Ockenden Report Assurance Committee

Ockenden Report Action Plan: Progress to Date

Date: 23 September 2021

Presenters:

Martyn Underwood

- *Medical Director, Women's & Children's Division*
- *Senior Responsible Officer, Maternity Transformation Programme*

Guy Calcott

- *Consultant, Obstetrics and Gynaecology*
- *Workstream Lead: Clinical Quality & Choice*

Background to the plan: The 52 action items

Summary of the requirements set out in the Ockenden Report

Background to the First Ockenden Report

The Shrewsbury and Telford Hospital NHS Trust

- Independent review established following a number of serious clinical incidents beginning, in 2009.
- Commissioned by the then-Secretary of State for Health.
- Led by an independent Chair, Donna Ockenden, supported by a multi-disciplinary Review Team.
- Direct contributions from the affected families.
- Report and action plan based on 250 clinical reviews.
- Published in December 2020.
- Final report expected end of 2021.

Background to plan: The 52 action items

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Action Plan	Local Actions for Learning (LAFL)	4 Themes	1. Maternity care	27 Actions	52 Total Actions
			2. Maternal deaths		
			3. Obstetric anaesthesia		
			4. Neonatal service		
	Immediate and Essential Actions (IEA)	7 Themes	1. Enhanced safety	25 actions	
			2. Listening to women & families		
			3. Staff training & working together		
			4. Managing complex pregnancy		
			5. Risk assessment throughout pregnancy		
			6. Monitoring fetal wellbeing		
			7. Informed consent		

Local Actions for Learning (LAFL) summary

The Shrewsbury and Telford Hospital NHS Trust

LAFL (4 themes) ***Only applicable to SaTH***	1. Maternity care *13 Actions*	Risk assessment, supporting and enabling informed choice, resourcing of fetal monitoring and governance teams *Actions 4.54 - 4.66 inclusive*	27 Actions
	2. Maternal deaths *3 Actions*	Escalation and referral pathways, multi-disciplinary specialist input and planning, named consultant overseeing care *Actions 4.72 - 4.74 inclusive*	
	3. Obstetric anaesthesia *7 Actions*	Inclusion and input of obstetric anaesthetists in the wider maternity team, including training, incident review and audits *Actions 4.85 - 4.91 inclusive*	
	4. Neonatal service *4 Actions*	Combined notes, consultation with tertiary units, staff resourcing and observational attachments *Actions 4.97 - 4.100 inclusive*	

Immediate and Essential Actions (IEA) summary

The Shrewsbury and Telford Hospital NHS Trust

IEA (7 themes) ***All NHS Providers of Maternity Services***	1. Enhanced safety *6 Actions*	Incident Investigation: working with LMNS and Trust Board to review all serious incidents *IEA 1.1, 1.2, 1.3, 1.4, 1.5 & 1.6*	25 actions
	2. Listening to women & families *4 Actions*	Maternity Voice Partners (MVP): Working with MVP to ensure women and families are listened to *IEA 2.1, 2.2, 2.3 & 2.4*	
	3. Staff training & working together *3 Actions*	Multidisciplinary training: Ensure that staff train and work together efficiently *IEA 3.1, 3.2 & 3.3*	
	4. Managing complex pregnancy *4 Actions*	Named consultants: Ensure there is a robust pathway for complex pregnancies *IEA 4.1, 4.2, 4.3 & 4.4*	
	5. Risk assessment throughout pregnancy *2 Actions*	Antenatal care pathways: Ensure thorough risk assessments are in place *IEA 5.1 & 5.2*	
	6. Monitoring Fetal Wellbeing *3 Actions*	Saving Babies Lives v2: Appoint fetal monitoring leads and implement SBLv2 *IEA 6.1, 6.2 & 6.3*	
	7. Informed consent *3 Actions*	Respect of choice: Ensure all information is available to women in different formats (leaflets, video, web, etc.) *IEA 7.1, 7.2 & 7.3*	

Delivery and Progress Rates to Date

The latest statuses as accepted by the Maternity Transformation Assurance Committee at their monthly meeting 14/09/21

Colour coding: delivery & progress reverse RAG rating

The Shrewsbury and Telford Hospital NHS Trust

Delivery Status

Colour	Status	Description
	Not yet Delivered	Action is not yet in place, there are outstanding tasks to deliver.
	Delivered, not yet Evidenced	Action is in place with all tasks completed, but has not yet been assured/evidenced as delivering the required improvements.
	Evidenced and Assured	Action is in place; with assurance/evidence that the action has been/continued to be addressed.

