Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust – the final Ockenden report

Yesterday (30 March), the final report from the Ockenden Review of maternity services at Shrewsbury and Telford Hospital NHS Trust (SaTH) was published. This follows the first report from the inquiry, published in December 2020, which outlined a set of local actions for learning (LAfL), as well as immediate and essential actions (IEAs) to improve the quality of care and patient safety across maternity services nationally. This second and final report identifies several new themes intended to be shared across all maternity services in England.

This briefing summarises the key points from the report, along with NHS Providers' view and press statement. The report is substantial, and we hope this briefing offers a helpful and accessible insight into it, but we would encourage colleagues to read the report itself in full. As well as extensive recommendations for trusts and wider NHS partners, the report contains detailed descriptions of the care provided and first-hand accounts from mothers and their families of their experiences and the impact care failings have had on their lives. It also includes accounts from past and present SaTH staff.

If you have any questions about this briefing, please email Keegan Shepard, policy advisor for quality (keegan.shepard@nhsproviders.org).

Key points

- The final Ockenden report sets out the findings and recommendations from a five-year review of maternity care at the Shrewsbury and Telford Hospital NHS Trust (SaTH). It focuses predominantly on the period from 2000 to 2019 and looked at 1,592 clinical incidents involving mothers and their babies.
- The review found 'significant or major concerns' around the maternity care provided by SaTH in 201 deaths, 131 stillbirths and 70 deaths during the neonatal period. Close to 100 other children suffered permanent injuries, including brain damage and cerebral palsy.
- The review team used medical records, documentation from the trust, as well as interviews and surveys with families to conduct each clinical incident review. The team also conducted an

engagement exercise with staff – both past and present – to ascertain an understanding of the culture of the organisation.

- The review found that large-scale failings around governance and the quality of care had led to widespread avoidable harm and death. Failings identified include a nationally driven prioritisation of natural births, widespread workforce shortages, a lack of adequate training for staff, and concerns routinely not being listened to, investigated or learned from.
- The review team identified thematic patterns in the quality of care and investigation procedures carried out by SaTH and identified where opportunities for learning and improving the quality of care and governance had been missed.
- The review found patterns of repeated poor care and failure in governance and leadership. The report outlines over 60 local actions for learning (LAfL) by SaTH, as well as 15 immediate and essential actions (IEAs), the latter of which should be considered by all trusts providing maternity services.
- The IEAs include recommendations around funding a safe maternity workforce, developing robust procedures to assess and manage risk with pathways established for complex pregnancies, improving postnatal care, ensuring proper training for staff who work together, improving trust board oversight of maternity services, as well as conducting robust investigations that lead to wider learning.

Background

The Ockenden Review into maternity services at SaTH predominantly covers the period from 2000 to 2019. The report was initially commissioned by Rt Hon Jeremy Hunt MP in late 2016 – then Secretary of State for Health – who requested the review after hearing the concerns of 23 families thanks to the dedicated efforts of the parents of Pippa Griffiths and Kate Stanton-Davies, who passed away after birth at SaTH. From the original 23 cases, the review expanded as more families came forward to share their experiences. The interim review, first published in December 2020 to capture and share emerging themes that required rapid action, was requested by Nadine Dorries MP, then Minister of State for Patient Safety, Suicide Prevention and Mental Health, and covered 250 cases.

Many more families then came forward, and the review continued to evolve, with the final report looking at 1,592 clinical incidents, representing the largest clinical review of a single service in the history of the NHS. This final report builds upon the work outlined in the interim report by providing an update on findings, current progress of the immediate and essential actions, and highlighting the recommendations from the overall review.

Summary of findings

Senior midwife and review chair, Donna Ockenden, working with more than 90 doctors and midwives, conducted the five-year investigation and found failings across governance and the quality of care, including a nationally driven prioritisation of natural births; widespread workforce shortages; a lack of adequate training for staff; safety concerns routinely not being voiced, investigated, or learned from; and substandard organisational culture and leadership. As a result, 'significant or major concerns' around the maternity care provided by SaTH were identified in a total of 201 deaths (including 12 maternal deaths), 131 stillbirths and 70 deaths during the neonatal period.

