The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Publication of:

The report of the independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust,

chaired by Dr Bill Kirkup CBE

Date: 22.11.2022

Hayley Flavell

Executive Director of Nursing

East Kent Hospitals NHSFT

- The report of the independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust, chaired by Dr Bill Kirkup CBE, was published on 19 October 2022
- This report details extremely harrowing examples of service failure, and our thoughts are with the women and families affected by them.
- It is important to read the report in full, as there is no substitute for this.
- There are many similarities and themes to the findings of the Independent Review of Maternity Service at this Trust
- In the report, Dr Kirkup sets out that his approach to setting recommendations is somewhat different on this occasion. Dr Kirkup describes that, despite numerous similar investigations over the previous five decades, each setting out specific recommendations, that, *"at least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places"*. Dr Kirkup expresses the view that, *"If we do not begin to tackle this differently, there will be more to come"*.
- In line with this, Dr Kirkup sets out five recommendations, mostly to be led nationally, comprising:

Recommendation One

The Shrewsbury and Telford Hospital NHS Trust

(Theme: Monitoring safe performance – finding signals among noise)

"*The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.*"

This action describes the need for centring on the greater benefits of the effective monitoring of outcomes, as opposed to 'process' measures such as caesarean section rates. This sets out the need for a generation of measures that are more meaningful, risk adjustable, available, and timely. Also, that such data should be *"analysed and presented in a way that shows both the effects of the random variation inherent in all measures, and those occurrences and trends that are not attributable to random variation*".

Recommendation Two

The Shrewsbury and Telford Hospital NHS Trust

(Theme: Standards of clinical behaviour – technical care is not enough)

"Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained throughout lifelong learning; and,
Relevant bodies, including the Royal Colleges, professional regulators, and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance."

This action centres on standards of clinical behaviour, the need for greater inherent kindness, care, and compassion, and that 'technical care' is not enough on its own. Also, for these improvements to form part of undergraduate, post graduate and lifelong training and learning.

Recommendation Three

The Shrewsbury and Telford Hospital NHS Trust

(Theme: Flawed teamworking – pulling in different directions)

"Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives, and training from the outset; and,

Relevant bodies, including Health Education England, Royal Colleges, and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development."

This action focuses on the need for effective teamworking across different professional groups, and the requirement to find a stronger basis for teamworking in maternity and neonatal services.

Recommendation Four

The Shrewsbury and Telford Hospital NHS Trust

(Theme: Organisational behaviour – looking good while doing badly)

"The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

Trusts be required to review their approach to reputation management and ensure there is proper representation of maternity care on their boards.

NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership."

This recommendation focuses on the need for openness, honesty, disclosure, care, and compassion to outweigh any perceived benefit from denial, deflection, and concealment. It describes that the balance of incentives for organisations must be changed, and not just be solely on preventing reputational damage.

Recommendation Five

The Shrewsbury and Telford Hospital NHS Trust

(Action for the Trust)