Progress Status

Colour	Status	Description
	Not Started	Work on the tasks required to deliver this action has not yet started.
	Off Track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At Risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	On Track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that the action is being delivered and sustained.

Delivery & Progress of the 52 Actions (Sep 21)

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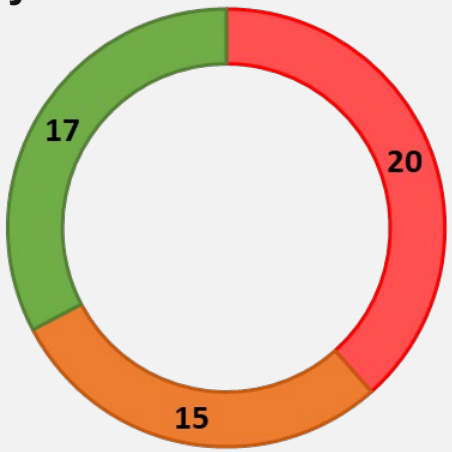
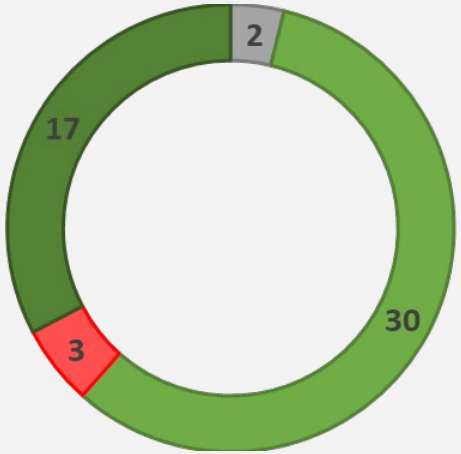
Delivery Status



- Evidenced & Assured
- Delivered, Not Yet Evidenced
- Not Yet Delivered

32 Actions Delivered (62% overall):
- 17 (33%) Evidenced & Assured
- 15 (29%) Delivered, Not Yet Evidenced

Progress Status



- Complete
- On Track
- At Risk
- Off Track
- Not Started

32 Actions Implemented (62% overall):
- 17 (33%) Complete
- 30 (58%) On Track

Assurance and Governance

How is SaTH providing assurance that the actions are fully implemented, and embedded so that they will continue to be adhered to and sustained?

Ockenden Actions split into 6 workstreams

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1. Clinical Quality & Choice	2. People & Culture	3. Governance & Risk	4. Learning, Partnerships & Research	5. Communications & Engagements	6. Maternity Improvement Plan
					
Guy Calcott Consultant – Obstetrics and Gynaecology	**Vicki Robinson** HRBP Women and Children's Division	**Shirley Jones** Interim Head of Midwifery	**Will Parry-Smith** Consultant – Obstetrics and Gynaecology	**Mei-See Hon** Clinical Director – Obstetrics	**Shirley Jones** Interim Head of Midwifery

