# A RESPONSE TO THE INDEPENDENT MATERNITY REVIEW

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SHROPSHIRE, TELFORD AND WREKIN DEFEND OUR NHS

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# Shropshire, Telford and Wrekin Defend Our NHS

# Response to Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

## Our involvement

Defend Our NHS is a campaign organisation, with priorities of opposing NHS cuts, closures and privatisation, and of doing all that we can to maintain the quality of local healthcare. Our own involvement with the maternity service at SaTH will therefore be a little different to that of others who respond, and a lot of our experience may be slightly tangential to the terms of reference of the independent review.

The campaign became involved with maternity following the publication of SaTH's 2016/17 Operational Plan, in April 2016. This identified – amongst a raft of cuts - an 'efficiency saving' of £1.5m a year, to be achieved through tackling so-called 'rural dis-economies of scale' in maternity services. This appeared to be code for closure of the rural MLUs, confirmed through subsequent discussions with senior staff at SaTH and the CCGs (and of course by the subsequent closure of the three rural MLUs).

Also in April 2016, SaTH held an Extraordinary Board Meeting to receive Debbie Graham's independent review into the death of Kate Stanton Davies. Some of our supporters were at the meeting, and were very moved by the courage and determination of Kate's parents. Over the following few months we got to know Rhiannon Davies, Richard Stanton, and Kayleigh Griffiths. We learned from parents not just of the tragedy of those avoidable deaths, but of a background of other babies being harmed, and in some cases dying. We also learned from Richard and Rhiannon of their long and lonely fight for justice; of being regarded as the 'enemy' for not going away quietly; and of an apology – for Kate's avoidable death in March 2009 - that was not issued by SaTH until January 2015.

We are immensely proud to have stood in solidarity with the parents who have fought so relentlessly to find out what happened to their babies; and who have worked for years to prevent avoidable harm or death for the mothers and babies who use local maternity services in the future.

Our own involvement has been for the most part mundane. We have shared information gleaned from SaTH, CCG and HOSC meetings. We have discussed and agreed questions to be put to Board meetings. We have helped in a small way to raise public awareness of a terrible and needless tragedy. We have recently shared information about the wider context for the SaTH maternity scandal with Jeremy Hunt as Chair of the Health and Social Care Select Committee.

We wholeheartedly welcomed the Ockenden review. As its scope widened, we publicised its work through our own networks and invited parents who had experienced poor maternity care to contact Donna Ockenden. Some parents contacted us directly, and in each case we suggested that they get in touch with the independent review. A small number of mothers made telephone contact with the campaign, and gave us accounts of deeply distressing events. For those families, we of course sought to provide empathy and support, and again urged contact with Donna Ockenden.

The nature of the work done by the campaign means that we do not hold any significant body of formal correspondence with NHS or other organisations that is directly relevant to the current

review. Nevertheless, we believe we have experience and knowledge that may perhaps be of relevance to the Ockenden review. We are therefore sharing this.

What else?

We worked immensely hard to try and prevent the closure of three rural MLUs, and shared information widely with national maternity leaders who were supportive of our stance. We were very involved in CCG engagement events around MLUs and encouraged participated in a SaTH engagement exercise. In both cases, core engagement outcomes were effectively sidelined. The MLUs were subject to repeated short-term closures in late 2016 and early 2017, and closed on an indefinite 'interim' basis in 2018. Local antenatal care is unavailable out-of-hours for rural women; postnatal care is sharply reduced; choice has all but vanished (with Shrewsbury MLU now closed as well). Women from across a vast geographical area face long journeys in labour to reach Telford. There have of course been safety concerns, including SaTH's practice of closing MLUs with two hours' notice, and the sharp increase in 'BBAs' in the Ludlow area that followed MLU closure. The closure of rural MLUs remains a hugely contentious area, but one that is probably well beyond the scope of this review.

This response is therefore much more around themes; reflections and observations on what has happened at SaTH and – even more importantly – *how* it has happened, as that is the key to prevention. There is documentary evidence to support some of this response; other conclusions are supported by anecdotal evidence from parents, midwives and doctors. There are also conclusions here that are necessarily subjective, but reflect a serious attempt to 'join the dots' of a complex set of intermingled problems.

We cover two major areas here. The first is an attempt to understand the complex multiplicity of issues around SaTH. The second is the wider context in which SaTH's maternity scandal occurred. There are necessarily many unknowns here, but those questions of 'Who knew?' and 'What did they do about it?' seem to us to be very important.

# SaTH

## Women have not had a voice

> *Do you know, it was the not being listened to; the being treated as if everything I said was insignificant. It was like she thought I wasn't trying hard enough or I was just being a wimp.*

This was from a woman who gave birth at SaTH in 2011 and still remembers her treatment with horror. The midwife did not believe the woman's account of the duration of her labour; did not check – or perhaps did not have access to - the notes that recorded this; and did not believe further intervention was necessary. This was a 'near miss'. The baby was born by emergency instrumental delivery after a relative made a fuss and demanded another opinion.

In 2016, one of the authors of this response carried out a quick trawl of publicly available information on deaths and serious harm occurring in SaTH's maternity service. The main sources were inquest reports and stories in local newspapers. A multiplicity of apparent causes behind the death or brain damage – but also a common thread running through virtually every account. Women had not been listened to. Pregnant women and women in labour were passive recipients of things done to them or for them. They were not partners in their own care or in the delivery of their babies. They did not have choice or control. They were not being heard.

Baroness Cumberlege's 2016 Better Births review emphasises the importance of partnership, control and choice for women during pregnancy and delivery. SaTH has struggled with these things.

## A history of weak leadership

Just out of curiosity, we looked at the comings and goings of SaTH Chief Executives over the last decade. There have been eight Chief Executives between 2010 and 2020; three of them there on an interim basis. Many of them have not been particularly effective. There has also been a considerable 'churn' at Board level, amongst Non-Executive Directors and the Executive team alike.

The poor continuity at the top of the trust has resulted in the loss of organisational memory, and perhaps in a tendency of each new Chief Executive to regard outstanding problems as 'history'; as something that belongs to people who have now gone. (The words 'history' and 'historical' have been applied again and again to growing evidence of avoidable harm and death in SaTH's maternity service. These are apparently things that couldn't possibly be happening on the watch of whoever leads the Trust at the time).

Put simply, the Executive team has failed to provide effective leadership. This has been apparent over many years.

The Non-Executive Directors have also not played an effective role. Our observation as a campaign is that the majority of Non-Executive Directors have had a very poor understanding that at times they need to call the Executive to account, and that part of their role is to provide scrutiny and challenge when it is required. Similarly, Chairs have drifted into a position of loyalty to an organisation and its Chief Executive, losing the required focus on openness and accountability, and on putting the interests of patients and local people at absolute centre stage.

The CQC reports of 2018[1] and 2020[2] have been immensely critical of SaTH's leadership. The overall rating of 'well led' was inadequate, in both reports. The recent 2020 CQC report provides a disheartening list of leadership weaknesses, including: a lack of stability in the Executive team; not all leaders having the capacity and capability to lead; leaders not being held to account; Executive members not always displaying behaviours consistent with trust values; unclear and ineffective governance arrangements; ineffective risk management; reliance on a top down and directive culture, with staff not feeling listened to; and leaders presiding over improvements that were not sustained.

This remains a very troubled organisation. The CQC's must do's for maternity include appropriate management of high risk women; grading of incidents to reflect the level of harm; the provision of one to one care for all women in established labour; and the senior management team acting to ensure processes for governance and oversight of risk and quality improvement. There are unlikely to be any quick fixes here.

## A culture of denial

At senior leadership level, or sanctioned at senior leadership level, there has also been a culture of denial where maternity service problems are concerned. Arguably, that has at times drifted into concealment.

### Simon Wright's denial of increasing review numbers

In August 2018, the media reported that the Ockenden Review was looking at a larger number of cases, an increase from the original 23; 'over 60' was the phrase used.

(It seems very likely indeed that this was true. A February 2019 status report from the Ockenden review was subsequently passed to the media in November 2019. This noted more than 270 cases identified by the review. The cases included 22 stillbirths, three deaths during pregnancy, 17 deaths of babies after birth, three deaths of mothers, 47 cases of substandard care and 51 cases of cerebral palsy or brain damage.)

SaTH Chief Executive Simon Wright responded to the 'over 60' report with straight denial. He described the figure as 'untrue' and 'misleading'. He told the Shropshire Star[3]:

> *To suggest that there are more cases which have not been revealed when this is simply untrue is irresponsible and scaremongering.*
>
> *This will cause unnecessary anxiety amongst women going through one of the most important times of their life and I would like to assure them that our maternity services are a safe environment with dedicated caring staff.*

[1] CQC. 29 November 2018. Shrewsbury and Telford Hospital NHS Trust Inspection report https://www.cqc.org.uk/sites/default/files/new_reports/AAAH6535.pdf
[2] CQC. January 2020. Shrewsbury and Telford Hospital NHS Trust Inspection report. https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ7638.pdf
[3] Shropshire Star. 31 August 2018. Shropshire maternity probe 'could be expanded to cover 60 baby deaths'. https://www.shropshirestar.com/news/health/2018/08/31/shropshire-maternity-probe-could-be-expanded-to-cover-60-baby-deaths/

Did Simon Wright not know what was happening? Did he not think to pick up the phone and find out? In the event, it was almost certainly his denial – rather than the media reports – that was misleading.

