

Board of Directors

Item 2.3

Subject: Review of Ockenden Report March 2022
Date of Meeting: 26th April 2022
Prepared by: Joan Mathews Deputy Director of Nursing and Quality
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Presented by: Susan Pemberton Director of Nursing and Quality and safety

BAF Ref	Impact on BAF
BAF 1	For assurance that opportunities for learning have been identified to further strengthen the quality and safety of care in LHCHH

1. Executive Summary

The Ockenden report (2022) is the outcome of an independent review of maternity services at the Royal Shrewsbury and Telford (RST) NHS Trust between the years 2000 and 2019. The Ockenden report (2022) considers clinical care, culture, staffing, governance, and a range of other aspects which impacted on the outcomes for women and infants within the organisation. It can be summarised into 6 main themes:

1. Staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families
5. Neonatal
6. Additional learning

Each Trust has been asked to review the findings from the report and identify from their own structures and processes, if considerations should be given to improve/change. LHCH cannot compare maternity services with its own, however, when aligning the themes generated from this review and conducting a self-assessment of LHCH, there are some key areas that can be aligned to processes and governance at LHCH, where there may be opportunities for learning. This paper outlines these areas and provides a robust action plan for assurance as to how these will be addressed.

2. Background

In summer 2017, an independent review, led by Donna Ockenden commenced into maternity services at Shrewsbury and Telford Hospital NHS Trust. The independent review involved a multi-professional team. The request for the independent review was made by the Secretary of State for Health and Social Care at that time, the Rt Hon Jeremy Hunt, and was commissioned by NHSE/I. The purpose of the independent review was to examine 23 concerns collated by two

families Richard Stanton, and Kayleigh and Colin Griffiths, whose daughters died as a result of the care they received at the Trust. The deaths of Rhiannon and Richard's daughter Kate in 2009, and Kayleigh and Colin's daughter Pippa in 2016, were both avoidable.

The care of 1,486 families was reviewed, the majority of which were patients at the Trust between the years 2000 and 2019. Some families had multiple clinical incidents, therefore, a total of 1,592 clinical incidents involving mothers and babies were reviewed, with the earliest case from 1973 and the latest from 2020. An initial report was produced in December 2021 which outlined a number of local actions for learning (LAFL) and a number of immediate and essential actions (IEAS) for the Trust.

The final report from this independent review was published on 30th March 2022. The focus of the review was the Trust's neonatal care, and midwifery services, the outcome of the review found the Trust had failed. The report stated that Trust Boards must have oversight and understanding of their maternity services and ensure that they listen to, and hear, local families and their staff. The report detailed that there was evidence of failure to investigate incidents in a robust and methodical way, in line with the NHSE/I serious incident framework, but also failed to learn from mistakes and errors. The effect of these failings led to the Trust failing to improve its services and consequently, therefore, often failed to safeguard mothers and their babies at one of the most important times in their lives.

3. LHCH actions/areas for review for consideration which are aligned to the local and immediate actions from the Trust review

From the self-assessment of the local and immediate actions contained within the Ockendon report (2022) (Appendix one) the following areas have been identified where there may be learning for LHCH. Whilst LHCH has a track record of improving safety and quality there is always room for improvement and this report has provided an opportunity to review and improve where possible.

The following have been identified as key areas for review where it is deemed that there may be further learning for LHCH.

1	LHCH Governance and reporting structure
2	Incident reporting systems and processes — external and invited reviews
3	Mortality Review and Process
4	Formal complaint process
5	Identification and investigation of serious incidents in line with its own and that of NHSE/I policy and procedures
6	Being open and honest with patients and families
7	Escalation and recovery of the deteriorating patient
8	Listening to staff that includes FTSU embeddedness - "them and us" cited in the report
9	Safe staffing
10	Education, training, and development of the workforce
11	Board of Directors being aware of Trust business not confined to SI incidents
12	MDT working
13	Diabetes care
14	Consultant ward rounds

An action plan has been developed to outline what LHCH must do to ensure the learning from this review is captured and embedded. (Appendix two)

4. Conclusion

The Ockendon independent review (2022) outlined systematic failures within maternity services at Shrewsbury and Telford Hospital NHS Trust. From this review there were a number of local actions for learning (LAFL) and a number of immediate and essential actions (IEAS) for the Trust. This final report of the Independent Maternity Review of maternity services is about an NHS maternity service that failed. It failed to investigate, failed to learn, and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives. LHCH has conducted a review to extrapolate learning and actions that will be explored and embedded to improve safety and quality for our patients. The Trust will continue to listen and hear the voice of our workforce and our patients through the varied mechanisms we have in place to ensure it is continuously improving.

