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The Royal Wolverhampton NHS Trust

University Hospitals of Leicester NHS Trust

NHS Barnsley Hospital NHS Foundation Trust

Shared Insights

The impact of Ockenden and implementation of the IEAs from ward to Board

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Introduction

Rachael Morris, Partner, Browne Jacobson

Rachael is a Partner specialising in resolving clinical negligence claims, in particular involving complex obstetric and neurological injuries, acting on behalf of NHS Resolution and various Trusts.

The final Ockenden report was published on 30 March 2022 and is a blueprint for safe maternity care. It develops the work done in the first report published in December 2020.

Overview of the final report

- Listened to the voices of families but also heard the views of staff.
- It reinforces the importance of establishing and improving critical oversight of patient safety in maternity units.
- The review acknowledges the huge pressure maternity services and their staff continue to face.
- The patterns of failings in care identified mirror issues raised by previous national reports into maternity care and themes we continue to see in the context of claims and inquests such as failures to follow national guidelines, work collaboratively across disciplines, escalate concerns and delays in transfer.
- The report highlights significant failings in governance procedures and leadership which resulted in repeated missed opportunities and failures to learn.
- As a result, the report sets out 15 Immediate and Essential Actions

Summary of the Immediate and Essential Actions

- IEAs complement and expand on the actions set out in the first report.
- These actions must be implemented across all maternity services.
- Change will not be achieved overnight but action is required now at all levels, from ward to Board.

Operationally and at ward level

Staff

- Workforce planning and sustainability, including the need for nationally agreed minimum staffing levels, or where there is no national agreement, staffing levels agreed locally with the Local Maternity and Neonatal System (LMNS).
- Training A proportion of maternity budgets must be ring fenced for the provision of appropriate training. Training should be multidisciplinary and include human factors and up to date CTG and emergency skills.
- Safe staffing - including the need to maintain a clear escalation and mitigation policy where staffing falls below the minimum staffing levels. Trusts must also review and suspend if necessary midwifery continuity of carer model

Introduction

Rachael Morris, Partner, Browne Jacobson

- **Escalation and accountability** - staff must be able to escalate concerns with clear guidelines for when a consultant obstetrician should attend.

Patients and families

- **Complex antenatal care** - ensure that women have access to pre-conception care.
- **Labour and birth** - various requirements to improve care, including the need for women who choose birth outside a hospital setting to be provided with accurate advice with regards to transfer times to hospital.
- **Pre-term births** - ensure systems are in place for the management of women at high risk of preterm birth.
- **Obstetric anaesthesia** - a pathway for outpatient postnatal anaesthetic follow-up must be available.
- **Post-natal care** - Women readmitted to a postnatal ward and all unwell postnatal women must have timely consultant review.
- **Bereavement care** - Women who have suffered pregnancy loss must have appropriate bereavement care services.
- **Neonatal care** - There must be clear pathways of care for provision of neonatal care.
- **Supporting families** - Care and consideration of the mental health and wellbeing of mothers and the family as a whole.

Clinical governance and Organisational Learning

- Incident investigation and complaints - this includes the need for incident investigations to be meaningful for families and staff and for lessons to be learned and implemented within 6 months.
- Maternity governance teams must ensure the language used in investigation reports is easy for families to understand.
- The importance of monitoring complaints, themes and trends is also highlighted.
- Learning from maternal deaths - nationally, all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy-related pathologies.
- A joint review panel or investigation of all services involved in the care must include representation from all clinical settings and learning implemented within 6 months.

Leadership including the Board

- Clinical governance leadership – the report reinforces the need for leadership and critical oversight of the quality and performance of maternity services.
- The director of midwifery and clinical director for obstetrics are to be jointly operationally responsible and accountable for the maternity governance systems.
- Trust boards must also work together with maternity departments to develop regular progress and exception reports and assurance reviews and review the progress of any maternity improvement and transformation plans.

