N

Leicestershire Partnership NHS Trust

Trust Board – July 26 2022

LPT's Response to the Ockenden review of maternity care following the Final Report Published 31st March 2022

Purpose of the report

To update and assure Trust Board on LPT's response so far and the transferrable learning to date and actions recommended. This report summarises the two previous reports and is prepared following the publication of the final Ockenden review of maternity care at Shrewsbury and Telford NHS Trust published March 2022. This paper has also been presented to the Quality Assurance Committee.

Background

In December 2020, the interim 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 an independent review in response to concerns from bereaved families, 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 response to these actions. The 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. A report was also presented to Trust board outlining the transferrable learning identified via our learning Community of Practice and actions to be taken. This paper was approved at Board and then shared via the Patient Safety Improvement Group in April 2022 for dissemination via governance teams for actions within Directorate.

The Ockenden final report was published at the end of March 2022 and as part of this a series of recommendations have been made that are applicable to all Trusts and this report will consider those in addition to those we have already identified.

Whilst this report has distilled and shared the transferrable learning, it is strongly recommended that all senior leaders within all NHS organisations consider learning from the report. The stories contained in the report provide the context to support the culture changes needed. The failings are twofold, babies and their mothers were harmed. The response/lack of response to the harm has caused further harm.

'To err is Human, to cover up is unforgivable and to fail to learn is inexcusable' (Sir Liam Donaldson 2010)

Analysis of the issue

The report defined final findings under four Key areas: Staffing, Training, Listening and Learning. Below our previous transferrable learning is listed under headings and expanded to include additional areas described in the final report. These have been considered and distilled into the below accumulative plan

Staffing

The report identifies a number of staffing areas to be addressed primarily the need for increased numbers which is being addressed in other workstreams within LPT. Culture is another staffing area of focus including the stability of teams.

The report details that constant changes within the executive team did not provide stability to the oversight of what was happening. The findings also support the need to consider where there is high usage of temporary staffing practices need to flex to account for this. The report concluded that the consideration of staffing numbers alone is not sufficient for the safe and effective working of teams

Management of locums

The transferrable learning is that there must be a robust process for the induction and supervision of Locum staff. Local processes need to be robust and clear to support Locum Colleagues to quickly integrate into teams. Concerns with practice of Locums needs to be addressed promptly in a supportive way to achieve improvements. We must think as a system and the practice of simply not booking Locums whose practice is not up to standard is not an appropriate response

Clinicians with responsibility for Governance

To support the above, the report advises that clinicians who have responsibility for governance must have sufficient time in their job plans to undertake this essential role, in addition to the training and support part of this role is to ensure there are suitable guidance and oversight of Dr's in the training grades as well as Locums. This includes the supervision of their work and clear routes to seek support.

Actions

- The induction of Locums should be reviewed to ensure that it is robust
- The Clinicians with responsibility for governance should have their job plans reviewed to ensure there is sufficient time to undertake this piece of important work.
- The process for managing performance of locum staff should be considered to ensure all possible support is provided and where there remain concerns this is managed and shared with the Locum agency

Training

'Working together'

Staff training and working together - this is about bringing the MDT together and not training staff groups 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 from 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 rather than separate staff groups
- Compliance with training to be prioritised and considered a measure of safety culture.

Listening

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

The report identifies that women and their families were not listened to. It also identifies that staff were not listened to. As we have seen in other high-profile reports if this continues staff stop speaking up. NHSE/I are currently refreshing the guidance around freedom to speak up. Freedom to speak up was introduced post the findings of the Francis review in 2014 and it is disappointing that we are still identifying this as a key contribution after all this time.

The Freedom to Speak process is a workaround in response to the symptoms of the problem and is not the solution to the problem. Organisational culture needs to create the conditions where staff opinion is invited and welcomed and responded to. Staff contribution to organisational change is integral to the processes of the organisation. Where changes are implemented, staff have been involved in the planning of the change and as part of the project there should always a feedback loop that invites feedback on how it is progressing and ideas for improvement.

In addition there is a need for 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 in progress

- 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. (if appropriate the detail is taken to IRM)

Actions to be taken

- DMH to strengthen personal safety planning (identified in SI's)
- 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.
- 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.
- All levels of the organisation to consider how staff can easily feedback

Leadership and poor workplace culture- this is key across the whole of the NHS. We need to create the conditions and leadership behaviors that create the conditions that allow staff to contribute and be heard. This spans the headings of Listening and Learning

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

Actions already in place

- 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 culture of Leadership for Safety
- High visibility of leaders in the clinical workplace promoting high standards
- Using all available data (thinking about outcomes)
- All projects that introduce change should have feedback loops built in to listen to staff and make changes in a timely way
- Consider all anonymous reporting as a red flag and not only respond to the content of the report but what led up to it
- The work to develop a clear process for de brief for staff post incident should be prioritised.

Learning

'Always learning and improving'.

This is essentially about visibility/transparency and oversight of incidents. The implementation of robust actions

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.

This is also improving the culture of learning conversations and the meeting is valued as a learning opportunity. Immediate actions are identified, and areas of immediate concern are escalated as appropriate.

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 in progress

- Trial of learning patient stories from SI's to share across the organisation.
- Improving the quality of Executive summaries for SI's so they can be shared and more readily accessible (to Board and the wider organisation).
- We have identified a Patient Safety champion NED on the Board.
- The CPST are working towards accreditation for the SI process with the Royal College of Psychiatrists (this supports family engagement and the use of appropriate language)

- Complaints that describe harm/potential harm are shared with patient safety and considered at IRM if appropriate – If a patient safety incident requiring a higher level of investigation is identified – the complainant is informed, and the complaint put on hold

Actions

- Strengthen the process for agreeing SMART actions and the timely implementation (within 6 months of identifying) using a QI approach to the implementation of these. This should include the post implementation audit for embeddedness
- Include in action plans the sharing of the learning with subject matter experts to ensure that the learning is included in training
- Improved theming and trending of complaints and triangulate with other information
- CPST to develop guidance for staff to support meaningful engagement with patients and families through the investigation process

Decision required

- Trust Board to be assured that the findings of the Ockenden review have been considered for transferrable learning and actions taken.

Governance table

For Board and Board Committees:	Trust Board 26th July	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward- (Patient Safety Specialist)	
Date submitted:	15th May 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):	QAC May 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 report combines the 1 year on report and the final 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	ORR 59 -management of the whole incident management process
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	