5. Recommendations

- To note the Board of Directors have received the Ockenden review 2022
- To approve the action plan to strengthen existing processes in Appendix 2
- The Board of Directors will receive assurance regarding progress from the action plan until completed

Appendix one

There were several local actions for learning (LAFL) and a number of immediate and essential actions (IEAS) for the Trust.

Local Actions for learning for the review Trust

- Improvement of patient and family involvement
- Support for staff raising a concern
- Improvement of complaint handling
- Improve audit process
- Improve Guideline Process
- Leadership and oversight – direct oversight of complaints
- Care of vulnerable and high-risk women
- Fetal growth assessment and management
- Fetal medicine care
- Hypertension
- Consultant Obstetric ward rounds
- Escalation of concerns
- MDT working

Immediate and essential Actions for the review Trust

- Workforce planning and sustainability
- Safe Staffing
- Clinical Governance and Leadership
- Incident investigation and complaints
- Learning from Maternal Deaths
- MDT Training
- Complex Antenatal care
- Preterm Birth
- Labour and Birth
- Obstetric Anesthesia
- Postnatal care
- Bereavement Care
- Neonatal Care
- Supporting Families

(L) – local action from the review of the Trust

(I) Immediate action from the review of the Trust

1.	LHCH Governance and reporting structure	(I)
2.	Incident reporting systems and processes - – external and invited reviews	(L) (I)
3.	Mortality Review and Process	(L) (I)
4.	Formal complaint process	(L) (I)
5.	Identification and investigation of serious incidents in line with its own and that of NHSE/I policy and procedures	(L) (I)
6.	Being open and honest with patients and families – Supporting families	(L) (I)
7.	Escalation and recovery of the deteriorating patient	(L) (I)
8.	Listening to staff that includes FTSU embeddedness - “them and us” cited in the report	(L) (I)
9.	Safe staffing	(L) (I)
10.	Education, training and development of the workforce	(L)
11.	Board of Directors being aware of Trust business not confined to SI incidents - receive assurance not reassurance	(I)
12.	MDT working	(L)
13.	Diabetes Care	(L)
14.	Consultant Ward Rounds	(L)

Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
<p>Clinical Governance – leadership Trust Boards must have oversight of the quality and performance of services</p> <p>Findings – Lack of oversight by the Board – lessons not learnt, mistakes in care repeated compromising the safety of mothers and babies.</p>		<p>Board receives a variety of assurance reports and updates in line with the workplan The governance/ committee structures were reviewed and strengthened in 2014 and annual reports are conducted on the effectiveness of the committees with positive feedback.</p>	<p>Review reporting committee structure with authority from the Board of Directors to ensure Terms of reference and reports are providing assurance as opposed to reassurance.</p> <p>Review the Board workplan to ensure they are receiving the appropriate reports to provide assurance on the quality and performance of services.</p>	<p>Director of Risk and Improvement</p> <p>September 2022</p>			

<p>Clinical Governance Incident investigation and complaints</p> <p>Findings – rigour and quality of investigations poor – in some cases there was no investigation and no learning identified- lacked input from the wider MDT. Investigations not carried out to a standard that was expected and did not identify the underlying systemic failings and some significant cases of concerns were not investigated at all. Examples of Serious incidents</p>		<p>Incident reporting is generally good across most areas and processes are effective. Work ongoing to train and support our workforce regarding the importance of reporting incidents and learning from them.</p> <p>Incident reporting policy in place.</p> <p>Training for staff who carry out investigations is in place and there is plan for other staff to access this,</p> <p>Potential serious incidents (SI) are reported and investigated as per policy with reporting externally as required. Training has been implemented to broaden the individuals who can undertake investigations. An incident review team comprising of some</p>	<p>Consider annual MIAA/ external review of LHCH reporting systems and process.</p> <p>Thematic analysis of incidents is conducted and reported to the Board of directors 6 monthly. Explore how the follow up of themes becomes part of the annual audit planning to ensure that appropriate actions have been taken.</p> <p>Review the language used in investigation reports ensuring they are easy to read for families.</p> <p>Explore how a team approach to SI investigation may strengthen the review and actions.</p> <p>The Clinical person/persons involved need to input into the evidence but not form part of the investigation team</p> <p>Regular training with</p>	<p>Director of Risk and Improvement</p> <p>September 2022</p>			
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<p>downgraded to a local investigation methodology to avoid external scrutiny. Limited consultant anaesthetists involved in investigations</p>		<p>executive directors and the divisional team has been instigated to review all actions prior to submission externally</p>	<p>evidence of training records for all staff who investigate SI at least every 3 years. Staff who work together should train together.</p> <p>All actions that can be audited from a SI investigation need to be identified to prevent re-occurrence – recommend a six monthly follow up review meeting for all serious incidents. To support this a review will be undertaken of all serious incidents during 2021/22.</p> <p>Change in practice arising from a serious incident investigation must be seen within 6 months after the incident has occurred.</p> <p>Staff involved in SIs including investigations are offered clinical psychologist input where appropriate for support.</p> <p>Development of</p>				
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Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
			<p>Schwartz Rounds to include SI outcomes and support for staff</p> <p>All complaints to be reviewed to ensure that incidents are highlighted, reported and learning identified</p> <p>All staff who formally write complaint responses to receive training at least every 3 years.</p>				

