Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 July 2022
	Agenda Item:	15

Report Title:	**Ockenden Report and Paterson Review : SHSC Self-Assessment**	
Author(s):	Salli Midgley, Director of Quality	
Accountable Director:	Beverley Murphy, Director of Nursing, Professions and Operations	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Quality Assurance Committe
	Date:	13 July 2022
Key Points recommendations to or previously agreed at:		

Summary of key points in report							
Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	
Recommendations accepted in full. It is recommended that the Board accept the recommendations and note the need for the Director of Quality to develop an implementation plan for the recommendations. The implementation plan to be presented back to the Quality Assurance Committee September 2022.							

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Getting through safely	*Yes*		*No*	***X***
CQC Getting Back to Good	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission	*Yes*	***X***	*No*		
IG Governance Toolkit	*Yes*		*No*	***X***	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	***X***	*No*		***Restrictive practice impacts on the experience of people using our services***
Financial (revenue &capital)	*Yes*	***X***	*No*		***Potential financial resource required to deliver the strategy***
OD/Workforce	*Yes*	***X***	*No*		***Skills and compassion are key elements of the workforce requirements***
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		*Please complete section 4.2 in the content of your report*
Legal	*Yes*	***X***	*No*		***Failure to comply with legislation is a breach and could result in legal challenge***

Title	Ockenden Report

Introduction

The Ockenden Report was commissioned by Department of Health to request an independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust.

The review started with 23 identified cases and grew to a review of 1486 cases of family care going back to 1973 to 2020. In addition to the review which included family members, 60 staff agreed to be interviewed and an additional 84 completed a questionnaire.

The interim report identified Immediate learning action which were reviewed at Quality Committee in 2021.

The key headline from the report is that the Shrewsbury and Telford NHS Trust failed to INVESTIGATE, LEARN, IMPROVE and ultimately to SAFEGUARD patients from harm.

The review found :

Failures to follow national clinical guidelines

Failures to escalate cases (individual patients) for MDT/ senior review

Failures of multi disciplinary teams to work together

This was contributed to by :

Lack of psychological safety in the clinical teams to work across the MDT

Lack of compassion when things went wrong from the clinical team to the corporate teams working with families, this included blaming families or family members when things went wrong

Unstable Trust Board meaning that improvement plans were not consistently followed through

Poor investigation governance which led to poor quality investigations, downgrading of incidents which meant some deaths were not investigated at all and a lack of executive oversight.

CQC and CCG reviews had not identified learning from concerns shared by families over the previous decade.

Whilst the report focuses on maternal care, there are key learning points that SHSC should attend to in order to ensure we continue to investigate, learn and improve from incidents of concern in order to safeguard our patients.

Paterson Review

This review was commissioned by the Government in December 2017 following misconduct enquiries which eventually spanned a doctors surgical career across both NHS and Private healthcare providers. The review delivered 15 recommendations across the private sector, CQC and Dept of Health and Social Care to enact. Three specific recommendations were aligned to NHS Provider trusts and are considered within this report in the context of learning.

In April 2017, Paterson was convicted of 17 counts of wounding with intent and three counts of unlawful wounding relating to nine women and one man, whom he had treated as private patients between 1997 and 2011. Paterson was sent to prison for 15 years. His jail sentence was felt to be too lenient and was increased by the Court of Appeal to 20 years in August 2017.

Reflecting on Ockenden

Whilst SHSC does not provide maternity services or conduct surgery it is important that we take opportunity to reflect on the key findings and recommendations. A self assessment tool was developed which was circulated to key leaders in the organisation. Those leaders were requested to take their nominated assessment questions through their respective groups/committees and ask for reflections in order to build a consensus of opinion about potential areas of growth and development for SHSC.

Findings

Theme One

Incidents and Learning

We received **significant assurance** across 4 enquiry lines for this theme

- Incidents are graded appropriately aligned to the level of harm suffered?
- We assign which investigations require a MDT rather than a single investigator through a robust mechanism
- We are confident that investigators are never assigned to an incident which involves them
- We are compliant with the Serious Incident Framework and preparing for the Patient Safety Incident Response Framework.

There were a number of enquiries where **assurance was limited**.

- **Training and capacity** for clinical staff to undertake investigations was felt to be variable across the organisation and is impacted by staffing levels and other commitments. This is an area of consideration across Trusts routinely and previously there has been investment in patient safety investigators, however this takes the learning and investigation away from services and is not formally recognised as good practice through Ockenden. The introduction of the Patient Safety Incident Review Framework is a timely opportunity to consider investigators aligned to a new investigation methodology and potential reduction in investigations.

