| Paper ref: | TB (05/22) 013 |
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NHS
Sandwell and West Birmingham
NHS Trust

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| **Report Title:** | Briefing paper on The Final Ockenden Report | | |
| **Sponsoring Executive:** | Melanie Roberts - Chief Nurse | | |
| **Report Author:** | Helen Hurst - Director of Midwifery | | |
| **Meeting:** | Public Trust Board | **Date** | 4th May 2022 |

**1. Suggested discussion points** *[two or three issues you consider the Committee should focus on]*

The Trust Board is asked to receive this briefing on the final Ockenden report into maternity care failings at Shrewsbury and Telford NHS Trust (SaTH), published on 30th March 2022. The report sets out the findings of the review into care provided to 1,486 families, (involving 1,592 clinical incidents), primarily between 2000 and 2019.The report has four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

15 Immediate and Essential Actions (IEA's) have been identified within the report. An overview is included in the briefing, these set out a blueprint for safety across England's maternity services.

In Annex 1 you will find a provisional self-assessed benchmarking against the 15 IEA's made up of 88 subparts. Guidance is awaited as quoted in chapter 15 sections 15.13 of the report on the specific programme of implementation of these IEA's.

**2. Alignment to our Vision** *[indicate with an **'X'** which Strategic Objective this paper supports]*

| Our Patients | | Our People | | Our Population | |
|---|---|---|---|---|---|
| To be good or outstanding in everything that we do | x | To cultivate and sustain happy, productive and engaged staff | x | To work seamlessly with our partners to improve lives | x |

**3. Previous consideration** *[where has this paper been previously discussed?]*

WCH Group Governance Board (19/4/22), Quality and Safety Committee (27/4/22)

**4. Recommendation(s)**

The Public Trust Board is asked to:

| | |
|---|---|
| **a.** | **CONSIDER** the Briefing on the Final Ockenden Report |
| **b.** | **ACCEPT** and discuss the service level scoping in Annex 1 |
| **c.** | **SUPPORT** the Maternity and Neonatal Service with requirements of the 15 IEA's |

**5. Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Trust Risk Register | | | | | | | |
| Board Assurance Framework | | | | | | | |
| Equality Impact Assessment | Is this required? | Y | | | | If 'Y' date completed | TBC |
| Quality Impact Assessment | Is this required? | Y | | | | If 'Y' date completed | TBC |

**SANDWELL AND WEST BIRMINGHAM NHS TRUST**

**Report to Public Trust Board: 4th May 2022**

**Briefing paper on The Final Ockenden Report**

## 1. Introduction

1.1 The final Ockenden report into maternity care failings at Shrewsbury and Telford NHS Trust (SaTH) was published on 30 March 2022. The report sets out the findings of the review into care provided to 1,486 families, (involving 1,592 clinical incidents), primarily between 2000 and 2019, and provides a blueprint towards safe maternity care. The report has four key pillars:

1.2

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

## 2. Overview of the final report

2.1 The review, which rightly put families' voices centrally also listened to staff experiences, builds on the findings of the first Ockenden report which was published in December 2020. It reinforces the importance of establishing and improving critical oversight of patient safety in maternity units and identifies 15 Immediate and Essential Actions (IEAs) to be implemented across maternity services in England to bring about timely, positive and fundamental change.

2.2 The review of 1,486 family cases, identified thematic patterns in the quality of care and investigation procedures carried out by the trust, including where opportunities for learning and improving quality of care have been missed.

2.3 In total, 12 cases of maternal death formed part of the review. It was concluded that none of the mothers had received care in line with best practice at the time and, in three-quarters of cases, the care could have been significantly improved. Only one maternal death investigation was conducted by external clinicians, and the internal reviews that were conducted were found to be of poor quality. As a result, significant omissions in care were not identified and, in some incidents, women themselves were also held responsible for the outcomes.

2.4 In total, 498 cases of stillbirth were reviewed and graded. One in 4 cases were found to have significant or major concerns in maternity care that, if managed appropriately, might or would have resulted in a different outcome.

2.5 Of the reviews into the cases of Hypoxic Ischaemic Encephalopathy (HIE), a new-born brain injury caused by oxygen deprivation to the brain, two thirds were found to have significant and major concerns in the care. It should be noted that following birth, most of the neonatal care provided was considered appropriate or included minor concerns. However, these were unlikely to influence the outcome observed.