Background information about SaTH

The maternity service provided by SaTH is based on a hub-and-spoke model, with a centralised consultant-led maternity unit that is surrounded by a number of midwifery-led units in Shropshire, which represents a geographically rural area. The reviewing team found that the birth rate at SaTH is gradually decreasing over time, and while aligning with the national birth rate, some women shared concerns that they chose to give birth elsewhere following the events that took place. The review also provided an overview of the ethnicity, deprivation rates and maternal age distribution within SaTH and concluded that they did not have a disproportionate effect on the morbidity and mortality rates when compared with national figures.

Clinical governance

The review team explored whether the local governance met the standards that would have been expected from 2000 to 2019. They found that the quality of incident investigation was poor and did not translate into learnings, that the handling of complaints lacked oversight and transparency, there were failings identified locally around the statutory supervision of midwifery investigations, as well as that there were concerns about the writing, review and use of clinical guidelines and audits.

Clinical leadership

Reviewers found that external reviews of the trust between 2013 and 2017 cultivated an image of a safe maternity service and lacked criticism of its leadership at that time, providing false reassurance and preventing earlier action. The review found that opportunities to address staffing shortages went unrealised, governance issues and concerns raised by families were not prioritised, and accountability for implementing recommendations and providing oversight was unclear. The review team added that they have heard from staff as recently as 2022, who voiced that they remain fearful of speaking up within the trust.

Internal oversight and external scrutiny

The review provides in-depth insight into the failings of care at SaTH and outlines where and why harm occurred over the course of the perinatal period. The report provides an extensive overview of findings, including the failings identified within antenatal care, intrapartum care, postnatal care, maternal deaths, obstetric anaesthesia, and neonatal care, which each helped to inform the subsequent recommendations they outline.

Calls for action

The report outlines a list of more than 60 local actions for learning for SaTH, as well as 15 immediate and essential actions for maternity services across England.

15 Immediate and Essential Actions – National Picture

IEA 1: Workforce planning and sustainability

Essential action – financing a safe maternity workforce

- *The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.*

The report states that while recent investments in maternity care are welcome, much more will be needed through recurrent annual spending to ensure that there is an adequate and safe level of workforce to provide high-quality maternity and neonatal care across England. To facilitate this, there should be an agreement on the minimum staffing levels required nationally or, when not possible, within Local Maternity and Neonatal Systems (LMNS), which must incorporate and consider the increased level of complexity and acuity of pregnancies and births, vulnerable families, as well as further mandatory training, to help trusts meet the organisational requirements from the Care Quality Commission (CQC) and Clinical Negligence Scheme for Trusts (CNST).

Additionally, the report states that minimum staffing levels must also incorporate a 'locally calculated uplift', which considers the data from the previous three years on staffing around sickness absences, annual and maternity leave, as well as mandatory training. The report states that all relevant health

bodies, including 'NHSE, RCOG, RCM and RCPCH'[1], should also review the feasibility and accuracy of the BirthRate Plus tool and its methodological approach.

Essential action – training

- *We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.*

The report says that all trusts should establish a 'robust preceptorship programme' for newly qualified midwives (NQM), to aid in their supernumerary status over the course of their orientation, as well as time set aside for professional development, in line with the RCM's position statement from 2017. Additionally, all NQMs should remain within the hospital setting for at least one year after they qualify to facilitate the development of their knowledge and skills to improve their experience, as well as the quality of care they provide. Beyond NQMs, all trusts should ensure that midwives responsible for coordinating care in a labour ward attend a fully funded and national recognised education model for labour ward coordination. Any newly appointed labour ward coordinators should then also receive an orientation package bespoke to their individual needs as a clinician, which includes opportunities for them to expand their personal and professional development outside of the labour ward.