- **The Board** are not fully sighted on the timeliness and key issues of serious investigations, the reporting to Quality Committee is high level.

- There is no specific criteria that is aligned to having **external specialist clinical review**, however there is a process through investigation which supports the robust discussion of every death that could identify if this were necessary.

- Investigations are not always written in **plain English**, whilst investigators try to avoid jargon the reports are written in such a way as to meet the current framework from NHS England. Complaint responses however are written in plain English. Investigators will go through investigation reports with families to ensure questions can be answered.

- **Learning from incidents** is not well embedded across clinical team development plans. Serious incidents do have action plans but these are held at directorate level and a senior team level. Complaints currently do not develop clear learning from teams and there is variation across teams as to how incidents/complaints/investigations and safeguarding are fed back. Trust wide themes are developed but the critical understanding at team level is not present in all teams.

- We currently do not have a robust system for **notifying GPs** of deaths in our services or routinely sharing findings from our investigations

- **Patient Safety Incident Response Framework (PSIRF)**. A number of questions and assurances were sought about the implementation of the PSIRF which enables organisations to determine their own areas for investigation. Ockenden were concerned about this and the potential ability of organisations to ignore key areas of potential learning or themes arising from other sources of concern. SHSC will develop local priorities for improvement by utilising past data and incident information. The investigation panel will continue to run and this collates incidents and concerns across not just serious incidents, but complaints and safeguarding supporting triangulation of concerns.

There is **no assurance** that the implementation of actions is audited for embeddedness following the closure of a serious incident action plan.

Recommendations :

1. A specific question was asked of Quality Committee members with regards to Board being sighted on Serious Incidents (Patient Safety Incident Investigations) each quarter with an overview of the key issues for scrutiny, oversight and transparency. Members of the committee strongly supported this suggestion and this should be received as a recommendation via Quality Assurance Committee to Trust Board.

2. A mechanism to receive assurance that the implementation of actions is audited for embeddedness following the closure of a serious incident action plan should be developed.

3. Quality Assurance Committee to continue to receive regular updates on the PSIRF implementation plan once the final document is published by NHSEI. The algorithm to calculate the type and number of investigations requires robust discussion and approval through Committee to Board given the impact of the decision making. Thereafter reporting on key themes and investigations will align with Recommendation One.

4. Develop a system for notifying GPs of deaths for people who have utilised SHSC services to ensure they are aware and offer opportunities to share findings from any investigations or learning.

Theme Two

Complaints and listening to service users and carers/families and significant others

We received **limited assurance** on the following enquiries

- Our level of confidence in the **involvement of people** affected by serious incidents in the investigations and that they receive honest and transparent feedback. We have worked hard to ensure we check in with investigators that they are confident to liaise with the appropriate individuals and we can see improved narratives in the reports on this. we also know we have had complaints about delays in being contacted and involved in investigations

- How **staff concerns** are investigated and addressed in relation to the freedom to speak up process and safety huddles. Work has commenced to monitor and respond to these through the Directorate performance and quality reviews.

- Work is ongoing to improve the kind and empathic nature of complaints responses in **plain English**, training is in development and themes are collected. There is a lack of learning from complaints overall and limited action planning to ensure issues do not occur again

- There is limited assurance as to how **Board listen to service users and carers**, Ockenden also seeks to understand if there is a senior lived experience director who feeds into board. Quality committee members gave a range of responses to this question but in summary felt that whilst there were improvements it still felt too distant at Board from lived experience

- Understanding **family support** after a loss and the provision of written information is an area of improvement that has been addressed with a family liaison officer supported into post and training to enable them to work with bereaved families and specialist training on supporting families post suicide.

- Understand **risk to patients** on waiting lists remains a critical area for enquiry, processes are being piloted which rely on staff measurement but there is no clear assurance that service user impact is understood and processes rely on self reporting to identify an increase in risk

Recommendations

5. We need to consider a sensitive approach to understanding involvement after an incident with affected individuals.

6. Learning from complaints needs to be addressed as a fundamental missed opportunity for quality improvement.

7. Training for complaint investigators needs to be agreed and rolled out.

8. Board should evaluate their learning from listening to lived experience stories and voices and consider having a shared developmental session with the Lived Experience and Coproduction Assurance Group

9. We should receive a report from the family liaison officer as part of the mortality/learning from deaths approach to ensure we are hearing the voices of families and significant others following a death to pick up areas of learning and support.