<p>Being open and honest with patients and families – Supporting families and bereavement care (L) (I)</p> <p>Findings- bereavement care was either inadequate or non-existent- examples of inappropriate comments made to some family members – examples where mothers were made to feel responsible by Trust staff for the loss of their baby – complaints about attitude of a consultant being rude and dismissive of families concerns</p>		<p>Compliance with duty of candour is good – led and overseen by the risk manager. The Deputy Director of nursing reviews all deaths for any evidence of family concern regarding care and treatment. With all serious incidents a lead to support families is established and regular contact is made as agreed with the family member.</p> <p>Meetings are offered to all bereaved families.</p>	<p>Explore how families are involved and can contribute to investigation questions with early involvement. investigations must be meaningful for families, and they need to be kept updated of progress with investigations.</p> <p>A meeting should be offered following the completion of the investigation.</p>	<p>Director of Risk and Improvement</p> <p>September 2022</p>				
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<p>Escalation, accountability and identification and escalation of the deteriorating patient (L) (I)</p> <p>Findings – escalation overarching theme – repeated failures to escalate for further opinion and review and when escalated failure to act appropriately Failure to recognise and escalate when mothers were deteriorating. Poor completion of early warning scores. Staff overly confident in their ability to manage complex pregnancies. Failure to</p>		<p>A review of out of hours nursing/medical cover has been reviewed in 2021/22 and Significant changes made to strengthen with 24-hour outreach, established and improved communication processes in the hospital hub.</p> <p>Early warning score is used trust wide and is audited and reported through to Quality safety experience committee and to Quality committee. Using the Modified Early warning score is part of training for medical/ nursing staff.</p> <p>The Trust has appointed a patient safety lead.</p>	<p>Continue to monitor the effectiveness of the out of hours provision to ensure it remains effective and is improving safety and quality.</p> <p>Review training offered in relation to human factors.</p>	<p>Director of Nursing</p> <p>September 2022</p>				
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Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
<p>discuss cases with the MDT.</p> <p>Them and us culture – engendered fear amongst midwives to escalate concerns to Consultants – demonstrating a lack of psychological safety in the workplace. Poor working relationships were also witnessed by families.</p>							

Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
Listening to staff that includes FTSU embeddedness - "them and us" cited in the report (L) (I)		Freedom to speak up guardian and a network of guardians are in place. The speak up promise led by the Chief Executive is shared at each corporate induction and reiterated at each monthly team brief. Evidence that our workforce to speak up by the numbers received and positive feedback in the staff survey. Daily safety huddle led by the Chief Exec and Director of Nursing supported by a programme of walk rounds ensures that the Executive members are visible and engaging with teams trust wide.	<p>There are some areas across the Trust where culture improvement work is in place currently – catheter labs and radiology.</p> <p>Consider how the Board of Directors are appraised of this and receive progress updates.</p> <p>Review the FTSU arrangements and network to assess if further improvements can be made. Board self-assessment and MIAA review planned.</p>	<p>Director of Risk and improvement</p> <p>October 2022</p>			

Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
<p>Safe staffing (L) (I)</p> <p>Findings significant staffing and training gaps within the midwifery and medical workforce. Unsafe inpatient to staffing rations – staff reported feeling fearful and stressed at work due to poor staffing levels.</p>		<p>No action identified for nursing– Association United Kingdom University Hospitals (AUKUH) included in reports together with professional judgement reviews – which follows national guidelines for nurse/patient ratios. The Trust reviews staffing daily at safety huddle and at weekends the hospital coordinator and ward manager review and address as required. The Board receives an annual safe staffing report for nursing via People Committee and monthly compliance data on care hours per patient day.</p>	<p>Consider how the Board is assured of safe staffing in relation to disciplines other than nursing.</p> <p>Newly appointed band 7 and 8 clinical staff to be allocated a named and experienced mentor to support transition into leadership and management roles.</p>	<p>Chief People Officer</p> <p>September 2022</p>			

<p>Education, training, and development of the workforce (L)</p> <p>Findings – there was evidence that the clinical care and decision making of midwives did not demonstrate the appropriate level of competence – failure to recognise from the norm and failure to escalate</p>		<p>Preceptorship programme established</p> <p>Education strategy in place.</p> <p>Education team are developing role profiles with some for nursing completed – (what is expected of a registered nurse at each level and what training/development they require to ensure they have the relevant competencies)</p> <p>In high care areas such as POCCU and ITU there are expected critical care competencies that have to be completed prior to working in that environment.</p>	<p>Consider Supernumerary clinical skills facilitators to support clinical staff across all settings.</p> <p>Strategy for continuing recruitment and retention is in place and needs to be embedded. A focus on the development and training of ANPs is required to ensure that these staff are retained in the Trust.</p> <p>Multi professional training needs to be embedded trust wide.</p> <p>Explore a unit/ward leader coordinator development programme to support advanced decision making, human factors, situational awareness and psychological safety to tackle behaviours in the workforce.</p> <p>Develop a succession planning programme to develop potential future leaders and</p>	<p>Chief People Officer</p> <p>October 2022</p>			
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Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
			senior managers.				
Board of Directors being aware of Trust business not confined to SI incidents - receive assurance not reassurance (I)		The Board receives assurance reports on Trust performance across activity, targets, finance, workforce, and Quality.	Review workplan to identify any gaps for the Board	Chief Operating Officer September 2022			

Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
MDT working (L) Findings – lack of kindness and compassion from some members of the maternity team on many occasions – noted in follow up letters no words of condolences – examples of dismissing patients in pain and criticizing patients		<p>Be civil be kind established and rolled out trust wide.</p> <p>Team LHCH ethos is promoted continuously.</p> <p>Civility training is in place.</p> <p>Complaints are continuously reviewed to ascertain any themes</p> <p>All complaint letters are reviewed by the Director of Nursing and Chief Executive</p> <p>Assurance reports regarding the Trust pain service are reviewed at the QSEC committee.</p>	<p>All staff must receive training in civility, human factors, and leadership. These are in place and need to be rolled out trust wide.</p> <p>All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.</p> <p>Develop a programme of simulation training for the management of cute vents – e.g., cardiac arrest and the deteriorating patient</p>	Chief People Officer September 2022			

Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
Diabetes Care (L) Findings – issues regarding lack of service provision at weekends - Service should be able to run over holidays and weekends.		<p>The Trust diabetic team work Monday to Friday currently. A review has been undertaken of the nursing requirements and this is being discussed at operational Board this month.</p> <p>Out of hours it is the medical teams/Advanced nurse practitioner/outreach that will address any residual concerns.</p> <p>Reports regarding the diabetic service are presented to the Quality, safety, experience committee as per the work plan and are escalated to the Quality committee as required and to the Board via BAF key issues.</p>	Review assurance to the Board of timely assessments and management of patients with Diabetes	Medical Director September 2022			

Areas for Review	Current LHCH Process Rag Rated	Current conditions In LHCH	Consideration for strengthening/review	Lead Person and timeframe for completion	Progress of Actions	Date of Review	Date of Completion
Consultant Ward Rounds (L) Findings poor consultant oversight – delays in treatment – delays in seeking senior clinical advice		Ward rounds are in place across all wards and units in the Trust.	<p>SBAR (situation, background, assessment, and recommendations) to be considered to allow staff to escalate concerns in a structured way and timely.</p> <p>Review opportunity to set standards and quality of ward rounds.</p> <p>Need assurance that all unplanned admissions to be reviewed by a consultant within 14 hours.</p>	<p>Medical Director</p> <p>October 2022</p>			