Bradford Teaching Hospitals
NHS Foundation Trust

Ockenden Report, Findings and Actions for BTHFT Maternity Service

Sara Hollins, Director of Midwifery

March 2021

Together, putting patients first

Ockenden Report, 10 December 2020

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- 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.
- The total number of families to be included in the final review and report is 1,862.
- This first report includes the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.
- A second report including the remaining cases will be published in the summer.
- The review panel identified important themes which must be shared across all maternity services as a matter of urgency.
- 27 recommendations for the named Trust and seven early recommendations for the wider NHS, labelled ‘Immediate and Essential Actions’.

Key Findings

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- 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.

NHS Assurance actions required

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Action	Position
Submission of compliance with 12 asks related to the seven immediate and essential (IAE's) actions by 21 December 2020.	Complete 18/12/2020
Assurance assessment tool to go to next public board	Complete 20/01/2021
Completed assurance assessment tool to be submitted to Regional Midwifery Officer by 15 February 2021 including Birth Rate Plus confirmation	Complete 10/02/2021
Submission of assurance assessment evidence via National portal	Portal not yet open

Level of Assurance

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- High level of assurance demonstrated
- Many safety actions already embedded in practice at BTHFT
- Baseline audits completed
- Outstanding assurances are all linked to National or LMS actions and awaiting further guidance

What are we doing well?

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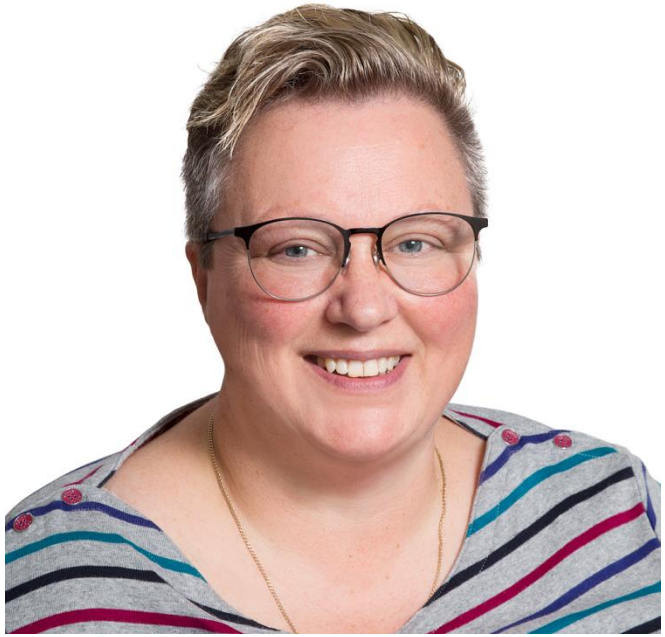
- Ward to Board reporting structure
- Consultant ward rounds exceed recommendation
- Maternity Safety Champion structure well established
- Open and honest reporting culture



Maternity Safety Champions

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- Who are they?
- Karen Dawber, Board Level Safety Champion
- Selina Ullah, Non-executive Board Level Safety Champion
- Sara Hollins, Midwifery Trust Level Safety Champion
- Nicola Cawley, Obstetric Trust Level Safety Champion
- Catriona Firth, Neonatal Trust Level Safety Champion

- What do they do?
- Meet bi-monthly, set agenda to discuss outcomes, risk and good practice
- Non-exec role to advocate for women and families at Board Level
- Challenge the service on safety issues
- Monthly safety meeting with staff
- All staff encouraged to escalate any safety concerns

Next Steps

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- Good level of assurance and practice/processes in place- pledge to continue
- Await further national guidance on outstanding recommendations
- Commitment to implement
- Independent Perinatal Advocate
- Repeat audits and build on results
- Further develop existing website and information provided to women
- Work with the MVP and service users to deliver safe services that meet the needs of the Bradford population

Questions?

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