2.6 Most of the neonatal deaths occurred in the first 7 days of life. Of these cases almost a third were identified to have significant or major concerns in the maternity care provided that might or would have resulted in a different outcome.

## 3. Summary of the Immediate and Essential Actions

3.1 The final report sets out 60 Local Actions for Learning (LAfL) specific to SaTH. However, many of the issues identified by the Ockenden review team are not isolated to SaTH and maternity services in England now need to build on the work they started following the first Ockenden report (2020).

3.2 The final report sets out a further 15 Immediate and Essential Actions (IEAs) which are intended to make a significant contribution to the delivery of safe maternity care, and which complement and expand on the IEAs issued in the first report. These actions must be implemented across all maternity services. It is recognised that change will not be achieved overnight but clear that action is required now at all levels, from ward to Board, in order to improve care and safety in maternity services. In Annex 1 you will find a provisional self-assessed benchmarking against the 15 IEA's made up of 87 subparts. Guidance is awaited as quoted in chapter 15 sections 15.13 of the report on the specific programme of implementation of these IEA's. The service will work towards incorporating the requirements into the overarching quality improvement journey already in process. The 15 IEA's are:

| Immediate and Essential Action | Descriptor |
|---|---|
| **IEA 1. Workforce planning and sustainability** | Financing a safe maternity workforce |
| **IEA 2. Safe staffing** | All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professional |
| **IEA 3. Escalation and accountability** | Staff must be able to escalate concerns if necessary |
| **IEA 4. Clinical governance – leadership** | Trust boards must have oversight of the quality and performance of their maternity services |
| **IEA 5. Clinical governance – incident investigation and complaints** | Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner |
| **IEA 6. Learning from maternal deaths** | Nationally, all maternal post-mortem examinations must be conducted by a |

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|---|---|
| | pathologist who is an expert in maternal physiology and pregnancy-related pathologies |
| **IEA 7. Multidisciplinary training** | Staff who work together must train together |
| **IEA 8. Complex antenatal care** | Local maternity systems, maternal medicine networks and trusts must ensure that women have access to pre-conception care |
| **IEA 9. Preterm birth** | 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 |
| **IEA 10. Labour and birth** | 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 |
| **IEA 11. Obstetric anaesthesia** | 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 |
| **IEA 12. Postnatal care** | Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review |
| **IEA 13. Bereavement care** | Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services |
| **IEA 14. Neonatal care** | There must be clear pathways of care for provision of neonatal care |
| **IEA 15. Supporting families** | 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 |

## 4. Impact of the Report

4.1 Nationally there has been a huge outcry following the release of the report, including adverse comments on social media platforms naming Trusts with job advertisements where normality is mentioned. Regionally there have been a high number of requests for cases to be reopened or reviewed. Some Trusts have also seen abuse of midwives whilst at work or in their personal time.

4.2 Within our own organisation we have provided an offer of additional support to our women and families. At present we have only seen a small uptake for this.

4.3 We ensured the report was shared with all staff on the day of release and have ensured high levels of visibility and open door sessions to listen and support our staff where they have queries and questions.

4.4 This remains a time of increased scrutiny and exposure across all media platforms for maternity services, which will not diminish with the imminent release of the Kirkup report into the maternity services at East Kent and the continued discussions around services at Nottingham. The impact on recruitment and retention of staff is inevitable, but we continue to work closely with colleagues from Health Education England. We are also part of the recruitment and retention pilot and continue to build on the cultural improvement work within our service.

## 5. Summary

5.1 The report recognises that many of the issues highlighted in the report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have also been highlighted in other local and national reports into maternity services in recent years.

5.2 The review acknowledged the huge pressure maternity services, and their staff continue to face, which have been compounded by the pressures arising from the Covid-19 pandemic. In addition to funding issues, there are significant workforce challenges, particularly in the recruitment and retention of midwives and obstetricians. Without this, maternity services cannot provide safe and effective care for women and babies. The service has undertaken a provisional benchmarking against all IEA's, however we await guidance as quoted in chapter 15 sections 15.13 of the report on the specific programme of implementation of these IEA's. We will work towards incorporating the requirements into the overarching quality improvement journey already in action. It is imperative we now take time to review and consider prior to implementation, to ensure we undertake quality impact assessments to support the pace of change; ensuring robust communication with women, families and colleagues is at the centre.