## Joint HOSC of 19th September 2018

A Joint HOSC meeting took place on 19th September 2018; the joint council committee across Shropshire and Telford and Wrekin with a statutory responsibility to 'scrutinise' local health and social care on behalf of the public.

***That morning*, the CQC had taken urgent enforcement action against SaTH. Chief Executive Simon Wright and Director of Nursing Midwifery and Quality Deirdre Fowler were both present at the meeting. Maternity safety concerns were high profile at the time, and a report from Deirdre on maternity services was one of two agenda items. Neither Simon nor Deirdre thought it relevant to mention the CQC enforcement action to the Joint HOSC.**

The minutes of the meeting show both the concern from councillors about maternity safety *and* the reassurance provided by Deirdre Fowler:

> *Members stated that it was important to know whether concerns of families who had made contact following the media coverage were historical as if they were recent this would be extremely serious. The Director of Nursing and Quality said that it was not possible to pre-empt those cases but that internal governance assurances, external assurance, and other assessment had shown evidence of significant learning in the Care Group.*

The omission of the CQC action sits very uncomfortably alongside the 'external assurance' reported by Deirdre. An HSJ summary of the CQC enforcement action, in a screenshot taken the following day, is here:

The Care Quality Commission has taken urgent enforcement action against Shrewsbury and Telford Trust and *HSJ* has learned the detail of the regulator's concerns which include:

- The trust not adequately assessing high risk pregnant women;
- Staff not following best practice guidelines in relation to high risk patients;
- Women classed as high risk women were not getting appropriate levels of consultant input;
- Midwives carrying out cardiotocography scans, which monitor a baby's heart rate, without sufficient consultant input;
- A lack of consultants' presence on the delivery suit with just one ward round per day.

The safety concerns raised by the CQC echo the findings of an independent review into the death of baby Kate Stanton-Davies who died in 2009. It found midwives and consultants at the trust had repeatedly failed to follow guidelines and best practice in relation to Kate and her mother Rhiannon Davies.

The CQC concerns were real and current. The CQC's belief in September was that patients were being put at risk. It is hard to see how a Scrutiny Committee can do its job if key information is withheld from it by NHS leaders.

Sitting in that meeting as an informed member of the public, there was a sense of language being used in a way that could have misled Joint HOSC members. Deirdre spoke about legacy cases and the legacy review, an internal SaTH process that at the time was separate to the rapidly escalating Secretary of State review. It felt at times that councillors wanted to know about the independent Ockenden review and may have believed they were being given information about the Ockenden review.

Deirdre's choice of words was consistently careful. The closest approach to describing avoidable mortality was a passing reference to 'potential opportunities for learning'. There was no suggestion at any stage, from Deirdre or from Simon Wright, of the CQC having identified maternity as an area of concern (despite much discussion of the CQC during an earlier part of the meeting). The overall impression given around maternity was a positive one, with an evident purpose of reassuring the Joint HOSC that there were not major problems in the maternity service. After all, there was internal and external assurance, and significant learning.

Chief Executive Simon Wright sat next to Deirdre and did not nothing to add to or correct her report. At that point in time - with knowledge of the content of the pending CQC report, with the Ockenden review clearly uncovering a terrible history, with a CQC enforcement notice on maternity safety that morning – both of them will have known that there was a gathering crisis here. Neither was willing to share this with the Joint HOSC.

There were two or three of us there from Defend Our NHS who had an overview of what was happening (and we actually learned by text and phone of the CQC enforcement action while the meeting was taking place). We left that meeting with a sense of shock over the profound lack of transparency and accountability from SaTH leaders.

## Cherry picking of data

A longstanding irritation has been the tendency of SaTH to 'cherry pick' maternity data in order to paint a positive picture. This has featured in reports to the Board and to the Joint HOSC. It has been the norm to compare SaTH stillbirth and neonatal mortality rates with the national UK rate reported by MBRRACE, often accompanied with a verbal comment that SaTH's performance is better than the national average.

This is simply misleading. MBRRACE assigns NHS organisations into 'comparator groups'. SaTH is in a comparator group of organisations with 4000 or more births per annum and *without* a Level 3 NICU. Hospitals with a Level 3 NICU typically have a *higher* perinatal mortality rate because service users will include women with a known high risk pregnancy and women bearing a child with a known disability. Similarly, organisations that offer neonatal surgery will tend to have higher mortality rates. Although it gets a little complex, this means that the national perinatal mortality rates will include those trusts that offer specialist care to a higher risk caseload. A comparison with national rates therefore makes SaTH look good, but has no validity. The only valid comparison, if MBRRACE data is being used, is with the comparator group average. A Chief Executive might not know this, but arguably a Director of Nursing and Midwifery, or a Medical Director, or a Clinical Director for Maternity should have this level of understanding.

At times, the data comparisons used have been completely meaningless. Deirdre Fowler, Director of Nursing Midwifery and Quality, gave a presentation[4] to the Joint HOSC meeting of 26th November 2018. This was entitled 'SaTH Maternity CQC Update'.

The presentation includes an extract from a SaTH maternity dashboard. The entry for 'crude stillbirth rate' compares the SaTH year-to-date stillbirth rate in 2017/18 with a 2016 national stillbirth rate from MBRRACE. It is an apparently favourable comparison: the SaTH YTD rate of 2.6 per 1000 against a cited national rate of 3.5 per 1000. The box is shaded green, to reflect what a positive result this is.

The comparison has no meaning, for several reasons:

- The *actual* national stillbirth rate for 2016 is shown by the MBRRACE report[5] to be 3.93 per 1000. It is hard to know where SaTH's figure of 3.5 came from.
- The comparison of SaTH's year-to-date 2018/19 data with national 2016 data should have been explained. It was the most recent MBRRACE data available, but in a period of falling stillbirth rates, its use needed to be qualified.
- *Any* comparison using MBRRACE data should be of SaTH against its comparator group, for the reasons outlined above.
- The reality is that in 2016, SaTH's crude stillbirth rate and the more meaningful stabilised and adjusted stillbirth rate were **higher** than the national rate. In 2017, the Perinatal Mortality Surveillance report[6] (MBRRACE) shows that SaTH's crude stillbirth rate was a rather frightening 5.7 per 1000, while the stabilised and adjusted rate of 3.79 per 1000 was the **highest rate** of all 45 organisations in the comparator group.

If the purpose of the report was to convey accurate information to the Joint HOSC, Deirdre could have explained that stillbirth rates over recent years were really concerning but 2018/19 was looking better. An informed Joint HOSC could then have explored with SaTH leaders what the possible reasons were, and whether or not this apparent improvement could be maintained. Given data that looked good but meant very little, the Joint HOSC could not do its job.

The exact same data on stillbirths was included in a maternity dashboard presented to the SaTH Board in February 2019[7]. Again, the presentation of information was without context and without discussion.

The problem of misleading maternity dashboard information has been solved by SaTH no longer making its maternity dashboard publicly available. (An outstanding question is, what lay behind that very high stillbirth rate in 2017? Prior to Covid restrictions, Defend Our NHS members attended almost all SaTH Board meetings and many Joint HOSC meetings. We are unaware of any public explanation by SaTH of that genuinely concerning stillbirth rate.)

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[4] Joint HOSC. 26 November 2018. SaTH Maternity CQC Update. https://shropshire.gov.uk/committee-services/documents/b12798/6%20-%20Shrewsbury%20and%20Telford%20NHS%20Trust%20-%20Maternity%20Services%2026th-Nov-2018%2010.00%20Joint%20Health%20Overvie.pdf?T=9

[5] NPEU. June 2018. MBRRACE UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2016. https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Surveillance%20Full%20Report%20for%202016%20-%20June%202018.pdf

[6] NPEU. December 2019. MBRRACE UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2017. https://www.npeu.ox.ac.uk/mbrrace-uk/reports#mbrrace-uk-perinatal-mortality-surveillance-report-for-births-in-2017

[7] SaTH Board. 7 February 2019. Maternity dashboard. https://www.sath.nhs.uk/wp-content/uploads/2019/02/11-Maternity-Services-Update-Feb-2019.pdf

## Treatment of parents

Unfortunately the defensive attitude from SaTH leaders seems to have extended at times to seeing bereaved parents as the enemy.

We give two examples here, because we witnessed them. The parents concerned will undoubtedly have other examples.

### Bereaved parents are not stakeholders

In 2017, SaTH took a decision to conduct its own review into maternity services. This was the Ovington review[8], reporting in June 2017. It looked at the history of SaTH's maternity service between 2007 and 2017, with a focus on issues around safety, learning, and engagement with bereaved parents. It seems to have reached rather 'sitting on the fence' conclusions. The review was launched at a stakeholder meeting on 27th June 2017.

