NHS
Somerset
Clinical Commissioning Group

Report to the NHS Somerset Clinical Commissioning Group on 26 May 2022

Title: Ockenden Update	**Enclosure F**

Version Number / Status:	1
Executive Lead	Kathy French, Director of Quality and Nursing
Clinical Lead:	Kate Staveley
Author:	Sarah Mark, Maternity Assistant Quality Manager Emma Savage, Deputy Director of Quality and Nursing

Summary and Purpose of Paper –

This Ockenden update provides a high level summary on the key learning from the further Ockenden review and second report which was published on 30th March 2022.

This briefing also sets out Somerset's maternity and neonatal governance framework for overseeing progress against the recommendations from Ockenden and our next steps.

This briefing addresses the following CCG strategic priorities and values:

- Integrated working
- Quality improvement
- Compassion

Recommendations and next steps

The CCG Governing Body is asked to note this Ockenden update and provide support to the following nest steps:

- Both our NHS Trusts have received a letter from NHS England & Improvement (NHSEI) setting out the actions required. There is now a period of reflection whilst waiting the East Kent report within next few weeks
- The CCG Quality and Nursing Team will continue to work closely with Women's and Children's Commissioning Team in implementing the actions from Ockenden
- Our Director of Maternity (joint appointment YDH & SFT) will be joining the Regional Ockenden Task and Finish Group
- Formal Insight visits are planned by NHSEI on 6th and 7th September 2022 to YDH and SFT respectively. CCG colleagues and Maternity Voices will join these assurance visits
- As a CCG and Somerset System we will continue to escalate any concerns via the LMNS Safety Group, LMNS Programme Board and Somerset System Quality Group

Impact Assessments – key issues identified				
Equality	There was an Equality Impact Assessment (EIA) completed for the Ockenden enquiry.			
Quality	Quality and Nursing lead on the implementation of Ockenden and takes every opportunity to learn and improve from peoples experience and patient safety issues			
Safeguarding	Somerset Local Maternity and Neonatal System works closely with safeguarding leads and is undertaking joint pieces of quality improvement work. Examples include learning from non-accidental injuries for babies and children under the age of 1.			
Privacy	None identified			
Engagement	Our engagement with parents is through Maternity Voices, Equality and Diversity leads, VCSE sector and insights through PALS, complaints, incidents and serious incidents via SFT and YDH			
Financial / Resource	An additional £127 million has been allocated nationally to implement the actions following Ockenden			
Governance or Legal	None identified			
Sustainability	Workforce issues is the main sustainability issue and development of a workforce plan will follow.			
Risk Description	No significant risks identified with regard to Ockenden			
Risk Rating	Consequence	Likelihood	RAG Rating	GBAF Ref

NHS
Somerset
Clinical Commissioning Group

Ockenden Update

CCG Governing Body

26th May 2022

v.03

Introduction

NHS Somerset Clinical Commissioning Group

- This independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017

- Ockenden's interim report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust was Published on 11 December 2020

- The final Ockenden report of the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30th March 2022

- The report included details on an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives

- The review included 1,500 families, whose experiences occurred predominantly between 2000 and 2019, and interviewed 60 present and former members of staff

Why this report is significant

NHS Somerset Clinical Commissioning Group

- The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent

- The events at maternity services at the Shrewsbury and Telford Hospital NHS Trust has not only put a spotlight on this service, but also on other maternity services across England

- Recognition of the failure to adequately address and learn lessons from serious maternity events

- In the final weeks leading up to publication, a number of staff withdrew their co-operation from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified

- The size and scale of this review is unprecedented in NHS history and we have a once-in-a-generation opportunity to improve the safety and quality of maternity service provision – now and in the future

Poor Care Identified (1)

NHS Somerset Clinical Commissioning Group

- 12 cases of maternal death were considered by the review team. 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

