R

Leicestershire Partnership NHS Trust

Trust Board – 29th March 2022

LPT's Response to the Ockenden review of maternity care (1 year on)

Purpose of the report

To update Trust Board on LPT's response to the Ockenden review of maternity care one year on.

Background

In December 2020, the Ockenden Report was published, which set out immediate and essential actions for maternity services across England under seven key themes. The Ockenden report was written following a review at another NHS Trust in response to letters from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm while receiving maternity care at the hospital. Recommendations were issued for all acute Trusts offering maternity care and the wider maternity community across England to be addressed as soon as possible.

There was no formal requirement for LPT to provide a formal response to these actions. The corporate patient safety team did however use a Learning Lessons Exchange (LLE) meeting to consider the transferrable learning from the enhanced safety areas identified in this report.

In addition to this, the aim was to further develop our culture as a Learning organisation to encourage and reach a level where all staff are thinking 'learning all the time' and moving from a safety 1 position (reacting to incidents) to a safety 2 position (focusing on what goes right and doing more).

In January 2022 all Chief Executives received a letter from NHSE/I, requesting that one year on from the Ockenden report publication, all Trusts reviewed and discussed any progress with learning before the end of March 2022. The following report presents five key areas from the Ockenden that were considered to be transferrable within LPT and details actions and progress and alignment to LPT's leadership behaviors.

Analysis of the issue

1 Enhanced safety – This was about visibility/transparency and oversight of incidents

We have robust processes to ensure that any potential serious incidents are discussed at Incident Review Meeting (IRM) to strengthen the governance of decision making and transparency. Commissioners are invited to attend. These are reported to Board via Exec bulletins and learning via Bi -monthly report. Our commissioners and CQC are informed via 72-hour reports, meeting the requirements for external input and oversight.

We also report performance against a range of safety measures to the Trust Board on a regular basis using Statistical Process Control (SPC) to support appropriate analysis. We have employed eight designated patient safety investigators to strengthen the quality of Serious Incident investigations and more system focused actions using a 'just culture' approach.

Actions to be taken

- Trial of learning patient stories from SI's to share across the organisation.
- Improve the quality of Executive summaries for SI's so they can be shared and more readily accessible (to Board and the wider organisation).

'Always learning and improving'.

2. Listening to women and their families - this is a key theme and very transferrable to listen to our patients and their families

- The CPST have begun a piece of work 'caring confidentiality' this is around working with patients who may be demonstrating suicidal behaviour to support staff to involve their family without fear of breaching confidentiality; this is being taken forward in DMH with Psychology and other expert input.
- The CPST work closely with the complaints team to ensure that where patient safety concerns are identified through complaints they are shared, heard and responded to and triangulated for learning.

Actions

- Identify a Patient Safety champion on the Board.
- DMH to strengthen the identification of a Next of Kin/Significant person and ensure this is recorded and conversations are had with patients around involving them in their care as appropriate.

'Working together'

3. Staff training and working together - this is about bringing the MDT together and not training staff separately. This is also relevant to temporary staffing and links to the research around safety benefits of cohesive teams.

The Medical Director has identified a team of senior medical staff to attend IRM to bring together the MDT at this point as part of learning from incidents form a transparent approach.

The CPST are working with the Medical Directors deputies in DMH to strengthen the input to investigations from medical staff.

LPT still could improve this opportunity of promoting shared learning amongst medical staff.

Actions

- Medical representative for PSIG
- Review all training and consider where this can be delivered to teams

'Valuing one another & recognising and valuing people's difference'.

4. Informed consent and shared decision making-This is not new **'nothing about me without me' (DH 2012)** and more recently **Cumbeledge 'first do no harm' 2020**

- Our record keeping and care planning policy (2019) describes that care plans are 'developed with the patient, and their carers where appropriate' and the 'care plan where possible should be left with the patient and their carers where appropriate'. Along with the current Consent to examination or treatment policy (2020) which outlines the process in conjunction with the legal and best interests' approach does consider the importance and inclusion by 'the health professional must consult with those close to the patient (e.g., spouse/partner, family and friends, carer, supporter, or advocate) as far as is practicable and as appropriate'.

The importance of clear documentation in patient records around these aspects of shared decision making is key for good governance and continuing communication between the healthcare professionals

Actions

- DMH to strengthen personal safety planning (identified in SI's)
- CHS to further embed motivational interviewing and the training of DN's in assessing mental capacity to support good quality decision making (identified in SI's)
- Medical staff to strengthen the documentation of shared decision making and information used to make decisions including risks as well as uncertainties.

'Recognising and valuing people's differences' & 'Working together'.

5. **Leadership and poor workplace culture-** this is key across the whole of the NHS.

Safety culture is a key fundamental of the Patient Safety Strategy (2020).

- The CPST are encouraging leadership for safety - promoting a culture that safety actions are for our patients and not for our regulators
- Presentation at Leadership forum
- Presentation at foundations for great patient care
- CPST are working with HR and our change champions to support psychological safety

Actions

- Directorate leadership teams to support and promote this
- High visibility in the clinical workplace promoting high standards
- Using all available data
- Learning from incidents, embedding change
- Consider all anonymous reporting as a red flag and not only respond to the content of the report but what led up to it

Decision required

- Board to be assured that the findings of the Ockenden review have been considered for transferrable learning and actions taken.
- To support Patient Safety Champion at Board level.

Governance table

For Board and Board Committees:	Trust Board 29TH March 2022	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward- (Patient Safety Specialist) Sue Arnold (Lead Nurse patient safety) CPST	
Date submitted:	2nd March 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	SEB 4th March 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	This is a 1 year on report – the work from this and the previous report should become BAU in Directorates	
STEP up to GREAT strategic alignment*:	High **S**tandards	yes
	Transformation	
	Environments	
	Patient Involvement	yes
	Well **G**overned	yes
	Reaching Out	
	Equality, Leadership, Culture	yes
	Access to Services	
	Trustwide Quality Improvement	yes
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	This supports the safety of the public	
Equality considerations:	This is promoting equality	