All trusts should develop and train a core team of senior midwives in 'high dependency maternity care', with the team large enough to ensure that there is always one high dependency unity (HDU) trained midwife on each shift. The authors state that trusts should also develop a strategy for succession-planning to support and develop the knowledge and skills of future potential clinical leaders and senior managers. This programme should include a gap analysis of all roles at the leadership and management levels, as well as encompass supportive organisational processes and relevant practical work experience. The review team recognises the progress made from the creation of the maternal medicine networks across England and proposes the implementation of a sustainable training programme to address the shortfall of maternal medicine physicians.

IEA 2: Safe staffing

Essential action

- *All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.*

[1]NHS England (NHSE); The Royal College of Obstetricians & Gynaecologists (RCOG); The Royal College of Midwives (RCM); The Royal College of Paediatrics and Child Health (RCPCH)

When agreed staffing levels are not achieved routinely, the report says this should be escalated to the senior management team, the chief nurse, medical director, as well as patient safety champion and Local Maternity System (LMS). Where there are no separate consultant rotas for obstetrics and gynaecology within trusts, there should be protocols established around risk assessment and escalation for periods of competing workload, as agreed by the board.

The report suggests that all trusts must review and suspend the practice of the Midwifery Continuity of Carer (MCoC) model unless they can demonstrate that they meet the minimum safe staffing requirements to protect the safety of patients in consideration of the current operational pressures faced by trusts. The MCoC model should only be resumed when evidence is provided to demonstrate that the trust meets the minimum safe staffing requirements.

The report also states that there should be time provided around maternity training for consultants and local doctors within their job plans, which will set aside additional protected time beyond that of generic trust mandatory training. Trusts should also ensure that there are 'visible, supernumerary clinical skills facilitators' to support all midwives, with newly appointed Band 7/8 midwives also being allocated an experienced mentor. Finally, trusts should develop strategies to maintain robust pathways across midwifery staff in the community and hospital settings and follow the latest RCOG guidance on the management of locums.

IEA 3: Escalation and accountability

Essential actions

- *Staff must be able to escalate concerns if necessary.*
- *There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.*
- *If not resident there must be clear guidelines for when a consultant obstetrician should attend.*

In response to the findings that staff were fearful of speaking up about concerns, the report made several recommendations around escalation and accountability, including the suggestion that trusts develop and maintain a policy to support all staff to be able to escalate any clinical concerns when there is a disagreement between clinicians. Assurance processes should also be developed to ensure that any trainee or middle grade obstetrician has an adequate level of competence when managing the service without a direct presence of a consultant. Additionally, the report proposes that trusts should aim to increase the presence of resident consultant obstetricians where possible, develop local guidelines for when their attendance is mandatory in the unit, as well as create local guidelines

informing when the midwifery manager and consultant obstetrician on-call should be informed of any activity within the ward.

IEA 4: Clinical governance-leadership

Essential actions

- *Trust boards must have oversight of the quality and performance of their maternity services.*
- *In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.*

The report outlines several recommendations around clinical governance and leadership to address the failings uncovered. Trust boards must work closely together with maternity departments to jointly develop routine progress and exception reports, assurance reviews, as well as regularly review the progress of any plans based on improvement and transformation. The report proposes that all maternity service senior leadership teams must complete the National Maternity Self-Assessment Tool using appreciative inquiry and share it with the trust board. Additionally, they suggest that all trusts have a patient safety specialist dedicated to maternity care.

Concerning all clinicians with maternity governance responsibilities, trusts should provide enough time for them to engage with these responsibilities, as well as ensuring maternity governance teams are trained in 'human factors, causal analysis and family engagement'. Lastly, trusts should establish midwifery and obstetric co-leads for developing any guidelines in maternity care, and have these co-leads for audits of maternity care.