- Internal investigations did not recognise system and service-wide failings to follow appropriate procedures and guidance. As a result, significant omissions in care were not identified and, in some incidents, women themselves were also held responsible for the outcomes

- Of the 498 cases of stillbirth reviewed, 1 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

- Staff were overly confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care

Poor Care Identified (2)

NHS Somerset Clinical Commissioning Group

- Women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments

- Examples within this report where there were delays in women being:
  - admitted to the labour ward during induction of labour
  - assessed for emergency intervention during labour
  - reviewed by consultants in the postnatal environment

- Families being discharged from hospital, but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care

- Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions

Failure in governance and leadership (1)

- Failure to follow national clinical guidelines, whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation

- Delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies

- Lack of action from senior clinicians following escalation. Culture of ‘them and us’ between the midwifery and obstetric staff, which engendered fear among midwives to escalate concerns to consultants

- Lack of compassion expressed by staff – either while they were still receiving care or in follow-up appointments and during complaints processes

- Significant staffing and training gaps within both the midwifery and medical workforce that negatively affected the operational running of the service

- Medical staff rotas overstretched. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available

Failure in governance and leadership (2)

NHS Somerset Clinical Commissioning Group

- Trust leadership team up to board level to be in a constant state of churn and change. Failure to foster a positive environment to support and encourage service improvement at all levels

- Trust board did not have oversight or a full understanding of issues and concerns within the maternity service, resulting in neither strategic direction and effective change, nor the development of accountable implementation plans

- Reviews were not multidisciplinary and did not identify the underlying systemic failings, and some significant cases of concern were not investigated at all

- Where investigations took place, there was a lack of oversight by the trust board

- Throughout the review period, lessons were not learned, mistakes in care were repeated, and the safety of mothers and babies was unnecessarily compromised as a result

Local actions for learning, immediate and essential actions

NHS Somerset Clinical Commissioning Group

- Many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years

- Identified 15 areas that should be considered by all trusts in England providing maternity services. Some of these include:

  - The need for significant investment in the maternity workforce and multi-professional training
  - Suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present
  - Strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families

- Urgent need for a robust and funded maternity-wide workforce plan. Robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe and compassionate maternity care locally and across England.

Our Somerset System Approach

- We have a joint (SFT and YDH) Ockenden Action Plan (copy of which is included in Appendix A) which is overseen by Sallyann King, Director of Midwifery. No risks identified

- Both Heads of Midwifery have been appointed at YDH and SFT and report to the Director of Midwifery

- Progress against our joint Ockenden Action Plan is overseen by our Locality Maternity and Neonatal System (LMNS) Safety Group

- Our LMNS Safety Sub Group reports into the Somerset LMNS Programme Board

- The Somerset LMNS Programme Board reports into the South West Perinatal Quality Safety Surveillance Group (chaired by NHSEI) and our Somerset System Quality Group