10. Monitor closely waiting list experience of people who use services, their families and significant others.

Theme Three

Clinical audit and effectiveness

- There was **significant assurance** related to the **audit** activity in the Trust and the leadership of these audits by clinical leaders as part of the forward planning for the Clinical Audit Programme in 2022/23.

- It was also noted that audits are aligned to **national best practice standards** within this programme and oversight has been given to Quality Assurance Committee.

- It was also noted that clinical teams had robust mechanisms to request a **clinical review** if care pathways were felt to be “stuck” or particularly complex. There are a range of formats for this to occur including a system overview with the executive directors.

- Enquiries that are **limited in assurance** included the activity within individual teams of self assessing themselves against **NICE and regulatory** standards. This occurs in pockets across SHSC but is not widespread.

- The Ockenden report required clinical **care indicators** be developed for maternity services, in the context of SHSC we asked what clinical care indicators were developed as a result of local learning across the organisation. There are a range of KPIs and measures in place to support understanding adherence to care standards particularly for physical health, however applying this approach to mental health care indicators is more difficult.

Recommendation

11. The aim to have all teams self assessing against NICE and regulatory standards to be implemented as aligned with the Research, Innovation, Effectiveness and Improvement strategy.

12. Clinical care indicators for mental health care are developed and reported through RIEI. Reporting on physical health indicators continues through Physical Health Committee and for assurance to Quality Committee as per workplan.

Theme Four

Our Staff

We consider **limited assurance** across the staff enquiry questions

- **Support for staff** who are undertaking and involved in investigations is available through the corporate teams and also with the Heads of Nursing and other lead professionals. We know that this is not always timely and we can improve this approach

- We could not robustly assure that staff feel **psychologically safe** to escalate concerns and that the concerns are investigated and acted upon. This was reflected via learning from the staff survey and the staff network groups. Work aligned to the staff survey to support psychological safety should continue and is monitored via People Committee,

- **Protected time** for training and development outside of mandatory training is not available to every clinical team or person. Work in the directorates to identify the needs has commenced but given the pressures on clinical services this is not always achieved.

- **Support** for teams to train together was not facilitated within SHSC other than through awaydays which are valuable developmental opportunities.

- The management of **staffing shortfalls** across professions was evidenced with a robust escalation procedure however it is evident that sustained shortfalls impact on the ability of clinical staff to input into governance, audit and investigation activity whilst direct patient facing care is prioritised.

Recommendation

13. We need to review and improve our approach to supporting staff during investigations and prior to coroners court.
14. Service leaders to review with their clinical teams training needs analysis and protected time that may be required to support continuous update of skills.
15. Consideration of key scenario based training to support clinical skills development for team based learning to be worked up during 2022 for consideration in clinical teams.
16. Governance colleagues to consider how the involvement of staff in key learning activity is reported in order to give “at a glance” assurance about staff involvement (or highlight where specific engagement to complete the work is required)
17. Aligned to the Freedom to speak up work Leaders complete the learning module “listening up” and “following up” AND that leaders hold regular listening events.

Paterson Review

There were three key questions to consider in relation to the Paterson Review, these have been reviewed within the Medical Directorate and responses are summarised below

1. It should be standard practice for **consultants to write to patients** outlining their condition and treatment and copy the letter to the patient’s GP.

This is good practice and many will do it at points of assessment. We are unable to confirm that this is standardised practice. The new Electronic Record will help with monitoring this

Recommendation : Consider a quality improvement project to understand and improve the current practice of writing to patients and copying to GPs on the outcomes of consultations and treatment options.

2. Introduce a period of time in the **consent process**, so that patients can reflect on their diagnosis and treatment options

This recommendation was made for surgical practice and therefore is not necessarily transferable practice for all mental health consultation situations, particularly where delaying intervention could lead to harm. The focus of this recommendation should link with a cocreated management plan that enables active listening between practitioner and service user. This is a key driver in the clinical and social care strategy

3. Information about how to **escalate a complaint** is more effectively communicated

This work on complaints and raising concerns needs to fit into the wider work on supporting people to raise concerns about their care through the most appropriate route AND responding in a compassionate and kind manner aligned to agreed timescales.

Recommendations

The summary of recommendations is set out below.

1. A specific question was asked of Quality Committee members with regards to Board being sighted on Serious Incidents (Patient Safety Incident Investigations) each quarter with an overview of the key issues for scrutiny, oversight and transparency. Members of the committee strongly supported this suggestion and this should be received as a recommendation via Quality Committee to Trust Board.