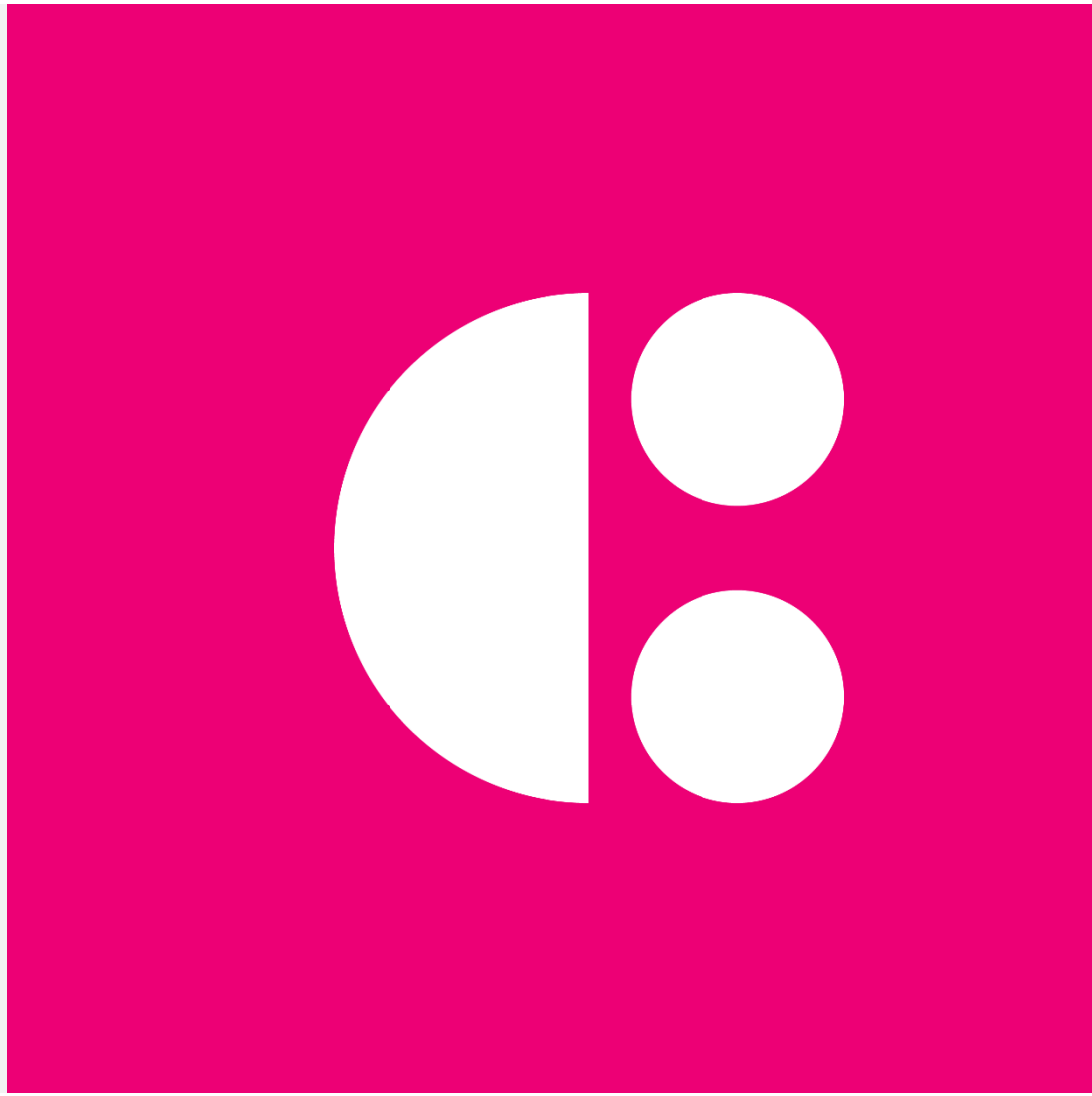
"*The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.*"

This is a specific action for East Kent Hospitals University NHS Foundation Trust. Nonetheless, it is relevant for all NHS providers of maternity care to consider.

Next Steps

The Shrewsbury and Telford Hospital NHS Trust

- Trusts have been advised (informally) by NHSEI to not progress with the actions from the final Ockenden Report and the East Kent report, pending the introduction of a national action plan/standardised approach for these.
- 4/5 of the recommendations require national action and leadership
- Despite this, we will continue to undertake a gap analysis against the East Kent Report themes, and map any additional actions/requirements to our Maternity Transformation Plan.
- We will apprise ORAC and the Board accordingly



Thank you. Any questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Ockenden action plan update (first report)

Date: 22.11.2022

Presenter:

- Mei-See Hon, Clinical Director for Obstetrics, W&C Division

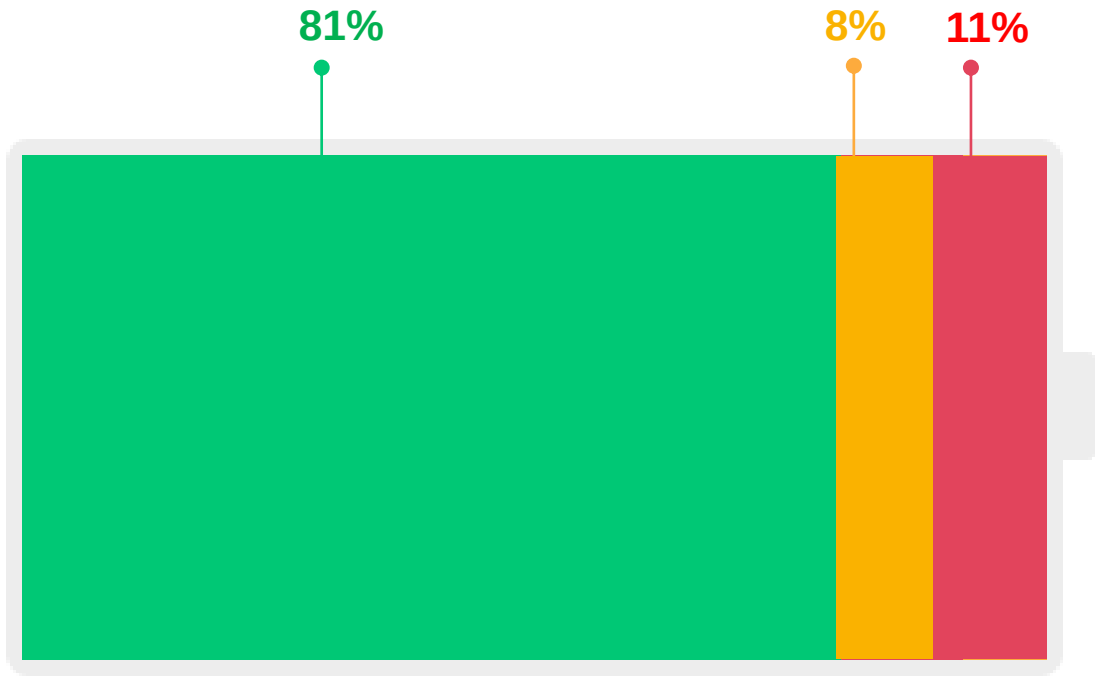
ORAC Forward Plan

The Shrewsbury and Telford Hospital NHS Trust

Date	Agenda Structure	LAFL/ IEA Reference	Theme	Presenter
Jul-22	1. Update on progress against actions from first and final Ockenden reports 2. Service user feedback	First Report: LAFL 4.65 & 4.66 Final Report: IEA 13	Maternity care – focus on bereavement care	1. A. Lawrence 2. C. Eagleton
Aug-22	1. High-level Ockenden plan update (first report) 2. High-level Ockenden plan update (final report) 3. Thematic engagement piece/measurable benefits	First Report: IEA 7	Informed consent – focus on birth preferences	1. A. Lawrence 2. M. Underwood 3. K. Williams
Sept-22		Meeting cancelled		
Oct-22		First Report: LAFL 4.54 & IEA 5	Risk assessment throughout pregnancy – focus on antenatal contacts and support	1. M. Underwood 2. A. Lawrence 3. M. Hon and C. Eagleton
Nov-22		First Report: IEA 3 & LAFL 4.62	Staff training and working together – focus on MDT training and demonstration of how this translates to the care provided in our Delivery Suite (safety huddles, ward rounds, CTG interpretation etc)	1. M. Hon 2. A. Lawrence 3. K. Williams/ G. Calcott
Dec-22		No meeting		
Jan-23		Compassion and kindness – core theme from both reports	People and culture – Focus on compassionate care from both our staff and service user perspective linked to complaints management	1. M. Underwood 2. A. Lawrence 3. C. McInnes/ A. Lawrence

Ockenden Action Plan (first report) – completion rates

First report - completion battery



46/52 Actions Implemented (89% overall), comprising:

- 42 (81%) Evidenced & Assured
- 4 (8%) Delivered, Not Yet Evidenced

6 (11%) Actions ‘not yet delivered’. Of these, 4 are ‘off track’, 1 ‘at risk’ and 1 ‘on track’

