

## Board of Directors

### Item 5.5

**Subject:** Ockenden Action Plan Progress Update Final  
**Date of Meeting:** 28<sup>th</sup> November 2022  
**Presented by:** Sue Pemberton, Director of Nursing, Quality and safety  
**Purpose:** To receive assurance

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

#### 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. The Board of Directors at LHCH received a report in July 2022 comprising a self-assessment against the outcomes of the Ockenden report against the governance and standards within LHCH.

LHCH cannot compare maternity services with its own, however, when aligning the themes generated from this review and conducting a self-assessment there are some key areas that can be aligned to processes and governance at LHCH, where there may be opportunities for learning.

This paper provides assurance on the significant progress against actions and recommends future updates via the Quality Committee.

## 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 action plan update

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.

From the self-assessment of the local and immediate actions contained within the Ockendon report (2022) there were a number of areas identified for review where it is deemed that there may be further learning for LHCH. The table below sets out a progress update including RAG rating against these areas.

Areas for Action	Current RAG	Comments
LHCH Governance and reporting structure		Actions complete and will form part of performance dashboard developments.
Incident investigations and complaints		Actions significantly complete and RAG moved from Amber to Green.
Mortality Review and Process		Actions significantly complete and RAG moved from Amber to Green.
Being open and honest with patients and families		Actions complete.
Escalation and recovery of the deteriorating patient		Actions complete.
Listening to staff that includes FTSU embeddedness - "them and us" cited in the report		Actions complete and RAG moved from Amber to Green.

Areas for Action	Current RAG	Comments
Safe staffing		Actions progressing. The Board receives full assurance of nurse staffing via monthly reports. The medical staffing model has developed a hybrid model of doctors and ANPs covering the service. All the ANPs have now been appointed – some are still in training. No issues or incidents with Tier 1 cover have been raised and no gaps other than acute sickness. The MESS meetings will continue to monitor the process. There are ongoing discussions over further developments of the staffing model. It is likely this will require additional funding.
Education, training, and development of the workforce		A number of actions complete and others progressing.
Board of Directors being aware of Trust business not confined to SI incidents		Dashboard reviewed and agreed. Further enhancements planned for 2023.
MDT working		Actions progressing. The remaining action is to ensure embedding of the be civil be kind trust wide.
Diabetes care		Actions significantly complete and RAG moved from Amber to Green.
Consultant ward rounds		Actions progressing. Ward rounds are in place. The use of the SBAR tool is being reviewed currently to assess its value in improving safety.

Refer to Appendix A for the full action plan and progress update.

#### 4. Conclusion

The Ockenden 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. LHCH conducted a review to extrapolate learning and actions to further improve safety and quality for our patients, and significant progress has been demonstrated against the actions. The Trust will also 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

The Board of Directors is asked to note the update and assurance against the Ockenden action plan and agree the route for assurance on the remaining actions through the Quality Committee.

## Appendix 1 – Action Plan Progress Update

<b>Governance and Reporting</b>		<p>(i) 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>(ii) 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>(i) A full review of the Board and Assurance Committee structure is underway including terms of reference, business cycles (workplans) and reporting.</p> <p>(ii) The Board business cycle (workplan) is being reviewed alongside the Committee review. Further enhancement of the performance dashboards has also been agreed</p>	<p>October 2022</p>
<b>Incident investigation and complaints</b>		<p>(i) Consider annual MIAA/ external review of LHCH reporting systems and process.</p> <p>(ii) 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>(iii) Review the language used in investigation reports ensuring they are easy to read for families.</p> <p>(iv) Explore how a team approach to SI investigation may strengthen the review and actions.</p> <p>(v) The Clinical person/persons involved need to input into the evidence but not form part of the investigation team</p>	<p>Director of Risk and Improvement</p> <p>September 2022</p>	<p>(i) Organisational learning was considered in the MIAA internal audit planning risk assessment and is in the outline plan for 23/24. This could be expanded to include a review of incident reporting aligned to the new patient safety framework.</p> <p>(ii) The Divisional Heads of Nursing have conducted a review of the learning from incidents. The Clinical Audit and Effectiveness Manager and the Clinical Lead for Risk Management will conduct a review of the actions from 2021/22 themes to assess actions taken.</p> <p>(iii) The reports are subject to extensive QA processes to ensure they are fit for purpose. This needs to be included in the investigation training.</p> <p>(iv) and (v) Investigation training to be sourced to consider changes expected in the new patient safety framework.</p>	<p>September 2022</p>