The Midwifery Perspective

Kate Cheshire, Head of Midwifery and Neonatal Services, The Royal Wolverhampton NHS Trust

Kate is Head of Midwifery and Neonatal Services at the Royal Wolverhampton NHS Trust. She gave an insight into what the Trust has been doing from ward to Board, in order to share and implement the IEAs and improve care and safety in maternity services.

Kate focussed on 4 themes:

1. Patient voice - at the point of care and beyond.

Improvement is needed in collating and triangulating complaints and action plans. Kate's Trust has a non-clinician team member who looks at complaints and reflections as well as feedback themes which, even when positive, may still result in learning.

2. Support for families

Having a named contact. The Duty of Candour letter identifies who the lead contact is to support families through what could be a long process.

Any learning from HSIB and the contact they have with families can be embedded into the Trust's services. Where appropriate, families have support available to them via the Bereavement Team and Professional Midwifery Advocates. The Trust also has a strong team of professional midwifery advocates who support families and staff.

Ambulance times are shared daily with the Director of Midwifery so women planning a home birth have informed choice. They are continuously updated in accordance with live ambulance delays. Attending staff are aware of delays and support is put in place for them if required.

3. Staff awareness and staff voice

This is immensely important to the Trust These are some of the ways the Trust has been raising awareness and encouraging conversations on Ockenden:

- Staff invited to complete a survey - you can see the questions here.
- Infographics on social media platforms for staff and the public
- Infographics on display in the unit identifying the IEAs
- Sessions discussing IEAs
- Discussions regarding what changes could occur going forward for individuals both as employee and practitioner
- Sharing learning with the wider Trust
- Slide deck for managers - a short set of slides for discussions with staff where appropriate
- Ward to Board posters regarding where information goes and how, up to Board level
- Monthly Safety Champion walkabouts which include Board level staff so that staff know they can speak to some service users where appropriate. The outcomes of these are collated and followed up.

The Midwifery Perspective

Kate Cheshire, Head of Midwifery and Neonatal Services, The Royal Wolverhampton NHS Trust

- Freedom to Speak Up colleagues come into teams and talk to staff ensuring they know this is available.
- Professional Midwifery Advocates are available to support staff
- Introduction of the "thinking of leaving" interviews where staff can discuss development and plans can be put in place.

Ockenden highlighted that where there are issues they need dealing with and suggests a need to look at conflict of professional opinion and support to nurture and restore staff following incidents.

The staff survey results suggest staff would like information sharing in a number of different ways including

- Woven into mandatory training
- Tea trolley training
- Information boards
- Webinars

4. Workforce training.

- Our Birth Rate Plus report showed very little gaps. Ockenden suggests that there are additional roles needed. In addition to Birth Rate Plus professional judgment is required regarding postnatal care.
- Daily staff huddles at Kate's Trust are led by a Matron and are attended by all area managers and a nominated Community Team Leader. This covers:
  - data collection
  - expected staff ratios for areas (staff are getting used to having to temporarily move areas)
  - night ahead and identify and address hotspots (extends into neonatal)
- Virtual PROMPT training and PROMPT training for community midwives using a 'bedroom' setting to practise skills drills.
- Active recruitment.

The Trust has been successful in its recruitment of midwives and currently has a waiting list. It is proactive about recruitment. It recruits substantively into maternity leave vacancies and holds recruitment interview days which

- Take place over a weekend when more people can attend and allows more use of space including management corridor
- Include skills drills, demonstrations and PMAs talking to staff
- Create a 'buzz'

How to bring Ockenden learning alive to new recruits?

The staff survey is about how people want us to approach education so the themes will be the same, with themes of Ockenden running through all that as a golden thread. We may have a session purely on Ockenden for new starters. We are also considering the Director of Midwifery meeting all new starters whilst they are all together in one place at induction.

The Board Perspective

Dr Brian McKaig, Chief Medical Officer, The Royal Wolverhampton NHS Trust

Brian is Chief Medical Officer at The Royal Wolverhampton NHS Trust. He has held several managerial roles within RWT including Clinical Director for Gastroenterology, Revalidation Lead (2012-2020) and Deputy Medical Director (2017-2021). He gave his perspective on the impact of Ockenden at Board level.