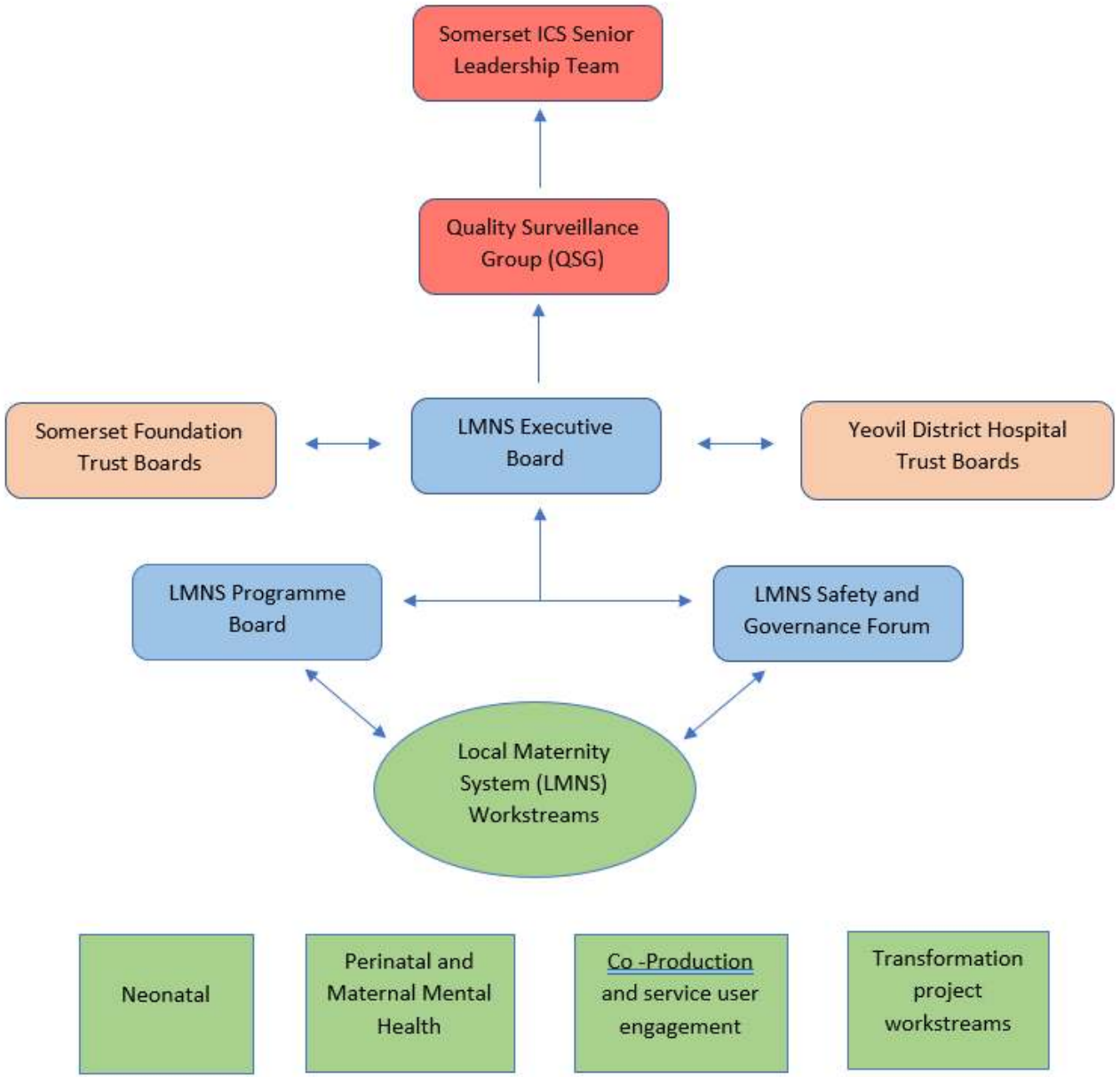
- An informal Insight visit to YDH and SFT took place on 5th and 6th May by Somerset CCG colleagues and Maternity Voices

Somerset's Maternity and Neonatal current governance arrangements

NHS Somerset Clinical Commissioning Group

Other areas we work with:

- NHSE Regional Maternity Programme Board
- NHSE National Maternity Transformation Board
- NHSE Regional Perinatal Quality and Surveillance Group
- South West Clinical Network
- South West Academic Health Science Network (SWAHSN)
- South West Neonatal Operational Delivery Network



Somerset CCG Insight Visits – May 2022

Below is a summary of our findings following our informal visits in May 2022 to both YDH and SFT's maternity units:

- Fostering partnership working
- Both YDH & SFT were welcoming, friendly, informative and calm
- Walked patient journey and the sensitive arrangements in place for those who have lost a baby
- Informal conversations held around the 7 Immediate and Essential Actions (IEAs) from Ockenden 1
- Visual representation displayed in both areas regarding Ockenden oversight
- Workforce support and confidential escalation of concerns displayed in a variety of areas