‘Not Yet Delivered’ – Red actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Dependent	Reasons	Due date	Progress
LAFL 4.89	Internal	Anaesthetics action. Quality improvement (QI) methodology used to audit and improve clinical performance of obstetric anaesthesia services. Action moved back to ‘not yet delivered’ and ‘at risk’ as QI lead no longer in post.	Jan-23	At Risk
LAFL 4.100	Internal	Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit. Plans underway for ANNPs to attend another NICU.	Mar-23	On Track
IEA 1.4	External	The action states that ‘an LMNS cannot function as one maternity service only’. LMNS colleagues are working to provide a due date and list of evidence requirements before this action can move forward. Action off track. Exception report to be presented.	TBC	Off Track
IEA 2.1	External	This action relates to Trusts creating an independent senior advocate role which reports to both the Trust and the LMNS Boards. These roles are being developed, defined and recruited nationally. It is understood that this process in underway. Action to remain ‘off track’ with due date of ‘TBC’ until timeframes are known.	TBC	Off Track
IEA 2.2	External	The action states that 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. Once in post, methodology for this is to be developed. Action linked to 2.1.	TBC	Off Track
IEA 2.4	External	This action indicates that CQC inspections must include an assessment of whether womens’ voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership (MVP). The rests with the CQC to deliver. Action to remain ‘off track’ with due date of ‘TBC’ until timeframes are known.	TBC	Off Track

Actions approved at Nov-22 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Ockenden action	Theme	Description	Status change approved
LAFL 4.73	Managing complex pregnancy	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.	
IEA 4.3	Managing complex pregnancy	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.	

Note: Networks established. ‘Green evidence’ will be an audit of cases referred to network

Summary (first report)

Summary (first report)

The Shrewsbury and Telford Hospital NHS Trust

- 46/52 actions ‘delivered’. We are carrying out audits to ensure that the actions remain green and are refreshing the evidence to keep it up to date.
- 6 actions ‘not yet delivered’, 1 ‘on track’ and progressing, 1 ‘at risk’, and 4 lying outside of SaTH’s direct control (external dependency linked to LMNS, CQC and NHSEI):

  - We have been informed by our system stakeholders that work is underway on all of them.

  - IEA 1.4, 2.1, 2.2 and 2.4 set as ‘off track’ until clear timeframes can be provided. Work is underway with system stakeholders to try and resolve these.

Thank you. Any questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Ockenden action plan update (final report)

Date: 22.11.2022

Presenter:

- Annemarie Lawrence, Director of Midwifery

Timeline of events

Timeline of events

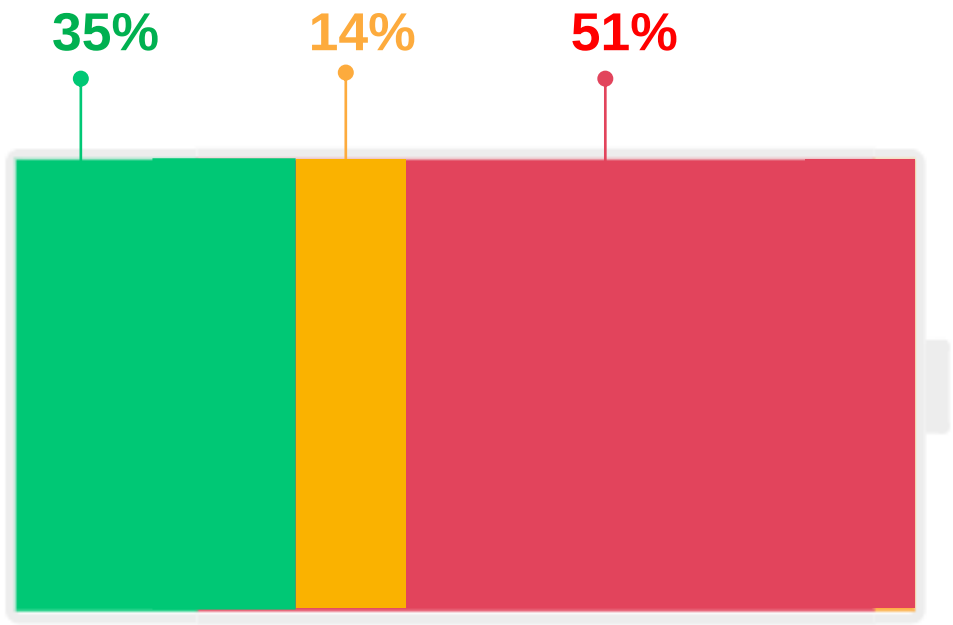
The Shrewsbury and Telford Hospital NHS Trust