Supporters of three local maternity campaigns were joined by Defend Our NHS to protest against the continued closures, with no notice to pregnant women, of the three rural MLUs. (It's quite stressful to have your midwife phone you and say *'Try not to go into labour this weekend'*).

More importantly here, bereaved parents quite reasonably thought they should be regarded as stakeholders in a review of maternity safety covering the time period in which their babies had died. Rhiannon Davies, Richard Stanton, Kayleigh Griffiths and Colin Griffiths asked to attend the launch meeting. They were not allowed to do so. They joined the protest outside – asking again to be allowed in. Richard asked repeatedly to speak to Simon Wright. Simon Wright eventually spoke to him on the phone, and again refused entry.

Bereaved parents (including a mother with a young baby) were left outside the meeting, in the rain. There was strong solidarity and support between campaigners and parents, but an atmosphere of hostility from SaTH. SaTH had also arranged a security presence – quite routine at SaTH meetings – and asked the police to attend in response to a plainly jokey message, on a social media account for about 20 minutes, suggesting that a Mum and her six-week-old baby should storm the meeting. This was a leadership that felt beleaguered – but responded in a way that deepened divisions and that was extraordinarily unsupportive of parents whose babies had died in SaTH's care. The Shropshire Star article[9] and photograph capture the event well.

### Attempts to shout down a bereaved father

A SaTH Board meeting took place on 27th September 2018. This was the week after the CQC's urgent enforcement action on maternity safety, and the week after the Joint HOSC meeting where Simon Wright and Deirdre Fowler had reported on a growing crisis in maternity by saying very little. This was also the first Board meeting following Simon Wright's vigorous denials in August that the Ockenden review was looking at a larger number of cases.

The maternity crisis was not reflected in Board paperwork. There is a brief report on the 'Legacy Case Review', and a 'Maternity Key Clinical Indicators' report introducing a maternity dashboard (which used 2015 MBRRACE data as a comparator despite the publication of 2016 data three months before). The Quality and Safety Committee report briefly notes the CQC enforcement action, and

[8] Colin Ovington. June 2017. Review of Maternity Services 2007 – 2017. https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

[9] Thomas Morton, Shropshire Star. 27 June 2017. Maternity campaigners protest outside Shrewsbury hospital meeting. https://www.shropshirestar.com/news/health/2017/06/27/maternity-campaigners-protest-outside-shrewsbury-hospital-meeting/

also that SaTH's EMBRACE (sic) stillbirth rate for 2016 was in a band 10% higher than similar trusts. An explanatory sentence mentions public health issues of smoking, obesity and diabetes – but does not acknowledge intrapartum stillbirth.

There were enough mentions of maternity that Non-Executive Directors were likely to reassure themselves that their Executive was dealing with things, but essentially it was a 'business as usual' meeting. It was to be a situation where the Executive continued to filter the information going to Board meetings and where Non-Executive Directors continued their failure to scrutinise or challenge effectively.

Richard Stanton, father of Kate Stanton Davies, attended the meeting. He attempted to ask questions of Deirdre Fowler, Director of Nursing, Midwifery and Quality as she finished her report. Chair Ben Reid refused to acknowledge Richard and repeatedly spoke over him. The 'top table' had a microphone system; Richard did not. It was therefore difficult for him to make himself heard. Ben Reid continued to talk over him. Ben then asked Chief Executive Simon Wright to make his own comments (and talk over Richard); Simon did this. Ben then asked Director of Nursing, Midwifery and Quality Deirdre Fowler to respond to Simon (again talking over Richard); Deirdre also did this. Each of them spoke loudly and through a microphone. Each of them knew very well who Richard was, and what had happened to his daughter. Each of them refused to acknowledge his presence. It was deeply disrespectful and deeply shocking.

Richard Stanton to his absolute credit continued his attempt to ask his questions. A supporter of Defend Our NHS stood beside him to lend physical solidarity. Other supporters of Defend Our NHS began a chant of 'Let him speak, let him speak'. When it became clear that the meeting could not continue, Ben Reid finally allowed Richard to ask his questions. It was a shameful episode. The minutes of the meeting[10] do not reflect what actually happened.

## Trust leaders and the maternity crisis

SaTH's leadership team has, frankly, not been up to the job. The CQC reports of 2018 and 2020 have been outspoken on this, and are accurate.

The impression of those of us who have attended Board meetings, and who spend evenings reading quality accounts and annual reports, is that the SaTH Executive over many years took very little interest in maternity. There was a brief focus on the death of Kate Stanton Davies in spring 2016, but the Extraordinary Board meeting of 4th April 2016 seems to have become the closing of a chapter for Trust leaders rather than the start of a process of rigorous learning. Increased interest was then deferred until the establishment of the Ockenden review in April 2017.

By the summer of 2018, the Executive cannot have been unaware that they were dealing with a tremendously serious crisis – but responded largely by downplaying the scale and importance of what was unfolding. There was a lack of transparency to their own Board, to partner organisations, and of course to bereaved parents, service users, and the wider public.

The challenge is that you have to acknowledge that a problem exists before you can deal with it effectively. SaTH's Executive became a barrier to learning and change.

[10] SaTH. October 2018. Minutes of Public Board Meeting of 27th September 2018. https://www.sath.nhs.uk/wp-content/uploads/2018/10/02-Minutes-Public-Trust-Board-270918.pdf

## Maternity leaders and the maternity crisis

The absence of an effective Executive creates a gap.

We have heard a view from SaTH doctors that there has been a dominant group of consultants at SaTH, people who have regarded themselves as the *de facto* leadership of the Trust. We have been told that these senior staff have historically got their own way, and that they have bullied colleagues who disagree with them. It's a group that has been described to us as 'The Boys Club' and 'The Shrewsbury Boys Club'.

It seems plausible that such a group exists. We have certainly seen evidence of a small group of consultants within SaTH fighting hard for their preferred policy direction within the Trust, and at times acting in an apparently organised way against members of the public who propose a clinically valid alternative. We have also seen online evidence of consultants using social media to bully colleagues who disagree with them on issues of Trust policy. Interestingly, last year's staff survey shows that 1 in 4 consultants report being bullied by colleagues; a remarkably high figure.

A dominant group of senior and largely unmanaged staff can wield immense power within an organisation, and can do so without any need for formal existence or a 'membership list'. If this group has existed – and we believe it has – then there is very little doubt that some of the senior medical staff in Women's and Children's Services have been a part of this layer. There have been two leaderships around maternity. One is the hapless Chief Executive, or others on the Board, struggling to know what's happening. The *actual* leadership has comprised senior medical staff, and in particular the Medical Director of Women's and Children's Services and the Clinical Director of Maternity.

Before drafting this document, we looked again at the papers for the April 2016 Extraordinary Board meeting. This was the meeting at which SaTH formally accepted the independent Debbie Graham report into the death of Kate Stanton Davies; a death that had occurred a full seven years before.

There was a remarkable omission from that meeting. There was not a single representative from the maternity service, nor from wider Women's and Children's services. The minutes[11] confirm this, and also show that no apologies for non-attendance were received from key staff who did not attend the meeting. Staff changes may perhaps explain the absence of the Care Group Director and the Head of Midwifery, but it is noteworthy that Andrew Tapp as Medical Director for Women's and Children's Services and Adam Gornall as Clinical Director for Maternity were both absent. Yes, it is difficult for busy clinicians to take time out of their schedule for meetings. But the absence of a single service representative, the absence of an apology or a message of support? Those things are much harder to explain, and seem at best to be deeply discourteous.

Part of the explanation may lie in the account given by Richard Stanton of a 2015 meeting attended by Andrew Tapp:

> *Central to the toxic management of the maternity department is consultant Andrew Tapp.*

[11] SaTH. Minutes of Extraordinary Board meeting of 4 April 2016. https://www.sath.nhs.uk/wp-content/uploads/2016/09/160428-02-Minutes-4-April.pdf

> *The minutes of a meeting specifically to discuss Kate's case in 2015, which Mr Tapp attended, stated the meeting was 'meaningless' and that her death was unavoidable as she had a terminal illness.*[12]

If Andrew Tapp was willing to ignore inquest findings, and believed so robustly in 2015 that discussions of Kate's death were meaningless, there is no reason to think he would have changed his mind a year later. There has been a significant level of arrogance amongst SaTH's maternity leaders.

## Clinical practice in the maternity service

There has been a long-established pattern in SaTH's maternity service: a high rate of induced deliveries combined with a very low rate of Caesarean sections, a lower than average rate of instrumental deliveries, and a high rate of vaginal deliveries.

There are two possible interpretations of this data. One interpretation is tremendously positive. Women are avoiding unnecessary intervention and therefore this is a good service.

The other interpretation requires a bit of thinking through. Low rates of Caesarean section and instrumental delivery suggest that the threshold for intervention at SaTH is different to the threshold for intervention used at other hospitals. Induction is associated with higher rates of subsequent intervention – so SaTH's low intervention rates therefore become even more surprising.