2. A mechanism to receive assurance that the implementation of actions is audited for embeddedness following the closure of a serious incident action plan should be developed.

3. Quality Committee to continue to receive regular updates on the PSIRF implementation plan once the final document is published by NHSEI. The algorithm to calculate the type and number of investigations requires robust discussion and approval through Committee to Board given the impact of the decision making. Thereafter reporting on key themes and investigations will align with Recommendation One.

4. Develop a system for notifying GPs of deaths for people who have utilised SHSC services to ensure they are aware and offer opportunities to share findings from any investigations or learning.

5. We need to consider a sensitive approach to understanding involvement after an incident with affected individuals.

6. Learning from complaints needs to be addressed as a fundamental missed opportunity for quality improvement.

7. Training for complaint investigators needs to be agreed and rolled out.

8. Board should evaluate their learning from listening to lived experience stories and voices and consider having a shared developmental session with the Lived Experience and Coproduction Assurance Group

9. We should receive a report from the family liaison officer as part of the mortality/learning from deaths approach to ensure we are hearing the voices of families and significant others following a death to pick up areas of learning and support.

10. Monitor closely waiting list experience of people who use services, their families and significant others.

11. The aim to have all teams self assessing against NICE and regulatory standards to be implemented as aligned with the Research, Innovation, Effectiveness and Improvement strategy.

12. Clinical care indicators for mental health care are developed and reported through RIEI. Reporting on physical health indicators continues through

Physical Health Committee and for assurance to Quality Committee as per workplan.

13. We need to review and radically approve our approach to staff during investigations and prior to coroners court.
14. Service leaders to review with their clinical teams training needs analysis and protected time that may be required to support continuous update of skills.
15. Consideration of key scenario based training to support clinical skills development for team based learning to be worked up during 2022 for consideration in clinical teams.
16. Governance colleagues to consider how the involvement of staff in key learning activity is reported in order to give “at a glance” assurance about staff involvement (or highlight where specific engagement to complete the work is required)
17. Aligned to the Freedom to speak up work Leaders complete the learning module “listening up” and “following up” AND that leaders hold regular listening events.
18. Consider a quality improvement project to understand and improve the current practice of writing to patients and copying to GPs on the outcomes of consultations and treatment options.

Additionally it should be considered with the action planning for these recommendations and actions how we will respond in a way that recognises the diversity, equality and inclusive nature of our staff and service users.

Risks

Learning from organisations and institutions that have failed to meet required standards and public expectations is critical. The biggest risk to SHSC is to fail to consider the implications of the Ockenden Report and Paterson Review and dismiss these as inappropriate due to the nature of the services delivered.

The review carried out by key leaders across SHSC with their teams and colleagues demonstrates a willingness to consider our approaches and recommend improvements or adjustments to increase assurance related to the four key themes highlighted within the report.

There is a risk that due to the nature of the consultation approach that not all recommendations will have had a lived experience opinion given, this is a risk that can be addressed if Quality Committee accept the report findings. Lived Experience input can be sought to develop the action plan in response to the review and consider how lived experience can be embedded in taking a number of the actions forward.

Implications

Strategic Priorities and Board Assurance Framework

This report and the recommendations speaks to two Strategic priorities :

1. CQC – Continuing to improve
2. Partnerships – Working together to have a bigger impact

Continuous improvement through learning from wider system issues demonstrates our journey to be an outstanding provider of care. In order to do this we need to work in partnership with others to have a bigger impact, particularly our communities and people who use services so we listen to them and act on thematic feedback

Equalities, diversity and inclusion

It is of note that the Ockenden review does not highlight any inequalities or issues related to diversity as part of its findings, the overall failure to listen to staff and patients/families was widespread. SHSC knows that we have systemic issues with accessing services from diverse ethnic backgrounds, therefore work to hear from people who use services needs to focus on those voices that may be under represented in some services and over represented in services that are more likely to restrict individuals. The Patient and Carer Race Equality Framework will give us the mechanism by which to pay attention to these issues and to interweave equality, diversity and inclusion into our ways of working for both service users but also for staff.

Summary

This report demonstrates a commitment from SHSC leaders to reflect on the learning from other organisations where failings have led to patient harm.

We have identified a number of actions that can be taken forward to address the lack of robust assurance related to the learning. If Quality Committee support the recommendations, the request to progress with the work will be shared with the appropriate action owners and confirmation of the appropriate governance routes confirmed.

It would be suggested that the monitoring sits via a high level programme management function with quarterly reporting and that an update returns to Quality Committee in six months on progress.