Brian reflected on the impact Ockenden has had at Board level. Ockenden is about maternity services and the need for more oversight at Board level but the learning is much wider than maternity services.

Consider

- Are the Board hearing what they are being told?
- Are they listening to what comes through when looking at the different reports that have happened around Ockenden which highlighted concerns?
- How many go to Board Level awareness?
- When action plans are drawn up, are the Board paying attention to the impact of action plans and not just ticking a box?

Culture is critical (for all services):

- Are staff able to be heard?
- Listening to staff - there is an expectation that all directorates have away days attended by exec teams, around training and leadership and encouraged to be multi professional
- Being aware of what staff are saying, where any concerns are and being proactive i.e. Freedom to Speak Up / walkarounds
- Triangulation with what you are hearing and data and any reports.

For Boards, there needs to be:

- Staff engagement - the response to surveys tells you a lot about the organisation.
- Communication from Board to staff and staff to Board.
- True patient engagement - How do Boards better hear the patient's voice?
- Collation of any external reviews to ensure the Board has visualisation and oversight of them at Board level and that action plans have meaningful impact.

Be mindful of the need to preserve organisational memory during significant changeover at Board and executive level.

Wider national initiatives – Fetal Monitoring Network

Sarah Blackwell, Fetal monitoring Lead, University Hospitals of Leicester NHS Trust (UHL)

Sarah is Fetal Monitoring Lead for UHL and founder of the National Fetal Monitoring Network. She spoke about the role of the Network, how it has grown significantly from humble beginnings and reflected on the impact of Ockenden and how the Network can continue to help support clinicians. Sarah also runs the Monitoring May event with Catherine Hopley (see next page)

Background & Beginnings

- Took part in Mat/Neo project in 2019 re collaborative working and ideas
- The role led to finding our feet around basic guidance of SVBLv2 and CNST requirements
- Reaching out to other fetal monitoring leads for support through the consultant midwife network
- Initial meeting August 2020
- COVID allowed us to meet virtually, and six midwives met to assist each other and share ideas
- Social media implemented to help spread the word

Why the Network?

- Shared learning
- Shared ideas
- Sharing concerns/hurdles
- Supporting the new role
- Collaborative working

Where we are now

- April 2022: 167 units, 365 network members including in Australia
- Extended to Consultant leads as a recommendation from Ockenden
- Monthly meetings

Next Steps

1. Collate leads and classification tools
2. Utilise digital platform - already have a well established NHS futures platform with forums
3. Buddying up with different units
4. Training
5. Birth stats

Wider national initiatives – Fetal Monitoring Network

Sarah Blackwell, Fetal monitoring Lead, University Hospitals of Leicester NHS Trust

Ockenden Report

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 wellbeing**
  - **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.**

Nationally

- **Move forward with one voice collaboratively**
- **National Fetal monitoring leaflet - working party**
- **Looking as a collective challenging training needs of GP/FY Drs on fetal monitoring for MIS**
- **Share case studies to allow for ongoing knowledge and discussion**
- **Work with LMS systems, RCOG, RCM and this institute on national fetal monitoring tool, ABC collaboration**
- **Continue to support the implementation and sustain the recommendations of Ockenden report and look at other CQC reports to move forward and offer support to those fetal monitoring leads within that Trust.**

Wider national initiatives – Monitoring May

Catherine Hopley - Barnsley Hospital NHS Foundation Trust

Catherine is In-patient Matron at Barnsley Hospital NHS Foundation Trust. In her previous role as Fetal Monitoring Lead for Mid Yorkshire Hospitals NHS Trust she established Monitoring May which she continues to run with Sarah Blackwell (see previous page). She explained what it involves and how to join in.

Monitoring May (MM) came from humble beginnings, wanting to bring an element of physiology with NICE guidance so gradually Catherine's Trust decided to introduce some elements into their Trust guideline which was due to go live in May. Catherine decided to run 'Monitoring May' for a month.

Catherine spotted a Senior Midwife with a pinard tucked behind her back and put a photo of this on Twitter. From two Trusts being involved and the power of social media this became a national learning event.