Next Steps

NHS Somerset Clinical Commissioning Group

- Both YDH and SFT have received a letter setting out the actions required. There is now a period of reflection whilst waiting the East Kent report within next few weeks
- The CCG has appointed an Assistant Quality Manager who started on 19th April 2022 and is a trained midwife. Her role will be to help progress the actions from Ockenden
- The CCG Quality and Nursing Team is working closely with Women's and Children's Team in implementing the actions from Ockenden
- Our Director of Maternity will be joining the Regional Ockenden Task and Finish Group
- A formal Insight visit is planned by NHSEI on 6th and 7th September 2022 to YDH and SFT respectively. CCG colleagues and Maternity Voices will join these assurance visits
- As a CCG and Somerset System we will continue to escalate any concerns via the LMNS Safety Group, LMNS Programme Board and Somerset System Quality Group

Appendix 1 – Somerset System Summary

Subject	Information	Actions/Mitigations:	Oversight from:	Further support request from PQSSG	Escalated to:	
					Local ICS	SWQSG
Themes of incidents graded as moderate and above	**SFT** – • 1x level 3 incident for IUD • 3x Incidents - x1 transfer to ITU, x1 Eclampsia, x1 return to theatre **YDH-** • Maternal admission to ITU following a possible delay in delivery for a pre-eclamptic mother. • Shoulder dystocia resulting in erb's palsy injury • Neonatal death following birth of baby with known lethal abnormality • Term baby admitted to SCBU with abnormal antenatal CTG – diagnosis of HIE, NND at 9 days of age.	• no care concerns identified • Lack of specific guidance for management of labour/ delivery with eclampsia within hypertensive guideline to be reviewed and amended/ use case in prompt training • Excellence report for staff involved • Timeline review undertaken – learning identified and case presented through departmental meetings. • Case reviewed. Well managed obstetric emergency. Patient had risk factors for SD and had been counselled appropriately in the antenatal period. • No actions required. Outstanding care provision. • No immediate actions required. Will be taken through PMRT process.	Safety subgroup Trust SIRG Trust Safety Champion monthly meetings CQAC/Quarterly board of Directors			
HSIB referrals	None					
Themes from reviews of perinatal deaths	SGA's Diabetics Fractured AN care due to mother moving area Family members who smoke were not offered referral to smoking cessation services. anaesthetist services not sensitive towards the bereaved parents.	To be discussed at LMNS safety sub-group to develop SMART actions to improve referrals. Anaesthetic team now receive bereavement training as part of a mandatory yearly update. Bereavement training is adapted following PMRT feedback.	Safety subgroup Trust Safety Champion meetings PMRT CQAC/Quarterly board of Directors			
100% of perinatal mortality reviews include an external reviewer	100%					