IEA 5: Clinical governance – incident investigation and complaints

Essential action

- *Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.*

The language used by maternity governance teams in reports should be accessible and understandable by families and written in simple and lay language. Any lessons from clinical incidents should be reflected within the delivery of the local multidisciplinary training plan, and any actions from a serious incident (SI) investigation should be audited when there is a change in practice within six months of the incident.

Complaints which meet the threshold for SIs should be investigated, and trusts should involve service users in developing processes for responding to complaints. Any trends and themes emerging from complaints should be monitored by the team dedicated to maternity governance within each trust to help identify underlying concerns earlier.

IEA 6: Learning from maternal deaths

Essential actions

- *Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.*
- *In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.*

NHSE/I should work with the relevant Royal Colleges to ensure that post-mortem examinations by a specialist maternal physiology and pregnancy related pathologist are provided in the case of any death. Any joint review panel must have an independent chair, be aligned with local and regional staff and must seek external clinical expert opinions where needed. The panel should include representation of all services involved in the provision of maternity care. Any learnings from such reviews should be introduced into clinical practice within six months of the panel and the learning should be shared across the local maternity system (LMS).

IEA 7: Multidisciplinary training

Essential actions

- *Staff who work together must train together.*
- *Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.*
- *Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.*

All members of the maternity multidisciplinary team should attend regular joint training events and regular training time should be included as a part of staff job plans. This training should also integrate the use of local handover tools into teaching programmes at trusts, and training recommended by the report includes annual human factor training for all staff working in a maternity setting.

There should be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies and all trusts should have a system in place to ensure that staff have

the most up to date training in cardiotocography (CTG) and emergency skills. Clinicians should not work on labour wards or provide intrapartum care in any location without the appropriate regular CTG training and emergency skills training.

IEA 8: Complex antenatal care

Essential actions

- *Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.*
- *Trusts must provide services for women with multiple pregnancy in line with national guidance.*
- *Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.*

Any woman with pre-existing medical disorders, including cardiac disease, epilepsy and chronic hypertension, must have access to a specialist who is familiar with managing that disorder and who can understand the impact that pregnancy may have. Trusts should have specialist antenatal clinics dedicated to women with multifetal pregnancies, and these should have dedicated consultant and specialist midwifery training.

Trusts should follow the NICE Diabetes and Pregnancy Guidance 2020 when managing women with pre-existing or gestational diabetes. For women with chronic hypertension, trusts should develop antenatal services that care for them. Trusts should ensure that women with chronic hypertension are seen in a specialist consultant clinic to discuss and evaluate the risks and benefits to treatment, and they should be cared for in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

IEA 9: Preterm birth

Essential actions

- *The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.*
- *Trusts must implement NHS Saving Babies Lives Version 2 (2019).*

Senior clinicians, the LMNS, commissioners and trusts must work in collaboration to make sure there are systems in place to manage women who are at high risk of 'very pre term birth'. Expert advice for women and their partners on what the most appropriate fetal monitoring should be, and what mode of delivery should be considered. Any conversations should involve local and tertiary neonatal teams, so that parents have the chance to understand the risks of possible associated disability and the

chances of neonatal survival. Additionally, audits should be a continuous process where all in utero transfers, cases where a decision has been made to not transfer, and when a delivery occurs in the local unit, are all reviewed. The report suggests that trusts across England should implement NHS Saving Babies Lives Version Two.

IEA 10: Labour and birth

Essential actions

- *Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.*
- *Centralised CTG monitoring systems should be mandatory in obstetric units.*

All midwifery-led units must undertake both yearly operational risk assessments and regular multidisciplinary team 'skills drills'. Additionally, any woman who is presenting in early or established labour must undergo a full clinical assessment, which includes a review of risk factors that may change the recommendations around place of birth. Any woman who decides to give birth outside a hospital setting must receive accurate and up to date written information about transfer times to the consultant obstetric unit, and this information should be co-produced by both maternity services and the local ambulance trust. For induction of labour, trusts must have a mechanism in place to describe a clear, safe pathway in case delays occur due to high activity or short staffing. In addition, CTG monitoring systems must be made mandatory in obstetric units across England.