Assurance and Governance process

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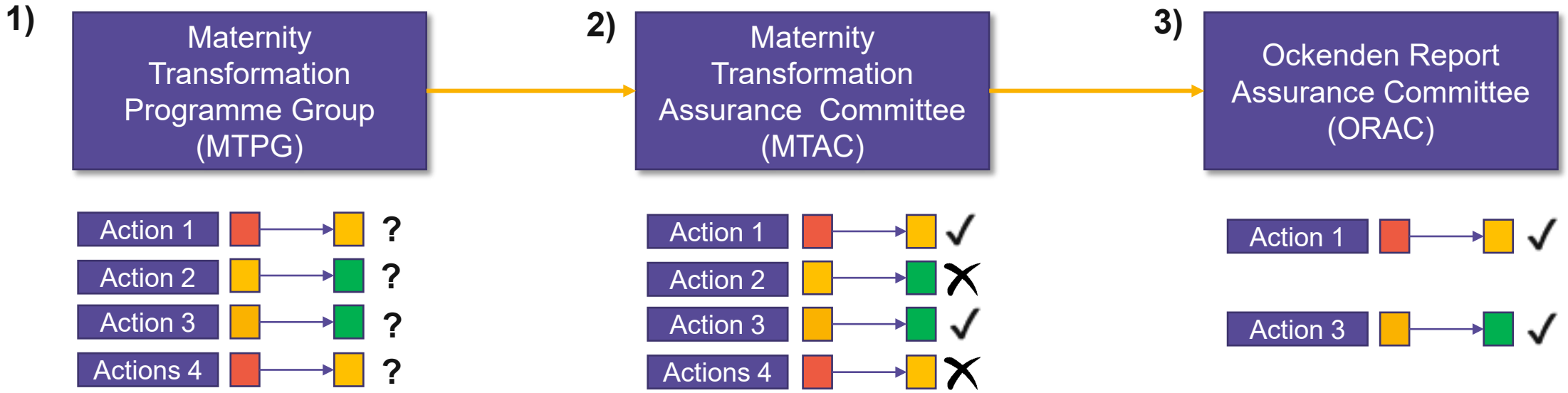

- Raise, manage and escalate risks & issues
- Oversee finance
- Document lessons learnt & best practice
- Review & propose status changes

- Review completion evidence
- Accept/Reject status change proposals
- Review and agree exception reports/change requests
- Act upon escalated risks & issues
- Provide forum for stakeholder input & discussion
- Agree key assurance topics for discussion at ORAC

- To provide assurance of Ockenden completion
- Sub committee of BoD
- Independent co-chair
- Stakeholder involvement
- Live-streamed to public

The Ockenden Report Assurance Committee

Review of topics covered to date, reminder of the initial concept of the Committee, and reflections on assurance provided to date

ORAC: why was it established?

The Shrewsbury and Telford Hospital NHS Trust

- The Ockenden Report Assurance Committee is designed to improve accountability and transparency.

  - ✓ Provides dedicated time, specific to the completion of Ockenden Actions.
  - ✓ Is a subcommittee of the Board of Directors.
  - ✓ Has an independent co-chair (alongside the Trust's Chair).
  - ✓ Ensures stakeholder involvement:
    - Maternity Voices Partnership
    - Healthwatch
    - Local Maternity and Neonatal System and Clinical Commissioning Group
    - Sherwood Forest Hospitals NHS Foundation Trust
    - Richard Kennedy – Associate Medical Director, NHSE/I Midlands Region
  - ✓ Is live-streamed to the public.
  - ✓ Invites questions from the public.

- Five ORAC meetings have been held so far, with this being the 6th Meeting.

ORAC: Topics discussed so far

The Shrewsbury and Telford Hospital NHS Trust

Month	Topic	Presenter(s)
25 March 2021	• LAFL Theme 1: Maternity Care	Dr Mei-See Hon Mr Martyn Underwood
22 April 2021	• IEA 1: Enhanced Safety • LAFL Theme 2: Maternal Deaths • LAFL Theme 4: Neonatal Services	Dr Mei-See Hon Mr Martyn Underwood
27 May 2021	• Review of the Ockenden Report Action Plan and current progress status • IEA 2: Listening to Women and Families • IEA 3: Staff Training and Working Together • IEA 4: Managing Complex Pregnancies • IEA 5: Risk Assessment Throughout Pregnancy • IEA 6: Managing Complex Pregnancies • IEA 7: Informed Consent	Mr Guy Calcott
24 June 2021	• Saving Babies' Lives (LAFL 4.57) : Background and SaTH's progress in implementing the Care Bundle	Ms Lindsey Reid Mr Guy Calcott
22 July 2021	• Obstetric Anaesthesia	Dr Lorien Branfield

