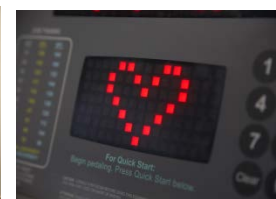
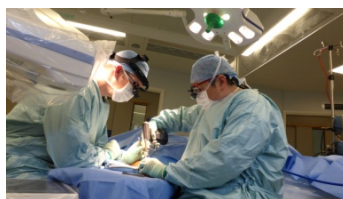


# Ockenden: One Year On

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## Background Summary

- First Ockenden Report, 10 December 2020.
- 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.
- 27 recommendations for the named Trust and seven early recommendations for the wider NHS, labelled 'Immediate and Essential Actions'.
- BTHFT complied with all immediate assurance requests and uploading of supporting evidence to a national portal.
- Internal audit found a high level of assurance.
- Expected publication of Ockenden part 2 is end of March 2022.

## Reminder of Key Findings Report 1

- 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.

## 12 Months On:

- National Request that Ockenden is again discussed at Trust Open Boards before the end of March 2022:
- Discussion to include:
  - Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance.
  - Maternity services workforce plans.
- To ensure local system oversight of progress updates to be shared with:
  - Local Maternity System.
  - Integrated Care System.
  - Regional Maternity Team (by 15 April 2022).

## Ockenden Evidence Submission

- Evidence submitted to the national portal as requested.
- Positive feedback from the LMS on the quality of the submission.
- Internal audit of the evidence submission gave a high level of assurance.
- Review of evidence submitted by the Regional team.
  - Evidence reviewed by non-clinicians.
  - Some variance between the Trust's self-assessed RAG rating and that provided by the Regional review.
  - Trust did not proceed with a re-assessment.
  - High level of confidence that a further self-assessment gives a predominantly Green and Amber rating and that we have the evidence to support this.
  - Anticipated Regional Team assurance visit will provide an opportunity to explain any discrepancies and provide required evidence to meet the standards.

Immediate and essential actions	Progress and details of outstanding actions
<p><b>1. Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.</b></p> <p>Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight</p>	<p><b>Good Level of evidence to demonstrate compliance with this action</b></p> <p><b>Areas to strengthen:</b></p> <ul style="list-style-type: none"> <li>• <b>Maternity Serious Incidents (SI's) to Trust Board every 3 months</b> <ul style="list-style-type: none"> <li>• We exceed this as SI's are included in the monthly Maternity/Neonatal update paper including descriptions, immediate learning and progress on investigations</li> <li>• <b>The final investigation recommendations and timescales for completion of actions are not currently included. Future papers will include the Quality of Care (QUOC) SBAR for all completed HSIB cases and internal SI's</b></li> </ul> </li> <li>• <b>Using the National Perinatal Mortality Review Tool to the required standard</b> <ul style="list-style-type: none"> <li>• Process for quarterly reporting to Board is well embedded</li> <li>• <b>External Peer Review of Bradford PMRT cases is not yet established. Neighbouring organisations have been contacted to ask how they are achieving this and mutual aid offered to those who also do not meet this standard</b></li> </ul> </li> </ul>
<p><b>2. Listening to Women and Families</b></p> <p>Maternity services must ensure that women and their families are listened to with their voices heard.</p>	<p><b>The service is extremely proud of its relationship with the Maternity Voices Partnership (MVP), who represent the seldom reached voices within our communities. It is also very proud of the Maternity and Neonatal Safety Champion process which has evolved significantly over the last 4 years . There is a good level of evidence to support this.</b></p> <p><b>Areas to strengthen:</b></p> <ul style="list-style-type: none"> <li>• <b>Non-Executive Director (NED) who has oversight of maternity services</b> <ul style="list-style-type: none"> <li>• The engagement of the NED safety champion with the maternity and neonatal safety agenda is excellent.</li> <li>• <b>The NED engagement and relationship with the local MVP can be further strengthened by attendance at MVP led meetings and events.</b></li> <li>• <b>NED Job Description needs updating to include the maternity/neonatal safety champion national role descriptor</b></li> </ul> </li> </ul>

Immediate and essential actions	Details of actions required
<p><b>3. Staff training and working together</b> Staff who work together must train together.</p>	<p>Some discrepancies between the Trust's Self-Assessment and the Regional review of the evidence submitted. Self-Assessment rates us predominantly green in this domain with confidence that this can be evidenced</p> <p>Multidisciplinary PROMPT training met the Maternity Incentive Scheme year 3 standard</p> <p>Areas to strengthen:</p> <ul style="list-style-type: none"> <li>• Training Needs Analysis needs aligning with the NHSR core framework</li> <li>• 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. Evidence submitted needs further review by General Manager as rated red against self-assessment of green</li> </ul>
<p><b>4. Managing Complex Pregnancy</b> 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</p>	<p>High level of assurance for this domain</p> <p>Areas to strengthen:</p> <ul style="list-style-type: none"> <li>• 1 overarching audit to achieve compliance with audit descriptors for questions 24,25 and 26 has been completed and is awaiting finalisation prior to presentation to the wider team</li> </ul>
<p><b>5. Risk assessment throughout pregnancy</b> Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.</p>	<p>High level of assurance and evidence of guidelines and SOP's in place</p> <p>Areas to strengthen:</p> <ul style="list-style-type: none"> <li>• Audit relating to completion of personalised care plans is outstanding and will not be commenced until post CERNER Maternity go-live. Personalised care plans are currently paper based and owned by the woman with no way of consistently retrieving them to audit. Post go-live the personalised plan will be completed electronically with an ability to audit</li> </ul>