		<p>(vi) Regular training with evidence of training records for all staff who investigate SI at least every 3 years. Staff who work together should train together.</p> <p>(vii) 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>(viii) Change in practice arising from a serious incident investigation must be seen within 6 months after the incident has occurred.</p> <p>(ix) Staff involved in SI offered clinical psychologist input where appropriate for support.</p> <p>(x) Development of Schwartz Rounds to include SI outcomes and support for staff</p> <p>(xi) All complaints to be reviewed to ensure that incidents are highlighted and reported if identified</p> <p>(xii) All staff who formally write complaint responses to receive training at least every 3 years.</p>		<p>(vi) L&amp;D are exploring investigation training to train the trainer in new investigation techniques from patient safety framework.</p> <p>(vii) and (viii) The Clinical Audit and Effectiveness Manager and the Clinical Lead for Risk Management will review 2021/22 incidents to ensure follow up and to work with Divisions to assess if change in practice has embedded.</p> <p>(ix) AMD/HON to arrange support for staff involved in SI's</p> <p>(x) Head of Risk Management to meet regularly with L&amp;D to discuss content of Schwartz rounds</p> <p>(xi) Head of Risk Management meeting with the Patient and Family Support Manager to confirm that complaints are reviewed to see if incidents reported. If no incident reported to assess nature of complaint and report incident if necessary</p> <p>(xii) The Patient and Family Support Manager is reviewing the training for complaint responses.</p>	
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<b>Learning from deaths and Mortality Review and Process</b>		<p>(i) The Medical Director is currently reviewing MRG and the processes. Need to focus on Identification of those reviews which require immediate review and reporting to prevent further deaths.</p> <p>(ii) Lessons learnt need to be implemented in practice in a timely manner – recommend 6 monthly review meetings for all deaths where there is any avoidability.</p> <p>(iii) The roll out of the learning database is imminent – this needs to be used to ensure that the learnings from mortality are highlighted and shared.</p>	<p>Medical Director October 2022</p> <p>Medical Director October 2022</p> <p>Director of Risk and Improvement July 2022</p>	<p>(i) and (ii) MRG timeliness is being improved and is a standing item on the Mortality Improvement Group (MIG). The reporting metrics are monitored at MIG with rolling 12-month data. The patient deaths that need early review are identified by the MRG administrator, the Medical Examiners, and the Deputy Director of Nursing (DDoN). Deaths reported as incidents go straight to full review and RCA. There is regular scrutiny of mortality screens by the Medical Director (MD) and Deputy Medical Director (DMD) to pick up early learning. Actions from mortality review are managed by the Divisions.</p> <p>(iii) The learning database was presented to the Clinical Leads and Operation Board meeting in June 2022. A soft launch with Divisions took place in September 2022 and this will be rolled out following completion of some final IT actions.</p>	October 2022
<b>Being open and honest with patients and families – Supporting families and bereavement care</b>		<p>(i) 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>(ii) A meeting should be offered following the completion of the investigation.</p>	Director of Risk and Improvement September 2022	<p>(i) Process for informing and involving families established (Head of Risk Management)</p> <p>(ii) Meetings are offered to families at the conclusion of an investigation (Head of Risk Management)</p>	July 2022

<b>Escalation, accountability and identification and escalation of the deteriorating patient</b>		<p>(i) Continue to monitor the effectiveness of the out of hours provision to ensure it remains effective and is improving safety and quality.</p> <p>(ii) Review training offered in relation to human factors.</p>	<p>Director of Nursing</p> <p>September 2022</p>	<p>(i) The out of hours provision has been strengthened by the outreach service being available 24/7. Good feedback from operational teams regarding the support available.</p> <p>(ii) Human Factors training is delivered on request, and it is part of Preceptorship, Care certificate, Advanced Critical Care and Safe from Harm Programmes. E-learning module is in progress and will be launched soon. This is now featured in the Learning Catalogue and based on demand. Regular standalone sessions are scheduled.</p> <p>(iii) The be civil be kind culture work continues and as a result the Trust has seen a reduction in issues regarding behaviour and incivility.</p>	September 2022
<b>Listening to staff that includes FTSU embeddedness - "them and us" cited in the report</b>		<p>(i) There are some areas across the Trust where culture improvement work is in place currently – catheter labs and radiology.</p> <p>(ii) Consider how the Board of Directors are appraised of this and receive progress updates.</p> <p>(iii) Review the FTSU network to assess if further improvements can be made.</p>	<p>Director of Risk and improvement</p> <p>October 2022</p>	<p>(i) and (ii) The Board receives quarterly FTSU updates which may include some of the culture improvement work. We continue to consider how the Board are kept sighted on the wider culture improvement work.</p> <p>(iii) The Board have completed an FTSU self-assessment exercise (April 2022), and progress is being made against the actions which included capacity and resilience of the network and roles.</p>	July 2022
<b>Safe staffing</b>		<p>(i) Consider how the Board is assured of safe staffing in relation to disciplines other than nursing.</p> <p>(ii) Newly appointed band 7 and 8 clinical staff to be allocated a named and experienced mentor to support</p>	<p>Chief People Officer</p> <p>September 2022</p>	<p>(i) Regular Compliance reporting is issued. Comms for managers reporting on ESR are scheduled. The information is already on the staff intranet.</p>	<b>In progress</b>