IEA 11: Obstetric anaesthesia

Essential actions

- *In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.*
- *Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.*
- *Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.*

Conditions that require further follow up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia or neurological injury relating to anaesthetic interventions. This will help to create a pathway for outpatient postnatal anaesthetic follow-up, which

must be available in every trust to address incidences of physical and psychological harm, in addition to the routine inpatient obstetric anaesthesia follow-up.

All anaesthetic departments must review the adequacy of maternity patient records documentation, and where necessary, take steps to improve this as recommended in Good Medical Practice by the General Medical Council (GMC). Resources must be made available for the anaesthetic professional bodies to determine a consensus regarding what constitutes a satisfactory anaesthetic record and the contents of core datasets.

Staffing shortages in obstetric anaesthesia must be highlighted, and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed. Anaesthesia staffing guidance should include:

- What the role of consultants, staff, SAS doctors, and doctors in training is in service provision, as well as understanding where the need is for prospective cover to ensure safe services continue whilst allowing for staff leave.
- The full range of obstetric anaesthesia workload including elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
- What competency is required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments.
- How anaesthetists participate in the multidisciplinary ward rounds, as recommended in the interim report.

IEA 12: Postnatal care

Essential actions

- *Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.*
- *Postnatal wards must be adequately staffed at all times.*

Trusts must develop systems that ensure consultants review all postnatal readmissions and unwell postnatal women, including any women who require care on a non-maternity ward. Unwell women should have timely consultant involvement in their care and should be seen daily as a minimum. Additionally, postnatal readmissions must be seen within 14 hours of readmissions or urgently if

necessary. Postnatal wards must be appropriately staffed to cover the activity and acuity of care required for both mothers and babies, day and night.

IEA 13: Bereavement care

Essential action

- *Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.*

Trusts must provide bereavement care services for women and families who suffer pregnancy loss, and these services must be provided seven days a week. All trusts must ensure appropriate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. Staff should also be trained to deal with bereavement and the purpose and procedures of post-mortem examinations. Trusts must develop a system to ensure that families can be offered follow up appointments after perinatal loss or serious neonatal outcome. For all families who experience a perinatal loss, trusts must deliver compassionate, high quality and individualised care to them, with reference to guidance such as the National Bereavement Care Pathway.

IEA 14: Neonatal care

Essential actions

- *There must be clear pathways of care for provision of neonatal care.*
- *This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.*

Neonatal and maternity care providers, commissioners, and networks must agree on pathways of care, including both the designation of each unit and on the level of neonatal care that is provided. Any care that is delivered outside of this agreed pathway must be monitored by at least quarterly exception reporting, which should be reviewed by providers and the network. The results of this should then be reported to both commissioners and Local Maternity Neonatal Systems (LMS/LMNS) quarterly.

Neonatal Operational Delivery Networks must ensure that staff in provider units have the opportunity to share best practice and education to ensure provider units do not operate in isolation from their local clinical support network. Each network should report annually to commissioners summarising the

steps they are taking in this work. The report further highlights the importance of maternity services working towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite neonatal unit (NICU).

The report highlights the importance of sufficient staffing numbers who are appropriately trained in neonatal providers, and they must be available in every type of unit to deliver safe care. During neonatal resuscitations, if the consultant is not immediately available, there must be a mechanism in place that allows for real time dialogue. Additionally, the report endorses the recommendations from the Neonatal Critical Care Review and says this work must progress at pace. This includes increasing neonatal cot numbers, developing the workforce and enhancing the experience of families.

IEA 15: Supporting families

Essential actions

- *Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.*
- *Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.*

There must be robust mechanisms for identifying psychological distress and clear pathways for women and their families to access support. This must be an integral aspect of all parts of maternity care. Timely psychological support should be available without a formal mental health diagnosis, but for those who have complex needs, support should be delivered by specialist psychological practitioners who have experience in maternity care. This should be underpinned by ensuring maternity care providers actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.