Mar-22	Apr-22	Apr- Jun-22	Jun-22	Jul-22	Jul-22	Jul-22	Aug-22	Oct-22	Nov-22
Final Ockenden report published	MDT Lessons Learnt exercise & delivery strategy agreed.	MDT Workshops 1, 2 and 3 + risk stratification	MTP relaunch (including LMNS & MVP)	Anaesthetics Ockenden prioritisation workshop	Confirm & Challenge session	NHSE/I Insights visit	Action progress & deadlines revised	Delivery strategy shared with NHSE/I partners and Morecambe Bay colleagues	Further MDT workshops to revise deadlines & evidence requirements
	**Support to staff and families**	**Strategy agreed**	**127/158 deadlines agreed**	**New workstream structure**	**135/158 deadlines agreed**	**Action plan challenged, deadlines revised**	**Positive feedback from NHSEI (89% compliance)**	**57 actions 'on track' and 10 deadlines revised**	**Morecambe Bay colleagues joined Oct-22 MTAC**

MTAC																			
	Acknowledgements		18		1	17	5	29	9	33	10	36	14	50	22	55			
	Apr MTAC		May MTAC		June MTAC		July MTAC		Aug MTAC		Sep MTAC		Oct MTAC		Nov MTAC				

Ockenden Action Plan (final report) – completion rates

Final report – completion battery



- 55 actions (35%) green – ‘Evidenced and Assured’
- 22 actions (14%) amber – ‘Delivered not yet evidenced’

49% implemented (77/158 actions) as of Nov-22 MTAC.

From the 81 actions (51%) ‘Not yet Delivered’, 48 actions (30%) are ‘On Track’ for progress

Actions approved at Nov-22 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Ockenden action	Theme	Description	Status change approved
IEA 2.6	Workforce	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	
IEA 5.5	Governance	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	
IEA 10.5	Intrapartum care	Maternity Units must have pathways for induction of labour (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	
LAFL 14.8	Governance	The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.	

Actions approved at Nov-22 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Ockenden action	Theme	Description	Status change approved
IEA 1.5	Training	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	
IEA 11.1	Postnatal care	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	
LAFL 14.21a	Governance	Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.	
LAFL 14.51	Intrapartum care	The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.	

Actions approved at Nov-22 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Ockenden action	Theme	Description	Status change approved
IEA 10.4	Antenatal care	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust	
LAFL 14.10	Governance	The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.	
LAFL 14.11	Governance	All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.	
LAFL 14.36	Antenatal care	The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.	
LAFL 14.49	Intrapartum care	It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.	

Summary (final report)

Summary (final report)

The Shrewsbury and Telford Hospital NHS Trust

- From the final report, 77/158 have now been ‘delivered’ (49%). From the 51% ‘not yet delivered’, over half of these are underway.
- The Trust continues to receive positive external and stakeholder feedback (NHSE/I and CQC) on its progress to date: *RPQCG (Regional Perinatal Quality Committee) described SaTH, (and two other trusts) as ‘shining examples following the Ockenden assurance visit’.*
- There is still much more to do.
- Work continues at pace to deliver the rest of the programme.

Thank you. Any questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Staff training and working together – Focus on multidisciplinary (MDT) training and demonstration of how this translates to the care provided in our Delivery Suite

Date: 22.11.2022

Presenters:

Kim Williams, Deputy Director of Midwifery

Guy Calcott, Consultant obstetrician

Related Ockenden actions

Reverse RAG Rating

The Shrewsbury and Telford Hospital NHS Trust

Delivery Status

Colour	Status	Description
	Not yet Delivered	Action is not yet in place, there are outstanding tasks to deliver.
	Delivered, not yet Evidenced	Action is in place with all tasks completed, but has not yet been assured/evidenced as delivering the required improvements.
	Evidenced and Assured	Action is in place; with assurance/evidence that the action has been/continued to be addressed.