Immediate and essential actions	Details of actions required
<p><b>6. Monitoring fetal wellbeing</b></p> <p>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.</p>	<p><b>Discrepancy between Trust self-assessment and Regional review of evidence in this domain. Trust met and declared full compliance with Saving Babies Lives Care Bundle version 2, including the supporting audits. Despite these being submitted we were rated as red not green. High level of confidence that this will be resolved at Regional assurance visit.</b></p> <p><b>Obstetric Lead had ½ a PA to deliver the fetal monitoring lead role at the point of evidence submission. Job plan now evidences that 1 PA is dedicated for this role.</b></p> <p><b>Areas to strengthen:</b></p> <ul style="list-style-type: none"> <li><b>Submission of rotas and electronic diary entries to evidence that the required amount of time is being delivered by both the midwifery and obstetric lead</b></li> </ul>
<p><b>7. Informed Consent</b></p> <p>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.</p>	<p><b>The MVP supported us in providing evidence for this domain. However, there are areas requiring for action</b></p> <p><b>Areas to strengthen:</b></p> <ul style="list-style-type: none"> <li><b>Outstanding audit around choice and personalisation again relies on the completion of personalised care plans will not be commenced until post CERNER Maternity go-live.</b></li> <li><b>MVP to complete the LMS developed tool to undertake a gap analysis and rating of the information we provide to women</b></li> </ul>



## Maternity Services Workforce Plans

The national response to the Ockenden report included a £95.6M investment into maternity services including funding for:

- Midwifery roles.
- Consultant Obstetricians.
- MDT training.
- International Midwifery Recruitment.
- Support for the retention and recruitment of MSWs.

BTHFT received a significant amount of funding from the national bid, ring fenced for midwifery and obstetric consultant recruitment and training.

The national midwifery staffing crisis, unfortunately means that this was largely unspent despite proactive and innovative recruitment attempts.

Year 2 recurrent funding is expected via the ICS with more flexibility as to how this can be spent to achieve compliance in all 7 IAE's.

### Obstetric Workforce:

- Ockenden provided funding to support recruitment of 2 consultant Obstetricians.
- This funding was requested to assist in providing Daily Obstetric ward rounds of all high risk inpatients as well as consultant led cover in our acute ambulatory maternity areas.
- Ward rounds on labour ward 4 x daily are well embedded and audited.
- 1PA was provided in the job plan for our Fetal Monitoring Lead consultant.
- 2 substantive consultant posts were advertised nationally in October 2021 ( one with a focus on reducing pre term births and high risk Obstetrics and the other with a focus on Bereavement care). These posts also offered leadership time for multi disciplinary obstetric skills and drills training. There were very few applicants for these posts.
- In December 2021 we successfully appointed one Consultant Obstetrician ( interest in reducing pre term births) who is now in post.
- A further round of recruitment is in process with the intention of advertising for a Fetal Medicine consultant post- advert due out in February 2022.
- One further Obstetric consultant post was approved by our trust at the same time as the Ockenden funding and so plans are underway to advertise a further Obstetric only consultant post incorporating bereavement care and PMRT in the near future.
- At present with the above appointments only 3 PAs of consultant ward round cover and ambulatory care at consultant level is job planned. The other sessions ( 7 sessions) are delivered where is possible out of existing consultant job plans flexibly. This cover is not yet consistent or embedded due to competing clinical priorities and other existing job planned work.

## Midwifery Workforce

- Priority is to recruit and retain an additional 12.52 WTE midwives to achieve BR+ safe staffing recommendations, working towards a further 20 WTE to achieve Midwifery Continuity of Carer (MCoC) as a default position for all women.
- How will we do this?
  - Newly Qualified recruitment starts in May- this achieves the largest number of new starters annually in October/November.
  - International Recruitment: HEE funding secured for 4 midwives from regional bid. Business case prepared to increase this number by 6.
  - Rolling advert for band 5 and 6 midwives: Includes bespoke roles for special interest, tailored packages.
  - Planned national advertising campaign to attract midwives outside of the region.
  - Pastoral Support Midwife in a fixed term post. Request to substantiate this post to support retention.
  - Increase headcount of Maternity Support Workers and provide enhanced training to support infant feeding, smoking cessation, language skills.
  - Maximise and expand the use of non-midwifery roles in Obstetric theatres.
  - Work with Bradford University to develop midwifery short programme and joint university/provider appointments.
  - Continue to progress the RCM Leadership manifesto: Review the senior midwifery management structure to include Head of Midwifery, Deputy Head of Midwifery roles and outstanding specialist midwifery roles.
  - Continue to use existing mitigation in place to maintain safety of the unit on a daily basis.



**Bradford Teaching Hospitals**  
NHS Foundation Trust

# Questions?