## 6. Recommendations

6.1 **The Public Trust Board is asked to:**

a. **CONSIDER** the Briefing on the Final Ockenden Report
b. **ACCEPT** and discuss the service level scoping in Annex 1
c. **SUPPORT** the Maternity and Neonatal Service with requirements of the 15 IEA's

**Helen Hurst**
**Director of Midwifery**
**11th April 2022**

**Annex 1**

## Provisional Self-Assessment: Final Ockenden 15 IEA's

| IEA 1. Workforce planning and sustainability | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 3 |
| Some progress in this area | 1 |
| Significant work to do | 3 |
| National action - unable to rate | 2 |
| **TOTAL** | **11** |

| IEA 2. Safe staffing | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 6 |
| Near complete | 0 |
| Some progress in this area | 1 |
| Significant work to do | 2 |
| National action - unable to rate | 0 |
| **TOTAL** | **9** |

| IEA 3. Escalation and accountability | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 3 |
| Near complete | 1 |
| Some progress in this area | 0 |
| Significant work to do | 1 |
| National action - unable to rate | 0 |
| **TOTAL** | **5** |

| IEA 4. Clinical governance – leadership | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 3 |
| Near complete | 1 |
| Some progress in this area | 1 |
| Significant work to do | 2 |
| National action - unable to rate | 0 |
| **TOTAL** | **7** |

| IEA 5. Clinical governance – incident investigation and complaints | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 2 |
| Some progress in this area | 2 |
| Significant work to do | 1 |
| National action - unable to rate | 0 |
| **TOTAL** | **7** |

| IEA 6. Learning from maternal deaths | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 0 |
| Some progress in this area | 0 |
| Significant work to do | 0 |
| National action - unable to rate | 1 |
| **TOTAL** | **3** |

| IEA 7. Multidisciplinary training | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 0 |
| Some progress in this area | 2 |
| Significant work to do | 3 |
| National action - unable to rate | 0 |
| **TOTAL** | **7** |

| IEA 8. Complex antenatal care | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 3 |
| Near complete | 0 |
| Some progress in this area | 1 |
| Significant work to do | 1 |
| National action - unable to rate | 0 |
| **TOTAL** | **5** |

| IEA 9. Preterm birth | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 1 |
| Some progress in this area | 0 |
| Significant work to do | 1 |
| National action - unable to rate | 0 |
| **TOTAL** | **4** |

| IEA 10. Labour and birth | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 0 |
| Some progress in this area | 2 |
| Significant work to do | 2 |
| National action - unable to rate | 0 |
| **TOTAL** | **6** |

| IEA 11. Obstetric anaesthesia | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 0 |
| Near complete | 2 |
| Some progress in this area | 2 |
| Significant work to do | 0 |
| National action - unable to rate | 0 |
| **TOTAL** | **4** |

| IEA 12. Postnatal care | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 3 |
| Near complete | 1 |
| Some progress in this area | 0 |
| Significant work to do | 0 |
| National action - unable to rate | 0 |
| **TOTAL** | **4** |

| IEA 13. Bereavement care | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 0 |
| Some progress in this area | 2 |
| Significant work to do | 0 |
| National action - unable to rate | 0 |
| **TOTAL** | **4** |

| IEA 14. Neonatal care | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 2 |
| Near complete | 0 |
| Some progress in this area | 3 |
| Significant work to do | 3 |
| National action - unable to rate | 0 |
| **TOTAL** | **8** |

| IEA 15. Supporting families | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 3 |
| Near complete | 0 |
| Some progress in this area | 0 |
| Significant work to do | 0 |
| National action - unable to rate | 0 |
| **TOTAL** | **3** |

| Total Actions | |
|---|---|
| **RAG Summary** | **RAG Count** |
| Complete | 37 |
| Near complete | 11 |
| Some progress in this area | 17 |
| Significant work to do | 19 |
| National action - unable to rate | 3 |
| **TOTAL** | **8** |