Progress Status

Colour	Status	Description
	Not Started	Work on the tasks required to deliver this action has not yet started.
	Off Track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At Risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	On Track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that the action is being delivered and sustained.

Related Ockenden actions – First report

The Shrewsbury and Telford Hospital NHS Trust

First report: Immediate and Essential Action 3 – Staff working and training together		
ID	Summary	Progress
IEA 3.1	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	Complete
IEA 3.2	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.	Complete
IEA 3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Complete
LAFL 4.62	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. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	Complete

Related Ockenden actions – Final report

The Shrewsbury and Telford Hospital NHS Trust

Final report – Actions linked to PROMPT		
ID	Summary	Progress
IEA 2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Complete
IEA 5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	Complete
IEA 7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	On track
IEA 7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Complete
IEA 7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	On track
IEA 7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Complete

Related Ockenden actions – Final report

The Shrewsbury and Telford Hospital NHS Trust

Final report – Actions linked to PROMPT		
ID	Summary	Progress
IEA 10.5	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	Complete
IEA 11.6	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	On track
LAFL 14.9	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Complete
LAFL 14.36	The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.	Complete
LAFL 14.37	The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.	On track
LAFL 14.50	In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.	On track

All about MDT Training

What is it?

The Shrewsbury and Telford Hospital NHS Trust

- Practical Obstetric Multi-Professional Training (PROMPT)
- PROMPT is an evidence-based multi-professional obstetric emergencies training package that has been developed for use in maternity units.
- The whole team training together. This includes:
  - ✓ Anaesthetists
  - ✓ Consultant obstetrician (Tiers 1,2 and 3) and registrars
  - ✓ Junior doctors and students
  - ✓ All midwives (specialists, bands 5, 6 and 7, & senior management)
  - ✓ Women's Support Assistant (WSAs)
  - ✓ Maternity Support Workers (MSWs)

More about PROMPT

- PROMPT training aims to eliminate preventable harm in childbirth
- The aim is to improve care for mothers and families, reduce mistakes, manage emergencies and make childbirth safer
- Preventable harm still complicates half the cases that have poor maternal outcomes
- PROMPT training uses patient actors to simulate clinical scenarios
- Important to be situationally aware and to plan ahead - to spot problems before they happen
- This means that in real situations the team know where to go, who to call, for the equipment and the support they need
- Hierarchy has no place in patient safety, everybody in a team is important and everybody has a role to play
- Teams that work together should train together
- Understanding each others role is key

Outcomes of PROMPT

- 50% reduction in Hypoxic Brain Injury (HIE)
- 45% reduced school-aged cerebral palsy
- 100% reduced permanent brachial plexus injury
- 40% quicker delivery at emergency caesarean section
- Reduced length of stay for babies
- Reduced maternal deaths
- Increased staff morale

Source: PROMPT UK website. Available at: www.promptmaternity.org

PROMPT Training Programme

The Shrewsbury and Telford Hospital NHS Trust

1. Human Factors (1. civility counts and 2. escalation)
2. SBAR
3. Obstetric Haemorrhage simulation
4. Pre-eclampsia/ hypertension simulation
5. Debrief session
6. Maternal collapse simulation and case study
7. Workshop 1 (introduction to maternal critical care for midwives/obstetricians) / Workshop 2 (Documentation for WSAs)
8. Venous Thromboembolism (VTE)
9. Maternal sepsis lecture – Covid/ Group B strep/ pyrexia in labour)
10. Shoulder dystocia
11. Impacted Fetal Head
12. Vaginal Breech Birth
13. Key learnings and feedback sheet - finish

Making childbirth safer together

A day of MDT training at SaTH

Conclusion

PROMPT is more than just learning how to manage emergencies, it promotes a culture of psychological safety and a commitment to continuous improvement at all levels.

Thank you. Any questions?