Somerset System Summary

Subject	Information	Actions/Mitigations:	Oversight from:	Further support request from PQSSG	Escalated to:	
					Local ICS	SWQSG
Audit findings related to safety/quality	SFT- Outlier for puerperal infections	- SSI monthly meetings ongoing for continual update and identification of trends/ actions to reduce SSI's. - New dressing now implemented - Ongoing monthly audit and findings discussed at monthly governance meeting - Implementation of practice changes: Vaginal prep at LSCS as recommended by NICE, Midwife taking baby at LSCS to be scrubbed- both now implemented.	LMNS Trust clinical Governance			
Safeguarding allegations against providers inc. wider safeguarding issues potentially affecting maternity and neonatal	None					
Feedback from safety champions and any walkabouts	**SFT -You said…** Amazing teamwork! Lots of flexibility and moving between wards to cover High levels of staff sickness impacting ward areas Lots of safeguarding impacts workload Demand and capacity issues **We saw…** • Good adherence to uniform policy • Good use of 'I am clean' stickers • Some delays in essential checks • Busy information boards **YDH – You said…** Levels of sickness impacting staffing that day Concerns re theatre temperature How the changes to covid guidance would impact current testing/visiting We saw … • Clean environments • Daily checking completed • Key left in the drug cupboard in a labour room	**To action/update…** • To update notice board with 'easy to read' information • Midwives and MCA's recruited and due to start in the next few weeks • Netcall system to be installed into Triage and work in progress to look at workload and environment on the ward • Bank staff and agency used to cover vacancies, ongoing recruitment drive • Staff sent updated guidance for covid by maternity matron • Labour ward lead asked to remind staff re keys being returned to the key safe	Safety subgroup Safety Champion monthly Meetings			
Patient experience outliers • FFT outliers • Complaints	**SFT** three complaints surrounding bereavement care, infection control and partner visiting **YDH** one complaint clinical care concerns surrounding mode of birth	all actioned and closed Updated guideline and elective c/s pathway	PALS LMNS via dashboard			
% of all babies born at 27 weeks or under delivered in maternity hospitals with a designated NICU	**SFT** -Jan 22- 0 Feb 22- 1 baby born 24+5/40 (0.4% of monthly birth rate) **YDH** – none		Safety subgroup ODN			
% of term admissions to neonatal units	**SFT**- Jan 22. 4.2% Feb 22. 3.8% **YDH-** Jan 22. 6.5% Feb 22. 5.8%	Each ATAIN case reviewed by MDT team with discussion around unavoidable/ potentially avoidable admission to SNU. Include in governance meeting and share with staff themes of potentially avoidable cases. One avoidable admission at YDH this parental choice for admission to neonatal choice/maternal mental health	Safety subgroup Safety Champion monthly Meetings			
Number of times a maternity unit or neonatal unit has been suspended and had to divert admissions- and reasons for this	0					

Somerset System Summary

Subject	Information	Actions/Mitigations:	Oversight from:	Further support request from PQSSG	Escalated to:	
					Local ICS	SWQSG
External reviews/actions requested from • CQC, Coroner 28 reg • NHSR, HSIB, HEE • RCOG In maternity and neonatal services	None					
Workforce – concerns regarding staffing levels or skill mix	Staffing demands remain a concern due to covid absences, not affecting the safety of the services, regularly reviewed and some training cancelled to ensure safe staffing levels Deputy HOM role at YDH vacant	Staffing remains on trust risk registers Recruitment into band 7, MSW recruitment has been successful Deputy HOM interviews have been undertaking and a successful applicant has accepted the post	LMNS Trusts Board			
Progress/challenges in meeting the CNST safety actions	Smoking- CO monitoring Digital	Public health midwife driven forward improvement plan for co monitoring with community leads Procurement of a single digital system across Somerset (badge net) To advertise for staff to join the digital team	LMNS Safety group and Trust boards			
Education and training- implementation of the core competency framework and training compliance	Both trust compliant with the core competency framework Training compliance at	Discussed at safety sub group bi monthly, presented on dashboard	LMNS safety group Trust boards			
Significant gaps in assessment against NHSI maternity self assessment tool	Working through the self assessment as a merging trust	Task and finish group to complete	Trust boards			
Concerns raised in Annual Surveys and progress on actions to address • Staff • Maternity • Neonatal	Staff survey for 2021 areas of concern were burnout around feelings of being worn out and exhausted and working additional hours and availability of adequate supplies and materials to do my job, shortage of staffing	Action plan will be formulated to address work pressures, supporting health and wellbeing Recruitment in progress	Trusts boards			