Tangible benefits so far delivered as a result of implementing the Ockenden Report's actions

LAFL Theme 1 – Maternity Care

- ✓ Clinical Referral Team established.
- ✓ Updated birth information introduced.
- ✓ Two fetal monitoring champion midwives brought into post.
- ✓ Full delivery of Saving Babies' Lives care bundle.
- ✓ Cardio Tocography (CTG) guidelines validated by Clinical Network and audit completed to prove compliance.
- ✓ Partnered Clinical Governance review started, and three additional specialist midwives recruited to the team (in post in next few weeks).
- ✓ Multi-disciplinary twice-daily ward rounds are in place.

LAFL Theme 2 – Maternal Deaths

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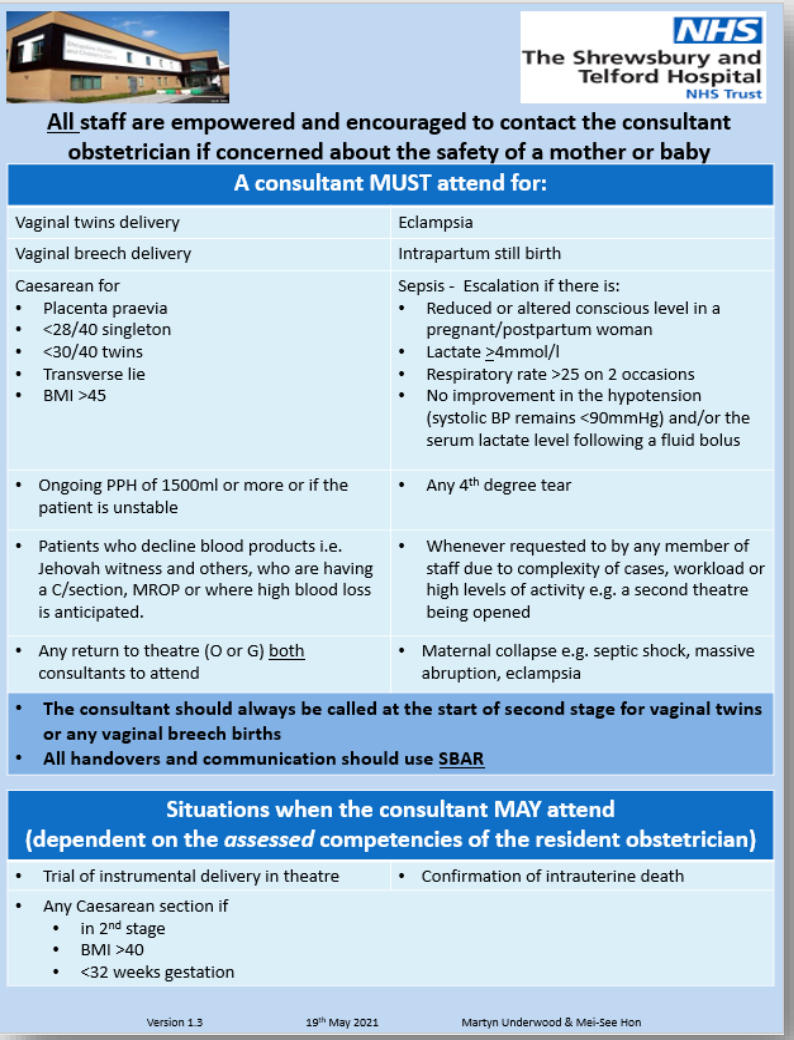

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All staff are empowered and encouraged to contact the consultant obstetrician if concerned about the safety of a mother or baby

