinicians time to complete audit	This will be completed in addition to current roles
If women develop risk factors or complications during the pregnancy they are referred at that point to a specialist clinic and at that point should be allocated a named consultant	As above	As above				
Women with complex pregnancies have a plan in the maternity records for labour and birth	Audit of intrapartum care plans, which can be included in monthly spot check audits					

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
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.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Women have a risk assessment at booking and then they are assessed through routine antenatal care at follow up appointments, although this is not evidenced as a formal risk assessment	Bookings are check on receipt by the maternity unit to ensure they have the appropriate referral	This process is embedded in the service and happens routinely any appropriate referral not made is reported on Datix	Seek clarity from regional maternity team as to what constitutes a risk assessment every contact	HOM 05.01.21	Support and advice from regional team	Continue clinical assessments every contact and document in records
Intended place of birth is reviewed at 36 weeks to ensure women are delivering in the correct environment, prior to this they would be advised to deliver in a consultant unit should they labour. A full assessment form is available for women choosing delivery at stand alone unit or home birth	These can be evidenced in the notes	These are not currently reported	As above	HOM 05.01.21		
Women have intrapartum risk assessments completed	The intrapartum risk assessments are monitored for compliance on monthly spot checks by the delivery suite co-ordinators	There is no formal process for reporting the spot check audits from the delivery suites. However the intrapartum matrons can collate these and report quarterly to CMG Board and LMNS as evidence	Prepare quarterly reports to evidence compliance with intrapartum risk assessments	Intrapartum matrons	Support from HOM and DHOM	Ensure timely monthly spot checks continue despite the pandemic

Immediate and essential action 6: Monitoring Fetal Wellbeing

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 the 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.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

UHL has a fetal monitoring midwife 0,4 wte for each site as per requirements of saving babies lives. A named fetal monitoring consultant, Twice weekly CTG review meetings are in place The fetal monitoring champion is involved in Training The fetal monitoring champion has set up a nation network for fetal monitoring champions to discuss best practise, guidelines etc UHL were fully engaged in roll out of a regional guideline for fetal monitoring **SAVING BABIES LIVES CARE BUNDLE** UHL were compliant with 90% of staff trained in December 2019 UHL compliant with all aspects of SBLCB2 element 4	Evidence of on line CTG meetings Member of faculty for fetal monitoring study day Record of national networking meeting Evidence of rapid reviews of incidence with CTG involvement Diary Evidence of cross site working The named consultant has just taken up the lead role but will join review meetings and training Education database Evidence as above	Improvement in compliance to fetal monitoring guideline Better understanding of fetal monitoring requirements Roll out of learning form incidents involving fetal monitoring Better outcomes where continuous fetal monitoring has been used Learning is shred at the regional networks Greater understanding of interpretation of intermittent auscultation	Prepare a business case for substantive support of two fetal monitoring midwives and obstetricians-this has just been added to Saving babies lives as above	**HOS and HOM 01.02.2021**	Financial support to ensure the post of 2 fetal monitoring midwives are funded substantively. Resource for the role to be included in the named consultants job planning	The risk is minimal in the short term as the fetal monitoring champion is currently covering both sites and has support from HOM, DHOM and delivery suite leads and also the education team

UHL compliant with 3 out of 5 elements currently due to COVID pandemic effect on CO monitoring and scanning criteria for growth						

Immediate and essential action 7: Informed Consent

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

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

The Leicester maternity website is updated with any new information and describes pathways and choices www.leicestermaternity.nhs,uk All the leaflets relevant to different pathways of care including Caesarean section, IOL, community midwifery care ect are available on line as a printable version if required There is an active MVP, the DHOM regularly attends and the maternity safety champion midwife is to commence attending. E.g information for BAME women in the pandemic was taken to the MVP. Regular review of FFT comments and results and reported to patient experience group Feedback to staff of complaints and compliments	The minutes of the MVP are reviewed at the LMNS and required for CNST. The HOM and DHOM have regular contact with the chairs of the MVP. There is attendance at the LMNS by the chairs of the MVP and they are invited on interview focus groups and reconfiguration process. They report womens views back to the service CMG quality and performance Board and CMG patient experience Board, this feeds into quarterly reporting at the Trust patient experience board	Review of patient feedback Feedback from the MVP Improved FFT results Reduction in complaints	Review of CMG patient experience group i.e. is it effective, is the service considering women's voices appropriately, involve members of the MVP	HOM and DHOM BY 31.01.21	Time	There are good processes in place presenting no risk currently

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

UHL Maternity services have completed a full birth rate plus exercise. Reports from these finalised in 2017 and 2019. A further review is booked in January 2021. Locally establishment reviews take place twice a year with confirm and challenge from the Chief nurse	Following each review business cases were submitted to the Trust executive Committee and finance Board	Maternity staffing report to be presented at Trust Board following bi-monthly review at maternity safety meetings, maternity Governance and CMG quality and performance Board	Complete birth rate plus review in Jan 2021 which is to include requirements for Continuity of Carer models, prepare a further business case to present to Financial recovery Board	HOM, DHOM and midwifery matrons. To meet the requirements of the Ockenden report a workforce plan is to be completed by 31.01.21 This will then be updated following receipt of final updated Birth rate plus report	Time and financial support	Staff rotate around the areas most pressured, there is an escalation policy in place, a 24/7 manager on call rota, currently supported with part time overtime payments. Robust recruitment and retention plan

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care
In UHL the Head of Midwifery reports to the chief Nurse. The organisation does not meet the criteria in the above manifesto as there is no Director of Midwifery in post and the Head of Midwifery does not attend the Trust Board to report on Maternity services

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

All NICE Guidelines are received and monitored by the Trust The maternity service completes a proforma to state that the guideline is been followed. If there is deviation from the NICE guideline justification for this is documented and referred back to the Trust	This is an item on the CMG quality and performance Board agenda and Executive Quality Board agenda Guidelines are monitored at the CMG performance review meetings with the executive teams	Guidelines are reviewed at the Womens guidelines group and signed off at the Maternity Governance meeting Appropriate clinicians with specialised knowledge in the clinical practice of the guideline review and update them	Review all guidelines again that deviate from NICE guidance.	HOS, Delivery Suite Leads, HOM and DHOM 31.01.21	Time	There is currently a process in the Trust that mitigates risk as described