Local Actions for Learning (LAfL) for Shrewsbury and Telford Hospital NHS Trust

Beyond the immediate and essential actions for application across England, the report also includes actions for SaTH to undertake. These local actions span across nine areas:

- Management of patient safety
- Involvement of patients and families in care and investigations
- Management of complaints
- Care for high risk and vulnerable women
- Care for diabetes

- Multi-disciplinary working
- Births out-of-hospital and midwifery-led units
- Staffing; in particular, anaesthetic staffing
- Communication with GPs.

Interim report and progress to date

The interim report released in December 2020 – which encompassed 250 family cases – outlined seven IEAs for maternity services in England, and 27 LAfLs for SaTH. Following this report, Amanda Pritchard, Ruth May and Steve Powis, sent a letter to the chief executives of all trusts endorsing the findings of the report and requesting that trusts begin to implement the outlined recommendations. NHS England and NHS Improvement also published their national response to the interim report, where they introduced a quality assurance process to assess trust progress on implementing the recommendations, as well as outlined the next steps necessary to improve maternity care.

In response to the publication of this final report, the Secretary of State for Health and Social Care, Sajid Javid, provided an oral statement to Parliament yesterday, where he summarised the findings, progress made to date, and referenced Donna Ockenden's support of the proposals he announced in January 2022.

Funding was made available to help trusts implement these IEAs, including £95.6 million in March 2021 to recruit 1,200 midwives, 100 consultant obstetricians, backfill to facilitate multidisciplinary training, and an additional midwife in every unit to support NQMs as they begin their career. Last week, £127 million was allocated to increase and maintain staffing numbers in maternity and neonatal services, improve organisational culture, as well as increase the number of neonatal beds across England.

The plans within the Maternity Transformation Programme (MTP) have been aligned with the seven IEAs, and NHS standard contracts now include conditions that providers of maternity services must develop and implement a board-approved action plan to address implementation of the IEAs. There have been recent changes to the Healthcare Safety Investigation Branch (HSIB), with an ongoing development of a Special Health Authority (SHA), which will be taking over the responsibilities of HSIB concerning maternity investigations. The new SHA will be established in 2023 and will run for five years, where it will aim to maximise learning from errors, as well as will help to equip trusts with 'expertise, resources, and capacity' to conduct maternity investigations going forward. Within the

report, Ockenden endorsed this shift and welcomes the potential of robust investigations to reduce the likelihood of safety concerns being missed or going unheard in maternity care.

NHS Providers view

The Ockenden report provides a clear, comprehensive, and well thought through plan to improve the quality of care and patient safety across maternity services nationally. In particular, we welcome the focus on addressing widespread workforce shortages, improving trust board governance and oversight of maternity services, improving training for team working, learning from safety incidents and the promotion of a culture based on learning and continuous improvement.

The mothers and their families who contributed to this report, participated courageously in the review, providing personal and life changing experiences. We understand that there are now necessary steps for trusts and for national NHS bodies to take to improve maternity services and enact meaningful change. This report represents a watershed moment for maternity care across the NHS in England and an opportunity to embed the learning locally and nationally to improve patient outcomes and experiences in the future.

The report found on numerous occasions that the concerns of mothers were not listened to or taken seriously, and draws attention to pregnancy as being a catalyst for increasing maternal vulnerability and inequalities. We would also highlight the particular inequalities and disparities in outcomes faced by Black and ethnic minority mothers and their infants within maternity care. It is essential that the vulnerability of women and their children within maternity care is fully recognised, and inequalities are sensitively and fulsomely addressed.