And most importantly, if local practice has been associated with high stillbirth rates and high neonatal mortality rates, then this should reinforce an urgent need to examine clinical practice. The history of individual deaths and harm could and should have acted as a catalyst for change. Similarly, MBRRACE data could and should have acted as a further very strong prompt for reviewing and, if necessary, changing clinical practice.

Clinical practice in SaTH's maternity service has been described to one of the authors of this document as 'eccentric' and 'unusual'. We have been told informally of a long history in SaTH's maternity service of women being left in active labour for very prolonged periods, with a resultant risk to both the woman and her baby. This includes women who are simply exhausted; it also includes babies who are 'stuck' and at significant risk. This has resulted in harm to women and babies. It has been suggested to us that this is one the factors behind SaTH's high stillbirth rate. Those stillbirths have included term babies, delivered after low-risk pregnancies.

The information here is anecdotal – but it is consistent with the history of increased perinatal mortality. Is this still happening? We don't know. SaTH no longer publishes its maternity data.

The latest HES data we have found is for 2018-19. This showed a continuing pattern of a high rate of induction (41% at SaTH compared to 34% nationally), and a low rate of Caesarean section (22% at SaTH compared to 30% nationally). Instrumental deliveries at SaTH were just slightly below the national rate (10% against a national 12%).

We do not accept the narrative that SaTH's safety issues are driven by a midwife-driven ideological quest for natural birth. Rather, the overwhelming majority of women giving birth in Shropshire are on a medically driven conveyor belt to the Obstetric Unit in Telford, with a strong chance of an induced delivery and minimal postnatal care. The opportunities for women to have a midwife-led delivery in a local setting were never high in Shropshire, and have massively diminished since 2016.

[12] Richard Stanton reported this to the SaTH Board meeting of September 2019, and the report was shared online by local radio station Signal107: https://www.signal107.co.uk/telford/news/local/toxic-culture-at-shropshire-and-telford-hospital-trust/

That is deeply regrettable. What happens in Shropshire is very far removed from any model of natural birth. It *could*, however, be about obstetricians chasing statistics – particularly on Caesarean section – that have historically been regarded as a marker of good care.

We are of course not arguing that increased intervention in childbirth is a good thing. But – and it is an important but – if clinical practice at SaTH has been out of step with national practice, and if this is associated with harm to babies or women, it is imperative that SaTH maternity leaders acknowledge this and implement any changes to clinical practice that will reduce risk to women and babies.

That acknowledgment had not happened by the end of last year. In November 2019, responding to a press article, Adam Gornall first claimed that SaTH's Caesarean section rates were within normal limits. Challenged on this, he then vigorously defended SaTH's model of care[13].

## Is change happening?

One of the authors of this document recalls an informal chat with a senior SaTH obstetrician probably in 2017. It was a little frustrating, as the obstetrician was just so confident that he was right and the service was right. The right deliveries were induced, the right women had C-sections, the right women had instrumental deliveries. It didn't matter that SaTH was out of step with other hospitals. SaTH had got it right.

Where is the motivation to change or learn, though, if you're already as good as you possibly could be?

It has been interesting to note that where change in SaTH's maternity service has happened and been publicised, the focus has been very much on 'technical' issues. This has been with the support of both maternity leaders and the Board. There has been a strong and repeated emphasis, for example, on CTG monitoring. In some ways, this emphasis on technical issues has perhaps been an 'easy option'. We have seen nothing – at any SaTH meeting or in any written document from SaTH – that acknowledges there may have been more fundamental problems in clinical practice.

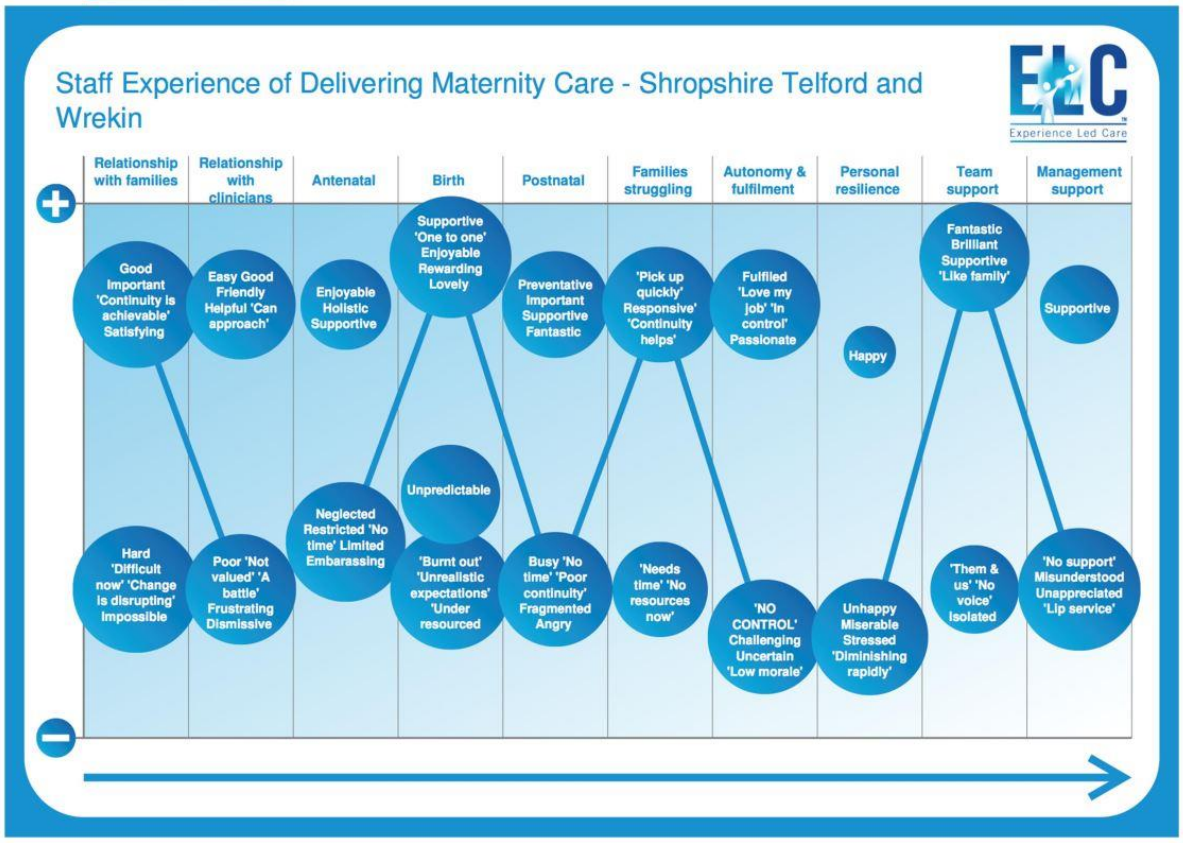
There has been no recognition either of 'cultural' issues; of unfounded self-belief, of women not being listened to; of difficult relationships between and within professional groups. Yes, these things are much harder to fix than CTG training – but are profoundly important.

## The SaTH midwifery service

The 'emotional map' below is powerful. It is from November 2017, and was produced during CCG engagement work on the future of MLUs.

Staff participants were overwhelmingly midwives and women's support assistants. The lines on the map capture their experiences and their views. The findings here are consistent with what we were hearing from a number of midwives at the time.

[13] Lintern, Shaun. Independent. 22nd November 2019. Shrewsbury maternity scandal: Hospital forced to backtrack on c-section claim. https://www.independent.co.uk/news/health/shrewsbury-maternity-scandal/shrewsbury-hospital-nhs-maternity-babies-caesarean-c-section-a9214236.html




The accompanying text shows how hard it has been to be a midwife at SaTH:

> *Whilst they enjoy good relationships with families and this is a highlight of their work, and they feel very supported by their immediate team and colleagues – a fact that is maintaining their personal resilience in the face of significant change and challenge within SaTH and the maternity service more broadly - relationships with colleagues beyond their immediate team are more fractured; and many people feel unsupported by management. This is more pronounced – although not limited to - amongst staff based in MLUs and the community than those who work solely in the consultant led unit. Staff report that antenatal and postnatal care are now very time pressured, and whilst in the past they delivered great family centred care, they feel this is changing as a result of changes made. Birth is still a high point for most; although the unpredictable nature of birth; unrealistic expectations and a sense of being under-resourced get in the way. Whilst some staff have maintained a sense of control over their working lives, many feel they have no voice and no control at all.*
>
> *This is undoubtedly impacting on their emotional wellbeing and resilience.*

Some of the negative experience reported by staff will have reflected escalating awareness (and media coverage) of safety issues in the service, and also the closure of the rural MLUs. Some of it was about underlying long-term problems. These included not being valued by 'dismissive' obstetricians, a lack of support from senior managers, and under-resourcing (including poor staffing). These strands of midwifery and support assistant experience will not have supported a safe service.

The stated views of the Clinical Director for Maternity would be consistent with a lack of regard for midwifery colleagues. On 22nd March 2018, Clinical Director for Maternity Adam Gornall attended a Joint HOSC, alongside the Head of Midwifery Sarah Jamieson, and senior colleagues from Shropshire CCG. The meeting was told of the future model of maternity care (yet to be implemented) that will formalise the closure of rural MLUs.

