Paper ref:	TB (01/21) 007

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Ockenden Report - Emerging Findings and Recommendations from the Independent Review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust		
Sponsoring Executive	David Carruthers, Interim CEO and Medical Director		
Report Author	Helen Hurst, Director of Midwifery		
Meeting	Trust Board (Public)	**Date**	7th January 2021

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

a) Overall findings of report and cascade of failings at all levels, from Board to floor, it is clear that inconsistencies, failure to learn, lack of transparency at all levels, failure to escalate and failures in process led to poor outcomes and institutionalised failings.
b) 12 immediate actions for all organisations have been identified, which are contained within the appendices, where work is required by the Trust and Local Maternity and Neonatal System to improve services and outcomes
c) Clear directive of inclusion at board level of maternity services with direct access by the Director of Midwifery

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	√	Public Health Plan	√	People Plan & Education Plan	√
Quality Plan	√	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

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

4. Recommendation(s)

The Trust Board is asked to:

a.	Note the report and findings
b.	Note and approve the evidence and actions in the assurance tool (appendix 1)
c.	Note the high priority of Maternity Services at National level and the requirement for Board oversight

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		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 7th January 2021

Summarised Findings of the
Ockenden Report - Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust
Published 10th December 2020

1. Introduction or background

This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies. In addition, a small number of earlier cases have emerged these are being reviewed by the independent team wherever medical records are available.

The total number of families to be included in the final review and report is 1,862. This first report arising from the 250 cases reviewed to date. The number of cases considered so far includes the original cohort of 23 cases.

The review panel has identified important themes which must be shared across all maternity services as a matter of urgency and have formed **Local Actions for Learning** and make early recommendations for the **wider NHS Immediate and Essential Actions**.

2.0 Findings

2.1 Review of the Trust's maternity governance processes

- Inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.
- Inconsistent multiprofessional engagement with the investigations of maternity serious incidents.
- In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care.
- Lack of objectively in Serious incident reviews and a lack of consideration of the systems, structures and processes in the reports.
- Limited evidence of feedback to staff following incident review.
- Examples of failure to learn lessons and implement changes in practice. This is notable:
    - in the selection of, or advice around, place of birth for mothers
    - the management of labour overall
    - the injudicious use of oxytocin

- the failure to escalate concerns in care to senior levels when problems became apparent
- Continuing errors in the assessment of fetal wellbeing.

- Incidents not investigated in a timely manner.
- Serious incidents not investigated using a systematic and multiprofessional approach.
- Lack of evidence that lessons were learned and applied in practice to improve care.

2.2 Trust Board oversight

Turnover of Executive leadership has impacted organisational knowledge and memory.

2.3 Midwifery and Obstetric issues identified

2.3.1 Compassion and kindness

- Lack of kindness and compassion seen in women's medical records, and in letters sent to families.
- There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to.

2.3.2 Place of birth: Assessment of risk

- At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth.
- Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate.
- All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision-making processes and make informed choices about their care. Women's choices following a shared decision-making process must be respected.
- Women should have information regarding anticipated transfer time to the obstetric-led unit might be in case of a complication during childbirth should she choose to birth in an environment away from the labour ward.

2.3.3 Clinical care and competency: management of the complex woman

- Clinical care and decision making of the midwives did not demonstrate the appropriate level of competence
- Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.
- There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary.
- The labour ward should have regular safety huddles and multidisciplinary handovers.

- The labour ward should have regular in-situ simulation training.
- Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.

2.3.4 Escalation of concerns

- Failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants.
- When concerns were escalated, they were not then acted upon appropriately or escalated further to the appropriate level.
- Multidisciplinary communication and collaboration and/or senior clinical supervision are key.

2.3.5 Management of labour: monitoring of fetal wellbeing, use of oxytocin

- Intermittent auscultation and in the interpretation of CTG traces. Maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.
- Fetal monitoring leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines.
- Implementation of recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines should include regional peer reviewed learning and assessment.
- These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.
- Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.
- Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour.
- The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour.
- Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour including the siting of an epidural.

2.3.6 Traumatic birth

- Obstetricians should follow established local or national guidelines for safe operative delivery.

2.3.7 Caesarean section rates

- The caesarean section rate was consistently been 8%-12% below the England average.
- Women should have freedom to express a preference for caesarean section or exercise choice on their mode of delivery.

3.0 Bereavement care

- Maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care
- The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

4.0 Governance

- The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.
- The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework.

5.0 Maternal Deaths

- Maternity services must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.
- Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.
- There must be a named consultant with demonstrated expertise with overall responsibility for the care of high-risk women during pregnancy, labour and birth and the post-natal period.

6.0 Obstetric Anaesthesia

- The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work.

- The number of women requiring advanced levels of medical and anaesthetic care from maternity services
- The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability 'around the clock', as maternity is a 24 hours a day and 7 days a week service.
- The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.
- Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards.
- Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.
- Adherence to guidelines by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited.
- Any changes to obstetric anaesthetic clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.
- Obstetric anaesthesia services develop or review existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service.
- Quality improvement methodology should be used to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.
- Ensure appropriately trained and appropriately senior/ experienced anaesthetic staff participates in maternal incident investigations and that there is dissemination of learning from adverse events.
- Ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

7.0 Neonatology

- Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team.
- Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.
- There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.

- The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.
- Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

8.0 Immediate and Essential Actions to Improve Care and Safety in Maternity Services across England

8.1 Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.
- An LMS cannot function as one maternity service only.
- The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

8.2 Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome

- Each Trust Board must identify a nonexecutive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.
- Maternity services must ensure that women and their families are listened to with their voices heard.

8.3 Staff training and working together

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

8.4 Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead.
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.
- The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.
- This must also include regional integration of maternal mental health services.

8.5 Risk assessment throughout pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

8.6 Monitoring fetal wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
    - Improving the practice of monitoring fetal wellbeing
    - Consolidating existing knowledge of monitoring fetal well being
    - Keeping abreast of developments in the field
    - Raising the profile of fetal wellbeing monitoring
    - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
    - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle and subsequent national guidelines.

8.7 Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.
- Women's choices following a shared and informed decision-making process must be respected.

9.0 Recommendations

9.1 Following the publication of the report NHSE/I have mandated that providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. This completed tool is attached in appendix 1

9.2 The Trust Board is asked to:

a. Note the report and findings
b. Approve the evidence in the assurance tool (appendix 1)
c. Note the high priority of Maternity Services at National level and the requirement for Board oversight

Helen Hurst
Director of Midwifery
30th December 2020

Appendix 1: Maternity Services Assessment and Assurance Tool