Workforce shortages in maternity care are significant and the impact of these on the quality and safety of care cannot be underestimated, and played a key role in the events investigated by this report. Our recent workforce planning survey highlighted the significant level of concern held by trusts; most notably, the "serious and detrimental impact" gaps in midwifery leave, sometimes resulting in trusts having to close services. Trusts reported that they are very concerned that they will not be able to recruit an adequate number of staff to meet the standards outlined within the report, demonstrating the vital need for the government to tackle this issue as soon as possible.

It is notable that a number of staff withdrew their cooperation from the review, citing a fear of identification. There is still significant work to do across the NHS to come to terms with the findings of this report and its implications for maternity services and patient care more broadly. One of the keys

to developing better outcomes will be shifting from a culture of blame to one of learning and listening. This would help the NHS as a whole move from reactive to proactive approaches to safety, including within high-risk settings, and encourage open conversations. The range of staffing gaps and resultant pressures on staff have a detrimental impact on progressing the cultural changes needed, with the latest results of the NHS Staff Survey providing a clear indication of the level of work-related stress and interplay here with quality of care.

While the recent national funding announcements for maternity services are important, we see them as a first step. NHS Providers calculated the extra costs required to fund the extra workforce needed to successfully implement the recommendations outlined in the Ockenden report, total between £200 and £350 million in recurrent annual funding. In our public letter to the Health and Social Care Committee, we provided a fuller rationale and breakdown of these calculations. We strongly welcome Donna Ockenden's explicit and upfront endorsement of this necessary investment in the maternity workforce (which cites our work) and urge the government to take steps ensure that the NHS and trusts can have appropriate staffing levels to implement these recommendations to improve quality and patient safety.

More widely, it is important that the national bodies engage with trusts to understand the challenges they face and the risks they manage, and to ensure that trusts have the necessary resources, capacity and time required to ensure that the recommendations in this report are properly implemented.

With much more to be done, it is also important to recognise the work that is already underway and the improvements that have been made. Approximately 600,000 babies are delivered by the NHS each year, and an overwhelmingly majority of those are delivered safely. Substantial progress has been noted in maternity care over the past decade, as the stillbirth rate has reduced by roughly 25%, baby mortality has reduced by 36%, and the new regulatory approach from the Care Quality Commission (CQC) is better focused on risk. We welcome the emphasis in the report on the progress made by trusts and staff over the recent years, which has improved the quality of care and patient safety as a result.

Press statement

Responding to the publication of the Ockenden report on maternity services, the deputy chief executive of NHS Providers Saffron Cordery said:

"This report must signal a turning point for maternity care in the NHS. It provides a clear, comprehensive and well thought through plan to improve the quality of care and patient safety across maternity services nationally.

"While the NHS has made significant strides in improving maternity outcomes over the last decade, there is still much more to do. As the report rightly highlights, one of the keys to delivering better outcomes for women and babies is developing the right culture – shifting from blame to one of learning and listening. This would better encourage proactive approaches to safety and more open conversations, and bring a more patient centred approach to managing maternity care.

"Action must be taken at a national level so that trusts have the necessary resources, capacity and time required to ensure that the recommendations in this report can be fully and properly implemented to improve maternity outcomes and experiences.

"In particular, trusts have told us that they are concerned that they will not be able to recruit sufficient staff to meet the standards outlined within the report, demonstrating the vital need for the government to tackle this issue as soon as possible. While we welcomed the funding boost of £127m to maternity services on Thursday, we estimated last summer that to recruit the numbers of maternity staff required would need in the region of between £200m and £350m in recurrent annual funding. We are pleased to see that the report today endorses our estimate.

"We welcome the review and its recommendations, and trusts are committed to taking these forward. In doing so, they will be working closely with the national NHS bodies to ensure high quality care for all women and their babies. This is part of a wider programme of work to address the range of issues facing maternity services. This includes the cultural issues within some services, worrying levels of pressure on staff, and the increasing complexity of pregnancies. It is also essential to bring a specific focus on tackling the stark disparities faced by black and minority ethnic mothers and their children, who are currently at an increased risk of adverse outcomes."