Adam Gornall spoke very dismissively about the rural MLUs, and his view that women believed them to be safe because they were based in community hospitals:

> *It doesn't convey any benefit. There are no doctors in those hospitals who will step in and do anything. There are no additional staff who will step in if there's a problem… I don't think people realise that's not the case. They could be giving birth in the supermarket with the same level of safety as in the MLU.*

He was also dismissive of home births. The phrase comparing midwife-led births with giving birth in a supermarket was one he evidently liked, and he used it, from memory, three times during the meeting.

The comments spoke volumes about the Clinical Director's commitment to choice and to implementation of Better Births. The lack of respect for the professional skills of midwife colleagues was also striking. Adam's perception seemed to be that midwives were of no greater relevance to the birth process than a cashier or shelf stacker in Tesco's. Sadly, Adam was not challenged by the Head of Midwifery or by senior Commissioning colleagues.

We have also been told of a senior obstetrician who remarked to a parent that he didn't speak to midwives.

Safety requires joined up care, effective team working, and mutual respect. It's as true in maternity as it is in any other clinical service. The views expressed by the Clinical Director of Maternity, relatively recently and with no embarrassment, were anachronistic, inappropriate – and may have reflected an underlying attitude that contributes to poor care.

We were in regular contact with midwives from 2016 through to 2018, reflecting the complete turmoil in the maternity service during this period. This was a desperately unhappy period for many midwives.

Midwifery managers told midwives in the urban centres, and particularly at the Consultant-Led Unit in Telford, that rural midwives 'sat around twiddling their thumbs'. There is no question at all that this phrase was used. It came back to us several times from different sources, and had reportedly been used at several meetings. It was an extraordinarily divisive management approach, and it led to really damaging relationships within the midwifery service. (It was also untrue, and failed to acknowledge that rural midwives provided antenatal and postnatal care to many of the women who gave birth at Telford. Different jobs, for sure – but no thumb twiddling involved). The poor working relationships were reflected in staff survey results.

Many of the midwives who had worked in Ludlow, Oswestry or Bridgnorth did not want to work in the very different environment of an Obstetric Unit, or were unable to balance their personal or family lives with a long drive to work in Telford. They had also lost the supportive close teams that had existed at rural MLUs.

A senior and well-respected midwife who had championed the rural MLU service suddenly disappeared, and had evidently been instructed or had agreed not to discuss the circumstances in

which she left her job. This contributed to a genuine climate of fear amongst rural midwives, who felt they could not openly express their disagreement either with the random short-notice closures of the MLUs, or with the subsequent long-term closures from mid-2017 onwards.

The midwives at Telford were working under huge pressure, and could not always maintain one-to-one care of women in labour. The service had run for several years on the basis of understaffing, and depended on midwives being prepared to work additional shifts when the Consultant-Led Unit was busy. As stress levels across the service rose, and sickness rates increased, willingness to work those additional shifts lessened – which in turn reinforced the stress levels, and resulted in further sickness.

And a significant source of stress has of course been the growing awareness that babies and women have been harmed in the service. Midwives want to take pride in their work, just as any clinical worker does. To be part of a service that has been failing is inherently stressful and demoralising.

These strands of experience came together to create a genuinely unpleasant working environment for many midwives. A significant number left, and morale was low for a prolonged period.

Some of that immediate crisis has passed. Recently, efforts have been made to provide more support to midwives. There are lessons here for SaTH though. Staff members need to be valued, supported, and treated with respect. That didn't happen for midwives. The Board was aware of stress and sickness levels, but unable or unwilling to explore what was actually happening here, or to take urgent action to support staff. And at no stage did maternity service managers accept any responsibility for the experience of many of their frontline staff. As public interest in the Ockenden review grew, the SaTH analysis became that low morale in maternity was caused by 'unfair' media coverage. Undoubtedly the media coverage had an impact on morale – but this was a very partial analysis.

It was also disappointing to read in the February 2020 Board papers that agreement was reached in April 2019 to recruit to the midwifery staffing levels established by a Birthrate Plus assessment in April 2017. When a service has run under this much pressure, it should not have taken two years to agree funding for adequate staffing. Again, there are lessons for SaTH (and no particular reason to suppose that they have been or will be learned).

## A charm offensive

As the crisis in maternity escalated, SaTH chose to respond with a major charm offensive designed to demonstrate the safety of the service.

Clinical Director Adam Gornall put together a 67 page PowerPoint presentation entitled 'Maternity Learning: the facts'. It can still be found quite readily online[14]. Adam used this presentation with the media (we think twice); it was shown to the SaTH Board on 25th October 2018, and to the Joint HOSC on 11th January 2019. It may have been used elsewhere. The presentation was withdrawn in February 2019 when Kathy McLean of NHSI wrote to SaTH and instructed the Trust to stop using it. This followed a complaint to NHSI made by Rhiannon Davies and Richard Stanton (parents of Kate).

[14] SaTH. Maternity Learning: the facts. November 2018. https://www.sath.nhs.uk/wp-content/uploads/2018/11/Maternity-Learning-Presentation-AG.pdf

The HSJ account[15] outlines SaTH's belief that the presentation was accurate and the NHSI view that it was not. Bizarrely, the Trust's position seems to have been that the presentation was accurate but only if viewed alongside the minutes of the 25th October Board meeting: *'Mr Gornall's presentation should be read alongside the minutes of that meeting – the two should not be taken in isolation.'* And although SaTH agreed to withdraw the presentation, the agreement was grudging: *'The presentation will not be used in any future forums due to the evolving nature of the subject and the need to ensure we present the most up-to-date picture.'*

One of the authors of this paper (Gill George) was at the Board meeting where the presentation was made by Adam. She was horrified by it; genuinely shocked and disgusted. She asked at the following Board meeting, on 29th November, for Adam Gornall's presentation to be withdrawn as it was misleading and was causing distress to bereaved parents. This request was turned down by the SaTH Chair. The exchange does not seem to have been minuted.

What was so shocking? By this time, it should have been very apparent to Adam Gornall that the service he was leading was deeply troubled. The Ockenden review was looking at a long history of avoidable harm and death, with the number of cases under review known to be at least 100 at that time. Although 2017 MBRRACE data had not yet been released, Adam of course knew that the stillbirth rate for the year was shockingly high (in the event, the worst in the MBRRACE comparator group). And although this was a month before the CQC report was published, Adam will have been well aware that the CQC had identified maternity as an unsafe service (and the CQC had already taken urgent enforcement action around maternity safety). It was a time for honesty; for acknowledging that things had gone wrong in maternity and expressing an absolute determination to achieve change.

Instead, the presentation was about giving the audience 45 minutes' worth of good news stories. It was not intended to convey information. The language used was hugely technical, and the slides – many of them detailed graphs or charts, others with very 'busy' text – could not possibly be read by most people present. This was about SaTH saying, 'Here is our expert to reassure you that we are getting things right'.

Adam airily dismissed MBRRACE results on the basis that SaTH had functioned for a time as a Level 3 NICU although it was not classified as one. (His dates for this seem to have been at odds with accounts he has given elsewhere). He did not mention the CQC or the CQC enforcement action at all. He did not mention the Ockenden review. He was insistent that SaTH wasn't an outlier in terms of mortality and was performing at better than the national average. He emphasised the learning and improvement that had taken place in preceding years and were continuing. He spoke of the thorough and objective investigations of incidents. Concluding remarks included that SaTH recognises when incidents occur and *'owns them from the outset'* and that *'overall harm at SaTH is lower than average'*.

The Board had no questions for Adam, which perhaps reflects the Board's knowledge of and interest in maternity at the time. The Chair then allowed public questions. Gill challenged the dismissal of MBRRACE data, which Adam was visibly irritated by. He was unable to explain what impact this Level 2/Level 3 confusion had had on MBRRACE data, nor why this apparent wrong categorisation had not been shared with the NPEU. He simply brushed aside the CQC enforcement action. And on the

[15] Lintern, Shaun. HSJ. 14 February 2019. NHSI cautions trust over inaccurate mortality picture. https://www.hsj.co.uk/policy-and-regulation/nhsi-cautions-trust-over-inaccurate-mortality-picture/7024409.article

increase in the number of cases being considered in the Ockenden review, his analysis was that media coverage meant that inevitably people came forward and they just wanted to ask questions. He conceded that investigations had not been perfect but this was the same as other hospitals.

There was no hint of humility, self-doubt, reflection or concern. This was at a point in time when it was already becoming clear that avoidable deaths or harm in SaTH's maternity service might well amount to the biggest maternity scandal in NHS history. There appeared to be absolutely zero awareness of this from the Clinical Director for Maternity.

At the Joint HOSC on 11th January 2019, the presentation seems to have been well-received. The minutes of the meeting[16] show:

> *Members expressed their gratitude to Mr Gornall for making the presentation to the Committee as it had helped them to achieve a real understanding of a positive picture within an emotive and sensitive area.*

Councillors were given reassurance that was – very sadly - misplaced.