MM 2021 was a very successful month-long learning event with different themes per week with involvement from Baby Lifeline and Fetal Physiology. The platform was launched over Teams with the support of the East Midlands Health Science Network and made available to all Trusts. The events were recorded and were available to all staff for a year.

Twitter has been very helpful making this dream a reality. The recordings from MM 2022 are getting ready to launch, with some changes in 2022 as follows

- MM was run over a week rather than a month.
- More input from Fetal Monitoring Leads to give the FML the opportunity to demonstrate what was done well in their own Trusts and answering the call to action from Ockenden.
- The theme this year is 'the time for action is now'. Recently there has been lots of looking back and evidencing what has been done rather than being able to step off the hamster wheel and see where we are going.
- "Small changes add up to huge differences - keep going, you've got this" was our message
- Making the actions achievable for the midwives on the shopfloor.

Catherine explained they would love to have a face-to-face conference, but it is very expensive for midwives. Donna Ockenden has been very supportive of MM and wants it to be face-to-face so watch this space!

Monitoring May - key facts

- YouTube - 3231 views
- 2022 - 780 participants
- Accessible for all staff
- International Conference

Monitoring May & Discussion

Catherine Hopley - Barnsley Hospital NHS Foundation Trust

How can people get involved in FML and MM 2023?

Email Sarah Blackwell at sarah.blackwell@uhl-tr.nhs.uk to join the network and be added to the email list and the FML platform.

Here is the link to access the recording of the sessions from MM 2022: https://youtube.com/playlist?list=PLF9RGvbTGqu1sdZL350xxsRM7jtFubYIk

Discussion

How to link in with Governance, Legal services and at Board level and ensure IEAs are implemented?

Brian McKaig - this goes back to organisational structure. Sub-Board committees are attended by executives. Information is initially scrutinised before going to Board for a higher level view. When it comes to Board we are confident it has been reviewed appropriately. Members are invited to challenge and discuss this at open Board.

Kate Cheshire - our Director of Midwifery sits on the Board to ensure that the messages are not diluted. Also we regularly get invited to Board. We can invite ourselves and take patient stories to Board and a member of the team can present and discuss the story and the resulting impact and changes.

How are Trusts using data from claims and inquests into maternal and neonatal deaths to support the fantastic work that Kate is describing? Is there anything that legal teams can do to help with this?

Examples were given as follows:

- **Monitoring the learning through claims, identifying the key points and feeding these back to Patient Safety Teams at monthly meetings so they can feed this back to their individual departments.**
- **Claims forums and high risk inquest meetings with Executives to discuss matters that present risk both legal and reputational.**
- **Liaison with Patient Safety Leads to collate the data for GIRFT**

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Please note:
The information contained in this document is correct as of the original date of publication.
The information and opinions expressed in this document are no substitute for full legal advice, it is for guidance only.

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What is your role?	Midwife
	Midwifery Manager
	MSW
	Obstetrician - Consultant
	Obstetrician – Non-Consultant doctor
	Anaesthetist - Consultant
	Anaesthetist – Non-Consultant doctor
	Other:

Have you read the Ockenden Final Report? (Published March 2022)	Yes
	No
	Partially
	Only the executive summary
	Only the Immediate & essential actions (IEAs)

	Completely disagree	Disagree	Neither Agree or Disagree	Agree	Completely agree
The contents of the Ockenden Report are relevant to my day-to-day professional responsibilities					
It is my professional responsibility to read the Ockenden Report					
The contents Ockenden report will change how I think about certain parts of my job					
The recommendations made in Ockenden report will change how I do certain parts of my job					
I regularly keep up to date with national reports and their recommendations					
The hospital makes it easy for me to keep up to date with national reports and their recommendations					

The best way to communicate about the contents and recommendations from the Ockenden Report is:	By group emails
	Included it in mandatory training
	Using live webinars
	Using pre-recorded presentations
	Via social media
	Departmental newsletters
	Tea trolley teaching sessions
	Other:

Any additional comments that you would like to share:	