		transition into leadership and management roles.		(ii) Mentoring for B7 & 8 clinical leaders-training content is designed, and all training sessions are scheduled for delivery in September. The programme was welcomed by staff and 19 colleagues expressed their interest to become mentors. To further support new colleagues and give them the opportunity to be welcomed and to learn from each other, we are re-launching our Buddy Scheme for clinical staff. The programme will be launched during the first week of October. 12 colleagues already expressed their interest to take part.	
<b>Education, training, and development of the workforce</b>		<p>(i) Consider Supernumerary clinical skills facilitators to support clinical staff across all settings.</p> <p>(ii) 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>(iii) Multi professional training needs to be embedded trust wide.</p> <p>(iv) 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>(v) Develop a succession planning programme to develop potential future leaders and senior managers.</p>	<p>Chief People Officer</p> <p>October 2022</p>	<p>(i) The programme is already established; we only need to consider Supernumerary clinical skills facilitators to support clinical staff across all settings. Content for the programme was updated in May 2022. Next Preceptorship cohorts are scheduled in October 2022 and April 2023.</p> <p>(ii) LHCH Education Strategy in place. As part of the launch of the new HR Front Door this will be promoted more widely. A focus on the development and training of Advanced Nurse Practitioners (ANPS) is required to ensure that these staff are retained in the Trust. The Head of Nursing is supporting ANPs with study time. Further investment in this is required. Regular meetings have been set up between Learning and development and the ANPs across all divisions to identify their needs and agree on support required. Working with the divisions to re-</p>	<b>In progress</b>



				<p>cruit for advance practice roles and supporting trainee ANPs via apprenticeships and traditional pathways.</p> <p>(iii) POCCU and ITU completion prior to employment or commencing working in that environment is already in place.</p> <p>(iv) This programme is on track and will include: - advanced decision making, human factors, situational awareness, and psychological safety to tackle behaviours in the workforce. An appreciative inquiry session was facilitated by the L&amp;D in August with ward managers to identify key areas of development. This will be followed up by some action learning to further scope the requirements and address some of the current challenges.</p> <p>(v) The adoption of Scope for Growth (Talent Management Framework) (S4G) and implementation of Career Pathways was launched on 31st October 2022. Tools and resources have been developed and launched on the HR Front Door.</p> <p>Training schedule and intro of the framework:  8 A and above- November/ December 2022  Learning and development team – November/ December 2022  Band 5 – 7 Jan – Feb 23  All – April 23</p> <p>This process will then be built into appraisals from next year.</p>	
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<b>Board of Directors being aware of Trust business not confined to SI incidents - receive assurance not reassurance</b>		(i) Review workplan to identify any gaps for the Board	Chief Operating Officer  September 2022	(i) The Board Dashboard was reviewed in Q1 in relation to the SOF (strategic outcome framework) and annual planning guidance.  (ii) Trust performance targets have been revised and updated to be monitored through the Operational Board and sub committees.  (iii) Assurance reports and action plans are provided to assure the board of progress.	July 2022
<b>MDT working</b>		(i) All staff must receive training in civility, human factors, and leadership. These are in place and need to be rolled out trust wide.  (ii) 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.  (iii) Develop a programme of simulation training for the management of acute vents – e.g., cardiac arrest and the deteriorating patient	Chief People Officer  September 2022	(i) Civility programmes e-learning, patient safety and human factors e-learning is available as part of Patient Safety Strategy. Bespoke human factors training for teams is available. (ii) Be Civil, Be Kind and FTSU arrangements embedded within the Trust.  (iii) Education and Organisational development team is currently in conversation to explore the new virtual Technology Enabled Learning provided by Health Education England. Plans under development for new simulation centre. High fidelity simulation manikin purchased.	<b>In progress</b>

<b>Diabetes Care</b>		(i) Review assurance to the Board of timely assessments and management of patients with Diabetes	Medical Director September 2022	<p>MD discussed with clinical lead for DM. A daily EPR report is generated for all patients who have had a HbA1c test at LHCH allowing the team to automatically identify those in need of their attention. Outpatients with poor control are flagged and correspondence sent to their GP requesting optimisation. Referrals for inpatient attention are timely and appropriate. Specialist nurses who regularly review our inpatients and write comprehensive reviews/ plans for blood sugar management. There is a thorough and detailed diabetic management policy detailing how these patients should be clinically managed.</p> <p>The pharmacy team have introduced a number of EPR alerts when prescribing insulin to try and prompt the prescriber to consider their choice of both insulin type and dose carefully. There are plans to make e-learning for insulin prescribing mandatory for medical staff. Point of care HbA1c monitors and ketone monitors have been purchased. A business plan for an additional specialist nurse is under consideration</p>	September 2022
<b>Consultant Ward Rounds</b>		<p>(i) SBAR (situation, background, assessment, and recommendations) to be considered to allow staff to escalate concerns in a structured way and timely.</p> <p>(ii) Need assurance that all unplanned admissions to be reviewed by a consultant within 14 hours</p>	Medical Director October 2022	<p>(i) The consultant ward rounds workload is being assessed to ensure safe patient management. The SBAR tool is used but not in all areas. A review to evaluate embedding SBAR will be undertaken.</p> <p>(ii) An audit has been completed on review of emergency admissions. 50 EPR records over a two-week period were au-</p>	<b>In progress</b>

				<p>dited. 14-hour consultant review was carried out in 100% of emergency patients. Daily senior review was performed throughout the inpatient episode in 94% of patients with 3 patients missing one day predominantly at weekends.</p>	
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