Gill spoke to a local journalist who had attended Adam Gornall's presentation at a media briefing. He said he didn't understand a word of it but SaTH seemed to be doing pretty well. This was probably SaTH's desired outcome.

## Accountability: it *should* be part of holding a senior NHS post

Cathy Smith, former Head of Midwifery, was sharply criticised in the 2015 independent review into the death of Kate Stanton Davies. Cathy moved to another senior post in the organisation in 2015, leading on Virginia Mason transformation work. She left SaTH last year.

Edwin Borman, who as Medical Director certainly should have known that things were going desperately wrong in maternity, moved sideways to a newly created post, Director of Clinical Effectiveness. He retained his seat on the Board. The move took place in November 2018, days before the publication of the very damning CQC report that led to SaTH being placed in special measures.

Andrew Tapp, as Medical Director for Women's and Children's Services, has quietly become Medical Director for Transformation at some point in the last year. Andrew Tapp has been less visible than Adam Gornall as the maternity crisis has unfolded, but his role and influence will have been at least equal to Adam's.

There is no culture of accountability at SaTH.

There was an interesting aside at the Board meeting of 6th February 2020. Gill George, in a public question, noted that three staff who might be culpable in terrible events had been moved sideways to senior posts within SaTH, and asked if this was the best and most accountable way of responding to the biggest maternity scandal in the history of the NHS. Medical Director Arne Rose replied*, 'A few people were referred to the GMC. Everybody was appropriately investigated. A handful of clinicians were investigated*'. He was interrupted by Chair Ben Reid, who said firmly, *'We'll leave it there'*.

[16] Shropshire Council. 18 March 2019. Minutes of Joint HOSC meeting of 11 January 2019. https://shropshire.gov.uk/committee-services/documents/s21622/final%20mins%20JHOSC%2011%20Jan%2019.pdf

It remains a mystery, of course, as to who was investigated, and why, and what the GMC conclusions were.

## Is SaTH a learning organisation?

No. At any rate, it has no tradition or history of being a learning organisation around maternity. It would be possible to trace through how RCOG concerns in its 2017 review resurfaced in the CQC 2018 report, and again in the CQC 2020 report. It would be possible to highlight that Kate Stanton Davies died in 2009 and it took SaTH until 2016 to produce a coherent action plan in response to her avoidable death. It would be right and proper to express utter amazement that MLUs had no operational policy at the time of Kate's death in 2009, and it took until 2015 – **2015!** – for SaTH to put that operational policy in place.

There would be any number of individual examples of failure to learn, and we suspect the Ockenden review will identify many of these.

There is a more fundamental problem though. The whole history of SaTH is of a Board that does not do detail and is not proactive. The Board waits for problems to happen – and when they do happen, the priority is not patient safety, but the protection of organisational reputation. Our view is that on maternity the default Board position has become one of denial and even active concealment. It is a truly depressing record. However you choose to describe it, this is not leadership.

And within the maternity service, undoubtedly learning has taken place on any number of things – as long as that learning has not in any way been seen as threatening by senior obstetricians. This means that a core problem of 'eccentric' clinical practice – which may be related in a very direct way to avoidable mortality and harm – has probably simply continued.

A complete inability to reflect is the hallmark of a truly rotten clinician. Our view is that the supreme self-confidence and self-belief of SaTH's maternity leaders have been a very big part of problems in SaTH's maternity service.

**Paula Clark, interim Chief Executive, told the Board meeting of 28th November 2019 that SaTH was *'one of the hardest organisations to change that I have ever been in'*. This followed an emotive and difficult discussion on maternity. It was a level of honesty that has not been heard previously from any other SaTH Chief Executive.**

**There are many things that need to change at SaTH (with the provision of adequate funding being one of them). The change that is needed will not happen unless the Board actually starts to lead. This would require the Executive to challenge the 'quasi leadership' that has evolved amongst a small layer of consultants. It would also require Non-Executive Directors to understand that they must scrutinise and challenge, instead of acting like nodding dogs. It would require robust systems around governance, risk, and learning from incidents; things that in reality would also require cultural change. It would require the Board as a whole to acquire habits of honesty, openness and accountability that have not existed at SaTH for very many years. And it would require the Board to ensure that all its staff are respected and valued, that all staff are confident in raising clinical concerns, and that all clinical concerns are taken seriously and responded to in a timely way.**

**Will these things happen? We hope so, because local people need safe care in these hospitals.**

# Who knew, and what did they do about it?

## Background

Mostly, the NHS is in the business of caring for people, saving lives, improving the quality of people's lives. It is a very precious and valuable thing.

From time to time, though, the NHS behaves badly. The complexity of human ill-health and of modern healthcare means that the people providing health will sometimes make mistakes, and patients will sometimes be harmed. What needs to happen under those circumstances is absolute honesty; a meaningful apology to the patient or their family; and a thoroughgoing effort to learn from mistakes and stop other people being harmed.

What can happen instead is a systematic process of looking the other way.

At Bristol Royal Infirmary, where babies and children died in an unsafe heart unit, it is fairly clear that there was widespread knowledge of what was happening. This was combined, though, with little teamwork and leadership, poor monitoring, a 'club culture' amongst senior medical staff who wielded great power, a period of years for concerns to be taken seriously – and children were not a priority. The Guardian summary of the independent review report[17] feels unsettlingly familiar.

In 2013, the CQC admitted that it had suppressed a report of its inspections at Morecambe Bay[18]. Three years before, in 2010, the CQC had registered the trust as fully compliant, noting only 'minor concerns' about the maternity service. The following year, it emerged that the trust had the highest death rates in the country. At Furness General Hospital, part of the Morecambe Bay trust, eleven babies and one woman were found to have died avoidably.

Most recently, the independent inquiry into the harm caused by rogue surgeon Ian Paterson identified 'a culture of avoidance and denial' that allowed Paterson to continue. Paterson reportedly had a 'God complex'. He knew best, always – and women were harmed as a consequence.

We strongly suspect that are parallels in these terrible events with what has happened at SaTH.

As the scale of the scandal at SaTH gradually unfolded, we began to ask ourselves – and others – who had known. It was hard to believe, given that harm had occurred probably over some decades, that every health leader in the area had apparently failed to notice.

Information comes to campaigners through the grapevine very often. You assess its credibility. You think about the sources. You confirm with documentary evidence, if there's anything there in the public domain. What the grapevine told us about SaTH was pretty shocking. The picture described to us was that NHS England has known for many years of avoidable deaths in SaTH's maternity service but actively opposed measures to deal with this publicly or effectively. The CQC knew of serious problems – but nevertheless gave the maternity service something very close to a clean bill of health in 2015, following a 2014 inspection. We were told CCG leaders had known – but had consistently failed to take decisive steps to respond.

Can we prove this? No. We can establish that both CCGs were aware of safety concerns in the maternity service from their inception. We can also establish that these concerns were discussed at

[17] Guardian. 19 July 2001. A tragedy born of hope and ambition.
https://www.theguardian.com/uk/2001/jul/19/stevenmorris
[18] Guardian. 23rd June 2013. CQC publishes suppressed report on Morecambe Bay inspections.
https://www.theguardian.com/society/2013/jun/21/cqc-publishes-morecambe-bay-report

an early stage with the Area Team of NHS England. The gap between the CQC report and the reality that existed on the ground has to raise questions. It is also very evident that although the CCGs and NHS England knew, this information was not made available to service users. And of course babies and women continued to die or be harmed. In a significant number of cases, this was avoidable.

Whatever the explanation, there has been a monumental failure of regulation in Shropshire. It has cost lives. If it can happen in Shropshire, it can happen anywhere else in England. We would like to see accountability and ***change*** on this. There should be no place in the NHS for looking the other way while babies die.

## CCGs

The Accountable Officer of both CCGs, Shropshire and Telford and Wrekin, attended a Joint HOSC meeting on 16th December 2019. SaTH's maternity service had been very much in the news in the preceding week or two. The CQC, following unannounced visits, had found some improvements in maternity care but identified serious concerns with the emergency departments and medical wards. Unsurprisingly, the media included in its coverage what was known at the time about the maternity investigation. The BBC, for example, reported that the Ockenden review was looking at 'more than 800 cases'.

David Evans was asked at the Joint HOSC about maternity. His answer was a startling one. He said,

> *The Trust delivers about 5,000 babies a year, or thereabouts. The media reports have been talking about going back over 40 years. Now of course I'm definitely not trying to say we shouldn't learn because definitely we should learn. But actually, if you take the number of cases that have been talked about over a 40-year period* ***it's relatively small in real terms*** *compared to the number of births*. (our emphasis)

This was to the Joint HOSC, the statutory body responsible for scrutinising health care on behalf of the public. David's instinct seems to have been to downplay and reassure. One wonders if this was the continuation of an established pattern of behaviour.

The CCGs were formally established in April 2013. David Evans has been Accountable Officer at Telford and Wrekin since its inception. Shropshire CCG has lacked leadership continuity, with a long succession of short-lived leaders. David Evans led both CCGs for around 6 months in 2016, and returned to that dual role last year.

