The BMJ

Cite this as: *BMJ* 2022;376:o858
http://dx.doi.org/10.1136/bmj.o858
Published: 31 March 2022

Failure to work collaboratively and learn from incidents led to deaths of babies and mothers at Shrewsbury and Telford trust, review finds

Clare Dyer

Around 200 babies and nine mothers would or might have survived had they received the right care from Shrewsbury and Telford Hospital NHS Trust, a damning review of the trust's maternity services has concluded.[1]

The Ockenden review, which looked at the cases of nearly 1500 families who experienced maternal or neonatal harm mainly from 2000 to 2019, found repeated shortcomings and failings throughout the services over the past two decades. These included a failure to follow national clinical guidelines on a range of issues such as monitoring fetal heart rate or maternal blood pressure, management of gestational diabetes, and resuscitation.

The review found a longstanding failure of clinical governance, where a "continual churn" of the executive team and board led to an inability to deliver improvement. A shortage of midwives and doctors meant that staff were spread too thinly. Staff described a culture of "them and us" between midwives and obstetricians, with midwives frightened to escalate their concerns to doctors. Even when cases were escalated senior clinicians did not always take action.

The failure to follow guidelines, combined with delays in escalation and a lack of collaborative working across disciplines, "resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and unfortunately death," said the report.

In hundreds of cases, including deaths, the trust had not carried out a serious incident investigation, so lessons were not learnt. Incidents that should have triggered such an investigation were downgraded to a high risk case review (HRCR), "apparently to avoid external scrutiny." HRCRs did not have to be reported to NHS England, the local clinical commissioning groups, or the trust board.

Many cases where mothers or babies had been harmed were not investigated at all, and when investigations were carried out they often failed to identify properly what had gone wrong and missed opportunities to improve safety. The report noted that external bodies reviewing the services over the years had not picked up the pervasive failings.

The review said that some mothers and babies had been harmed by the trust's determination to have a low rate of caesarean sections. It welcomed the recent advice to trusts from NHS England and NHS Improvement to stop monitoring these rates.[2]

Unprecedented review

The size and scale of the Ockenden review is unprecedented in NHS history. It was set up in 2017 by the then health secretary, Jeremy Hunt, after years of pressure from two mothers whose newborn babies had died. In the five year investigation cases were reviewed by multidisciplinary teams of midwives, obstetricians, neonatologists, anaesthetists, and other specialists where relevant.

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

"The reasons for these failures are clear. There were not enough staff, there was a lack of ongoing training, there was a lack of effective investigation and governance at the trust, and a culture of not listening to the families involved. There was a tendency of the trust to blame mothers for their poor outcomes, in some cases even for their own deaths."

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

Local and national actions

The trust's first report, published in December 2020, looked at 250 cases and recommended a number of actions to make maternity services safer.[3] The final report identifies more than 60 local actions for Shrewsbury and Telford, as well as 15 "immediate and essential actions" for all maternity services in England.

These include a multiyear workforce investment plan with minimum staffing levels agreed and adhered to, protected time for training, and a clear escalation and mitigation policy when the agreed staffing levels are not met. England's health and social care secretary, Sajid Javid, made a formal apology in parliament to the families who were harmed, and he committed to implementing all of the local and national recommendations.

The report acknowledged a recent funding announcement of £127m (€150m; $167m) by NHS

England for maternity services, but it also backed the £200m-£350m recommended by the Commons Health and Social Care Select Committee in June 2021.[4]

The trust's chief executive, Louise Barnett, offered "wholehearted apologies," adding, "We owe it to those families we failed and those we care for today and in the future to continue to make improvements."

Speaking for the whole NHS healthcare system, the NHS Confederation's director of policy, Layla McCay, said, "The NHS will closely examine and seek to understand these findings in detail and be ready to do all it takes to improve the provision of its maternity services across the board.

"The review highlights the need for increased investment in recruitment and retention of maternity staff in order to reduce the pressure on understaffing in these services, something which NHS leaders strongly support. It also shines a spotlight on the systemic failures that included external bodies and regulators—something which must also be addressed with urgency."

Edward Morris, president of the Royal College of Obstetricians and Gynaecologists, called the investigation "a watershed moment for maternity services." He added, "The RCOG is committed to enacting change, and a clear focus of this change must be to build and maintain safe staffing levels and positive workplace cultures. Protected time of staff training is vital, and this is only possible if there are enough staff.

"While we welcome the recent government funding for maternity services, we also hope to see £200m-£250m additional funding to ensure safe staffing in midwifery and obstetrics as recommended in this review and the Health and Social Care Select Committee report in 2021."

Steve Turner, registrar at the Royal College of Paediatrics and Child Health, said, "It is imperative that the terrible failings documented here over two decades are understood in order that all of the NHS can learn from them. It is shocking that clinical and managerial staff felt unable to speak out about what was happening for fear of retribution."

Claudia Paoloni, president of the Hospital Consultants and Specialists Association, said, "Several of the key findings echo our concerns that short staffing, not just in maternity services which are badly affected, is leading to a lack of training [and] over-reliance on locums, creating a negative working culture and ultimately risking patient care."

1 Ockenden Maternity Review. Independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. Final report: findings, conclusions and essential actions. 30 Mar 2022. https://www.ockendenmaternityreview.org.uk/

2 Wilkinson E. Hospitals in England are told to stop using caesarean rates to assess performance. *BMJ* 2022;376:o446. doi: 10.1136/bmj.o446 pmid: 35190378

3 Dyer C. Maternity care: services across England require "immediate and essential actions". *BMJ* 2020;371:m4797. doi: 10.1136/bmj.m4797 pmid: 33310782

4 O'Dowd A. Maternity services are not improving fast enough, say MPs. *BMJ* 2021;374:n1712. doi: 10.1136/bmj.n1712 pmid: 34230051