Bradford Teaching Hospitals
NHS Foundation Trust

Ockenden Report, Findings and Actions for BTHFT Maternity Service

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Together, putting patients first

Ockenden Report, 10 December 2020

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- Looked at maternal and neonatal harm between the years 2000 and 2019 at Shrewsbury and Telford Hospital NHS Trust.
- Includes cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.
- The total number of families to be included in the final review and report is 1,862.
- This first report includes the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.
- A second report including the remaining cases will be published in the summer.
- The review panel identified important themes which must be shared across all maternity services as a matter of urgency.
- 27 recommendations for the named Trust and seven early recommendations for the wider NHS, labelled ‘Immediate and Essential Actions’.

Key Findings

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- Poor governance across a range of areas, especially board oversight and learning from incidents.
- Lack of compassion and kindness by staff.
- Poor assessment of risk and management of complex women.
- Failure to escalate.
- Poor fetal monitoring practice and management of labour.
- Suggestion of reluctance to perform LSCS - women's choices not respected.
- Poor bereavement care.
- Obstetric anaesthetic provision.
- Neonatal care documentation and care in the right place.
- National recognition that lessons have not been learned from other notorious reviews including the Kirkup Report.

NHS Assurance actions immediately required

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- Letter to Chief Executives dated 14th December 2020.
- Submission of compliance with 12 asks related to the seven immediate and essential (IAE's) actions by 5pm 21st December 2020.
- Responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.
- In addition Trusts to complete and take to their next public board the assurance assessment tool, which will draw together elements including:
    1) All 7 IEAs of the Ockenden report.
    2) NICE guidance relating to maternity.
    3) Compliance against the Maternity Incentive Scheme safety actions, and
    4) A current workforce gap analysis.
- To be reported through LMS and submitted to Regional team by 15th January 2021.
- This will be used to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.
- Trust Boards to confirm that they have a plan in place to meet the Birthrate Plus (BR+) standard including confirming timescales for implementation to Regional Chief Midwife by 31 January 2021.

Immediate actions taken by BTHFT Maternity

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- Immediate benchmarking of the report by the Senior Midwifery and Obstetric leadership team completed within 3 days and included in presentation to NHSI on 15 December 2020.
- Assurance provided to WY&H LMS of compliance with the 2015 Kirkup report action plan, which included similar themes and recommendations.
- Letter of assurance of compliance with the 12 IAE actions sent to the Regional Midwifery Officer and LMS 21 December 2020. Full compliance declared.
- Assurance assessment tool completed and returned to the Regional Midwifery Officer and LMS 15 January 2021. Minimum evidential requirement of compliance met and areas requiring further strengthening identified.
- Trust Board provided with assurance that Birth Rate Plus was commissioned in November 2020 and 3 month prospective data collection in progress. Draft report expected end of February/March.
- Clinical Director and HOM involved in Regional approach to issues affecting all regional organisations, for example maternal medicine centre development.

Immediate and essential actions	Details of actions required
1. **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. • **All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB** • **A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly**

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. • **Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services** • **In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly**

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.** • **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.** • **The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.** • **Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety**
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. • **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place** • **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres**

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. • **A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance**

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: o Improving the practice of monitoring fetal wellbeing o Consolidating existing knowledge of monitoring fetal well being o Keeping abreast of developments in the field o Raising the profile of fetal wellbeing monitoring o Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported o 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. • **Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.**

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.** • **Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website**

Key Points for Trust Board Members

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- All maternity SI's to be shared with Trust Boards at least monthly (sub-groups will not be accepted).
  - Maternity SI's are already included in the overarching Trust SI report.
  - New maternity SI's and update on progress is included in the monthly Maternity Service Update report.
  - All HSIB reported cases will now be investigated as an SI even if they do not meet the original SI criteria. This will mean an increase in the annual number of maternity SI's declared.
- Each Trust Board must identify a non-executive director who has specific responsibility for ensuring the voices of women and families are represented at Board level and will bring independent challenge to the oversight of maternity and neonatal services.
  - Non-Executive Director identified.
  - NED will join the bi-monthly Maternity Safety Champion meetings.

Questions?