Older Board papers for Shropshire CCG vanished several years ago, but papers for Telford and Wrekin CCG remain available online. Maternity is mentioned as an area of concern in the minutes of what was presumably the very first meeting, held on 9th April 2013[19]. The Executive Lead for Nursing, Quality and Safety was to write to SaTH *'with regards to concerns with Midwifery numbers'.*

More significant concerns seem to have appeared by June 2013. The Quality and Safety report[20] shows this:

[19] Telford and Wrekin CCG. Minutes of 9th April 2013 Governing Board. 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

[20] Telford and Wrekin CCG. Quality and Safety Report. 11 June 2013. 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

**2.1.9 The Risk Summit**

Both Shropshire and Telford and Wrekin CCGs raised concern in relation to a number of quality and performance issues which lead to the establishment of a Risk Summit lead by the NHS- E Area Team held on 9th May 2013.

**Areas of Concern relating to quality of patient care and experience as stated by both CCGs**

1. Increasing number of adult safeguarding referrals – particularly at PRH. Main theme is related to discharges and transfers. (CQC Unannounced visit 25/4/13. Report awaited and
2. Non delivery of ED 4 hour target since June 2011 (except for June 2012) which has the potential to detract from quality of care and dignity. 12 hour trolley waits – mainly on RSH site but impacts on T&W population
3. Environment of care in ED means patients are seen to be cared for in the corridor impacting on privacy and dignity and potential for mixed sex accommodation breaches.
4. Trust not meeting recovery plan for RTT within T&O and urology.
5. Continued incidents of poor patient care resulting in pressure ulcers. Wards on internal quality improvement frameworks
6. Cancelled operations impacts on quality of patient experience
7. Maternity services model and the number of SIs reported (in particular 1 high profile case and coroner's inquest and a 2nd SI.

The Trust Directors gave a presentation of the risks, the impact of these risks and the actions planned from their perspective.

A series of actions were identified for monitoring by the CCGs as a result of the Risk Summit. No further meeting is planned at this time.

**This is a truly fascinating document. It confirms that in June 2013, from the very early days of their existence, both CCGs had concerns about SaTH's maternity service. They escalated these concerns to a Risk Summit led by the Area Team of NHS England. The coroner's inquest referred to here was of course the inquest into the death of Kate Stanton Davies, which concluded that her death was avoidable. The CCG concerns were well-founded.**

By the following month, July 2013, the CCGs were proceeding to an external review of SaTH's maternity service[21]. The 'lack of improvement' in maternity services was recorded in the Quality and Safety report as a risk:

**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.

Again, there is evidence of CCG concern.

And then something changed. Quality and Safety reports were replaced by shorter (and much less clinically focused) Chair's reports from the Planning, Performance and Quality Committee. There was discussion at the PPQ Committee of some clinical issues, around cancer care and local A&E performance, for example. Maternity had simply vanished as an issue, and the Board overall seems to have a sharply reduced clinical focus.

[21] Telford and Wrekin CCG. Quality and Safety Report. 9 July 2013. 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

We have spoken to someone who was a Board member at Telford and Wrekin CCG during this period. This person recalls discussion on other clinical areas – A&E performance and the Future Fit reconfiguration, for example – but has no recollection of maternity being discussed in public or private sessions of the Board.

### 'Questions to the Board'

Defend Our NHS has recently put written questions to the Boards of both CCGs, in an attempt to find out who knew what and when. (Copies of those questions and answers are of course available on request).

The answers confirm that both CCGs actively monitored perinatal mortality for SaTH from 2013 onwards, that they have been provided with regular data by SaTH, that maternity has been discussed regularly at monthly CQRM meetings, and that the CCGs have commissioned specific reviews of maternity, including reviews of specific serious incidents as well as broader reviews of the quality of SaTH's maternity service. The CCGs established a maternity specific CQRM in 2017 to allow a specific focus on this service area. There is apparently now a refreshed quality assurance process for maternity services.

Sadly, none of the CCGs' findings have been made publicly available, with the exception of the genuinely misleading 2013 maternity review.

It has also not been possible to gather information about maternity concerns by attending CCG Board meetings. Prior to Covid-19 restrictions, Defend Our NHS supporters attended virtually every meeting of Shropshire CCG, and a decent proportion of Telford and Wrekin meetings. The absence of any serious discussion about the safety of SaTH's maternity service has been striking. One question we asked of Shropshire CCG was whether the Board discussed mortality in the maternity service. Back came the answer, *'Yes. The Board discussed mortality in the maternity service on several occasions dating back to 2013'.*

Several occasions, between 2013 and 2020? This is not particularly impressive. It seems likely that most CCG Board members have been almost as much in the dark as service users and the general public.

**We can be certain that the CCGs have monitored stillbirth and neonatal mortality rates since 2013; that key people have been to a great many meetings; they have commissioned a great many reviews; they've looked at both individual cases and the 'big picture'. The CCGs have, by their own report, been very busy.**

**Two questions, then. Has any of this work been effective in ensuring a safe maternity service? And why has none of the information gathered by the CCGs been made available to service users?**

## The CCG Maternity Review

From the early Board papers, it appears that there were significant concerns held by both CCGs. The CCG concerns about the maternity service resulted in a maternity review, led by Shropshire but undertaken on behalf of both CCGs. This was described a few weeks ago as the 'Maternity Safety review' in a written answer from Telford and Wrekin CCG.

It was led by Josh Dixey, a secondary care consultant (a rheumatologist) on the Shropshire CCG Board. It was a relatively brief process, seemingly initiated in July 2013 and concluding in October 2013. It can still be found online[22].

The reality of the review being triggered by significant safety concerns is acknowledged in the foreword of the review report. We are told:

> *This review was commissioned by Shropshire Clinical Commissioning Group (CCG) and Telford and Wrekin Clinical Commissioning Group following concerns over an increased incidence of serious clinical adverse events and the safety of the model of maternity care in Shropshire.*

This is further elaborated a little later:

> *The review was commissioned to focus on patient safety, quality of care, the sustainability of the hub and spoke model and the sustainability of workforce numbers, alongside educational needs, the reporting of serious incidents, patient complaints and review of serious incidents. The review also focussed closely on the areas highlighted by the coroner following the outcome of an inquest into the death of a newborn baby within the county. Importantly, the maternity review board were also asked to seek the opinion of mothers who had received care within the local model, their partners and family members, to ensure that the patient voice was central to the findings.*

It's a broad remit for a three month review. It **began** as a review of maternity service safety – but seems to have become something very different; much more a review of patient experience. There was a very, very rare item on maternity in the December 2013 Board meeting of Telford and Wrekin CCG. This is recorded in the minutes[23] of the meeting. The Board received a presentation and a summary of the review report. It appears that a great deal of the work was around the thirteen focus groups (at 'Baby Bumps' sessions and other events with new mothers), and via a questionnaire and online web and email groups. It is of course absolutely commendable to listen to women; it hasn't happened enough. But with a self-imposed tight timetable and limited resource, it is just a slightly surprising emphasis for a review into serious and specific safety concerns. Interestingly, the review report notes that 8 to 10 % of maternal comments were negative. This could be seen as really worrying, and needing careful exploration. Instead, the conclusion around service user experience is *'Findings are positive, complimentary and consistently articulated a story of competent services, delivered by competent staff'*.

The review did give some consideration to safety, reportedly called upon external experts, and gave SaTH a clean bill of health. Those findings are summarised in that 2013 presentation to the Telford and Wrekin CCG Board.

Caesarean section rates were identified as *'quite low'*, and the intention was to *undertake 'further analysis'*. (Did the CCGs ever follow up on this?) Maternal complications were *'within the national*

[22] Shropshire CCG. October 2013. Maternity Services Review. The Shrewsbury and Telford Hospital NHS Trust. Report. https://www.shropshireccg.nhs.uk/media/1197/maternity-services-review-msr-report-281013.pdf
[23] Telford and Wrekin CCG. 13 Jan 2014. Minutes of the Meeting held on Tuesday 10th December 2013. https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2014/january-2/1720-03-ccg-board-minutes-10th-december-2013-v1/file

*average'*. Neonatal outcomes were *'difficult to measure'*. Admissions to the neonatal unit were *'within the national average'*.

The Board minutes also show:

*'The number of admissions to the neonatal unit resulting from clinical incidents was higher than the national average. The review team had not had an opportunity to analyse the data but there was a possibility that the Trust had been extra vigilant in its clinical incident reporting'.* This feels concerning. It is an uncomfortable and potentially high risk conclusion; at odds with the SaTH pattern of categorising serious incidents downwards that was subsequently identified by the CQC.

Equally concerning is this: *'They* (the external experts) *had identified a number of the serious incidents had not been closed, and this issue had now been addressed and all cases were now closed. The experts had highlighted the need to ensure that serious incidents were closed within the required timescale with follow through of action plans.'* RCOG identified the exact same issue in its 2017 review, four years on; the report that SaTH sought to 'soften'. The difference is that RCOG recognised this to be a very significant problem; Shropshire and Telford CCGs seemingly did not.