Somerset System Summary

LMNS view of the priority concerns/risks

NHS Somerset Clinical Commissioning Group

Comment / outcome		Formal escalation to			Support ask from LMNS to PQSSG
System summary of the priority concerns/risks	Actions/Mitigations:	Local ICS	PQSSG	SWQSG	
Delay in launching personalised care and support plans that has been Coproduced with MVP, awaiting guidance from regional PCSP task and finish group to ensure that the plan meets standards agreed across the region. Producing a animation to be launched alongside the plans for both staff and women and families. The plans will include bereavement care and support plans	Date for launch planned for May once staff training has been undertaken, to be provided by MVP				
Workforce and safe staffing remain a priority	Recruitment ongoing Suspension of some services SFT homebirths Use of bank and agency staff Staff incentives	Yes aware of ongoing pressures trust boards informed weekly of demands			

Ockenden – Somerset LMNS/System progress on implementation of recommendations

LMNS implementation – progress status	Blue	Complete	Actions/Mitigations:
	Green	On track	
	Amber	At risk- plan in place	
	Red	Not on track + support required	
To oversee quality in line with *Implementing a revised perinatal quality surveillance model*			
To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.			
To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care.			
To co design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships.			
To implement shared solutions wherever possible through shared clinical and operational governance.			
ICSs should set out a plan for how formal, structured and systematic oversight of how their LMNS will deliver its functions			
LMNSs, in consultation with regional teams, to identify a buddy LMS and implement processes for peer review and support			
ICSs to ensure the LMS Board is part of governance arrangements, and ensure that future arrangements maintain direct line of sight from the statutory ICS Board to the LMS Board, (although there may be a period of transition during 2021/22)			

Ockenden - Musgrove progress on implementation of recommendations

NHS Somerset Clinical Commissioning Group

The seven immediate and essential actions from the Ockenden report *please use data from your LMNS dashboard and assess as key	Green	1	**Actions/Mitigations:**
	Green/Amber	2	
	Amber	3	
	Amber/Red	4	
	Red	5	
Enhanced Safety	2		To submit SOP and organogram
Listening to women and families	4		Coproduced plan with MVP that demonstrates co design of service development is in place in progress. To be completed by NED/safety champion walkabouts to continue and a robust system to feedback to staff introduced
Staff Training and Working Together	4		Twice daily consultant ward rounds not compliant with recommendations Confirmation of funding ringed fenced for maternity to be submitted Review of training data attendance, compliance and training needs assessment part of the LMNS safety sub group agenda
Managing Complex Pregnancy	2		Undertake audit of 1% of notes, where women have complex pregnancies Agreed pathway for maternal medicine specialist centres
Risk Assessment Throughout Pregnancy	3		Evidence how all woman are formally risk assessed at every contact SOP/audit Personal care and support plans are in the last stages of development, ongoing audit once launched to demonstrate compliance
Monitoring Fetal Wellbeing	1		
Informed Consent	2		Audit that demonstrates women's choice including women who requested a care pathway which may differ from that recommended by the clinician during the antenatal period Action plan from GAP analysis

Ockenden -Yeovil progress on implementation of recommendations

NHS Somerset Clinical Commissioning Group

The seven immediate and essential actions from the Ockenden report *please use data from your LMNS dashboard and assess as key	Green	1	**Actions/Mitigations:**
	Green/Amber	2	
	Amber	3	
	Amber/Red	4	
	Red	5	
Enhanced Safety	2		To submit SOP and organogram
Listening to women and families	4		Coproduced plan with MVP that demonstrates co design of service development is in place in progress. To be completed by NED/safety champion walkabouts to continue and a robust system to feedback to staff introduced
Staff Training and Working Together	2		Review of training data attendance, compliance and training needs assessment part of the LMNS safety sub group agenda
Managing Complex Pregnancy	2		Submission of a audit plan to regularly audit compliance Agreed pathway for maternal medicine specialist centres
Risk Assessment Throughout Pregnancy	2		Personal care and support plans are in the last stages of development, ongoing audit once launched to demonstrate compliance
Monitoring Fetal Wellbeing	2		
Informed Consent	2		Audit of women's participation in decision making Audit that demonstrates women's choice including women who requested a care pathway which may differ from that recommended by the clinician during the antenatal period Action plan from GAP analysis