And on Kate's death? *'Following the very sad and tragic case that occurred in 2009 and the high profile inquest in 2012, a number of recommendations had been made by the Coroner. The external experts had assured the review team that the Trust had completed all the recommendations made by the Coroner with the exception of the midwife and ambulance crew training but this was now taking place.'* We now know that SaTH did not put together a coherent action plan following Kate's death, and delayed doing this until April 2016. Kate's parents of course are of the view that learning from her death, way back in 2009, has yet to take place.

The CCG Board was told of the review conclusions: *'The team had reviewed the quality of care to mothers and babies and no major issues had been identified'.*

The review report itself is remarkably positive. The foreword comments, *'It is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust and is appropriate for a mixed rural and urban population.'*

The conclusion on risk management is: *'There is a robust approach to risk management, clinical governance structures and learning from incidents which suggests a 'learning organisation'.*

And an overall conclusion is that, *'The overall findings of the review demonstrate that this is a safe and a good quality service which is delivered in a 'learning organisation'.*

This was the year in which MBRRACE data shows SaTH's perinatal mortality to be 'red rated', 10% or more higher than comparable organisations.

**What on earth happened here? The 'grapevine' suggested that the review was intended to look at serious safety concerns, but the NHS England Area Team used its influence to bring about a sharp change of direction, and to focus instead on service user experience. The change in focus is undoubted. There has been no public explanation of why or how it happened.**

**Despite the change of direction, the review identified clinical problems that were deeply concerning. These were brushed aside in the review report, and were allowed to carry on, unaddressed, as the years rolled by.**

Shaun Lintern, writing in the Independent, has spoken to 'CCG sources' about the review[24]. He was told that the 2013 report had been *'proven to be wrong, inaccurate and to have come to the wrong conclusions and recommendations'.* That sounds about right.

## The 2015 CQC Report

The CQC inspected SaTH in October 2014, and issued its report in January 2015. We clearly cannot prove that the CQC chose to overlook or ignore safety concerns in the maternity service – but this has been suggested to us.

If the CQC produced its report in good faith, then that particular CQC team was not fit for purpose.

The CQC report, more than anything else, simply feels 'odd'. There is no narrative at all on how maternity services are functioning, beyond a comment that the move of Women's and Children's Services to the Princess Royal Hospital 'had had a positive impact'. There is also a positive reference to SaTH's rating in the 2013 Survey of Women's Experiences of Birth.

Otherwise, maternity features in the colour charts showing overall ratings. For maternity, the Royal Shrewsbury Hospital is rated as 'Good' in all five domains: Safe, Effective, Caring, Responsive and Well-led. The overall rating is of course 'Good'. That same 'sea of green' on the ratings charts applies the MLUs at Oswestry, Ludlow and Bridgnorth.

The maternity service at Telford's Princess Royal Hospital – by this time, the site of the main Obstetric Unit– was rated 'Good' for Effective, Caring, Responsive and Well-led. For 'Safe', the rating is 'Requires improvement' – but with no explanation of why. The overall rating for maternity at Princess Royal is 'Good'. A careful search of the report finds this, in 'areas for improvement':

> *The trust must review the levels of nursing staff across A&E critical care, labour ward and end of life services to ensure they are safe and meet the requirements of the service.*

Presumably, then, poor midwifery staffing (a constant theme at SaTH) was the reason for the reduced rating of the maternity service at the Princess Royal – but this requires quite a lot of joining of the dots.

This is plainly not a comprehensive assessment of the maternity service across SaTH. If it is the case that the CQC team was advised of serious safety concerns, the content of the report becomes close to inexplicable.

Objectively, SaTH's maternity service had been struggling for a while. The MLUs still lacked operational policies at the time of the CQC visit. The Trust had not got around to apologising for Kate's death in October 2014, never mind creating or taking forward an action plan to prevent recurrence. It seems unlikely that SaTH's difficulty in investigating and responding to clinical incidents in a timely way – as identified by the CCG maternity review – was there in 2013, all sorted out when the CQC inspected in 2014, but had re-appeared by the time of the RCOG review in 2017.

The MBRRACE reports for 2013 and 2014 confirm that picture of a maternity service that was struggling. In 2013, SaTH was rated 'red' for its extended perinatal mortality (i.e. more than 10%

[24] Lintern, Shaun. Independent. 3 December 2019. Shrewsbury maternity scandal: NHS used report to create 'false narrative' on maternity services. https://www.independent.co.uk/news/health/shrewsbury-maternity-scandal/shrewsbury-maternity-nhs-babies-deaths-care-a9231486.html

higher than the average for similar organisations). In 2014, SaTH's rating was amber (up to 10% higher than similar organisations). By 2015, the year in which the CQC report appeared, that rating had reverted to red. The CQC of course did not have access to those summary reports showing high stillbirth and neonatal death rates, but it did inspect the service that produced them.

## NHS England

The role of NHS England remains very unclear. The bits and pieces of information that keep bubbling up are that NHS England has known about the safety concerns in SaTH's maternity service for many years, and has not wanted those concerns to be in the public domain. We've also heard the suggestion that NHS England actively tried to prevent partner organisations from responding openly and more effectively to safety issues.

We can establish that NHS England knew about the maternity safety issues in 2013, both from Board papers and more recently from written answers to questions we addressed to the July 2020 Telford and Wrekin Board. It is also evident that NHS England played an active role in the system response to safety failings in SaTH's maternity service. Arguably, this has not been an effective role; certainly it has not been an open or public role.

From those Telford and Wrekin CCG answers, we know that NHS England chaired monthly Quality Surveillance Group meetings, attended by CCGs, at which the safety of maternity services was discussed at intervals. CCG responses show that it was those Quality Surveillance Group meetings that led to the commissioning of the dreadful 2013 maternity review.

In the same set of CCG responses, we have been told that NHS England contributed to the 2013 review report.

**Telford and Wrekin CCG also told us last month:**

> ***Following publication of CQC reports of concern, the CCG participated in Risk Summits chaired by NHS England and NHS Improvement, with CQC, SaTH and others in attendance.***

**We have had for a long time a deeply uncomfortable sense that 'everybody knew but nobody said'. This answer does rather confirm this.**

## Conclusions

An example in passing of SaTH's failure to understand the gravity of its situation. Adam Gornall gave a remarkable interview[25] to the Shropshire Star in February 2016. This was in response to the publication of the MBRRACE 'red' rating for 2013. Adam commented on the thorough assessment of each case, and that no 'thematic reason' or 'common thread' had been found. On stillbirths, he said *'In 2012, the stillbirth rate was similar to the national average and in 2014 and 2015 it was lower than the expected national average'.*

The Clinical Director was out of touch. In 2014 and 2015, the stillbirth rate was **above** the average for the MBRRACE comparator group (i.e. for similar organisations). Adam, like the CQC, will not have had access to the MBRRACE reports and their stabilised and adjusted figures at the time he gave that

[25] Shropshire Star. 23 February 2016. Shropshire newborn baby deaths in decline, says trust. https://www.shropshirestar.com/news/2016/02/23/shropshire-newborn-baby-deaths-in-decline-says-trust/

interview, but he might reasonably have been expected to have a broad feel for how SaTH compared with comparable trusts.

In the same interview, there is also a genuinely surprising omission around neonatal mortality. Again, the MBRRACE stabilised and adjusted figures were unavailable – but Adam as Clinical Director of maternity should surely have had an overview of the crude neonatal mortality rate in the service he led. Adam gave the Shropshire Star the impression that 2013 was an anomaly; that SaTH's maternity service was steadily getting safer. In reality, in both 2014 and 2015, the crude neonatal mortality rate at SaTH was **above** that for 2013.

Adam either did not know if the number of babies dying in SaTH's care was going up or down, *or* he chose to withhold the information on neonatal mortality in favour of reassuring the local paper that everything was fine. We do not believe that either of these would be acceptable.

**SaTH is not well-led. SaTH is not a learning organisation.**

**The CQC's work in 2014/ 2015 was not fit for purpose. We welcome the closer scrutiny of maternity that has taken place subsequently. We would also welcome some robust questions being asked about why, in 2014/15, the CQC completely failed to describe a service in crisis.**

**On our local CCGs, and on the role of NHS England – whatever that may have been – it is clear that transparency has been almost totally absent.**

**We do not know at this stage what the eventual conclusions of the Ockenden review will be. From leaked information, it is reasonably clear that what has happened at SaTH can best be described as a scandal. We think it is likely that this is the worst maternity scandal in the history of the NHS. Women and babies have been terribly let down by SaTH. They have *also* been let down by the wider NHS system that failed to protect them: by our local CCGs, by the CQC, and by NHS England.**

**The NHS is doing a disservice to those who have died or been harmed if it does not now take forward two separate strands of work. The first is of course to ensure a safe maternity service for the people of Shropshire, Telford and Wrekin. The second is to stop comparable tragedies happening to other people in other areas. That second strand requires ending the secrecy that is endemic in the NHS, and overhauling the regulatory systems that are now conspicuously failing.**

**Gill George, Chair**
**Julia Evans, Secretary**
**Shropshire, Telford and Wrekin Defend Our NHS**

**5th August 2020**