A consultant MUST attend for:	
Vaginal twins delivery	Eclampsia
Vaginal breech delivery	Intrapartum still birth
Caesarean for • Placenta praevia • <28/40 singleton • <30/40 twins • Transverse lie • BMI >45	Sepsis - Escalation if there is: • Reduced or altered conscious level in a pregnant/postpartum woman • Lactate ≥4mmol/l • Respiratory rate >25 on 2 occasions • No improvement in the hypotension (systolic BP remains <90mmHg) and/or the serum lactate level following a fluid bolus
• Ongoing PPH of 1500ml or more or if the patient is unstable	• Any 4th degree tear
• Patients who decline blood products i.e. Jehovah witness and others, who are having a C/section, MROP or where high blood loss is anticipated.	• Whenever requested to by any member of staff due to complexity of cases, workload or high levels of activity e.g. a second theatre being opened
• Any return to theatre (O or G) both consultants to attend	• Maternal collapse e.g. septic shock, massive abruption, eclampsia
• **The consultant should always be called at the start of second stage for vaginal twins or any vaginal breech births** • **All handovers and communication should use SBAR**	
Situations when the consultant MAY attend (dependent on the *assessed* competencies of the resident obstetrician)	
• Trial of instrumental delivery in theatre	• Confirmation of intrauterine death
• Any Caesarean section if • in 2nd stage • BMI >40 • <32 weeks gestation	

Version 1.3 19th May 2021 Martyn Underwood & Mei-See Hon

- ✓ Escalation policy for junior obstetric staff and midwives on when to involve the consultant have been updated.
- ✓ Engagement with the soon-to-be-established specialist maternal medicine centres is in place and will inform referral pathways.
- ✓ More than 100 midwife and obstetrician places secured (25 booked for November) in Baby Lifeline's 'Recognition and Management of the Sick and Deteriorating Woman' course.

LAFL Theme 3 – Obstetric Anaesthesia

- ✓ Anaesthetists involved in the multi-disciplinary ward rounds.
- ✓ Obstetric Anaesthetic lead playing key role in development of ‘enhanced maternity care’ proposal and guideline.
- ✓ Anaesthetic audit requirements included in the bespoke Ockenden Report case notes audit tool (LAFL 4.89).
- ✓ Anaesthetic consultants >90% compliance with online PROMPT training achieved.
- ✓ Multi-disciplinary skills-drills and simulation training taking place.
- ✓ Evidenced compliance with anaesthetics-related sections of Clinical Negligence Scheme for Trusts Safety Action 8.

Colleague Name – Obstetric Anaesthetist

LAFL Theme 4 – Neonatal Service

Dr Sanjeev Deshpande – Clinical Director, Neonatal Unit

- ✓ Combined nursing and medical notes implemented.
- ✓ 7th consultant recruited; intended start date of January 2022.
- ✓ Rotational attachments to tertiary units to commence in October 2021.
- ✓ Escalation policy to tertiary units in line with Neonatal Operational Delivery Network, British Association of Perinatal Medicine and NHSE guidelines; externally checked and validated (by NHSE/I regional colleagues).

IEA Theme 1 – Enhanced Safety and IEA 2 – Listening to women & families

Ms Emily Evans – MVP Chair

IEA 1

- Audit confirms appropriate involvement of external experts in investigations.
- Strong links with LMNS/CCG include membership of Senior Quality Lead and Patient Safety Specialist in SaTH's Maternity & Neonatal Safety Champions Group.

IEA 2

- Maternity Voice Partners (MVP)-SaTH co-produced 'User Experience (UX) System' now in its second cycle with more than 80 inputs received from staff and service users.
- Active Non-Executive Director and Board-level Executive participation in Safety Champions group.
- Improvements underway to SaTH's digital offering.

IEA Theme 3 – Staff training together and working together

IEA 3

- ✓ LMNS-funded £360k investment includes simulation kit for multi-disciplinary training – significant quantity already acquired.
- ✓ SaTH investment of £190k in external training, including management of sick/deteriorating women, learning from adverse events, CTG masterclass and more. Multiple places already booked / attended.
- ✓ PROMPT yearly package, including ‘train-the-trainer’ acquired.
- ✓ Ring-fenced funding for MDT and EFM training.

Mr William Parry-Smith
Consultant, Obstetrics and Gynaecology

IEA Theme 4 – Managing Complex Pregnancies & IEA Theme 5 – Risk Assessment throughout Pregnancy

IEA 4

- ✓ Recruitment of eight additional obstetric consultants – six in post, two more yet to be appointed – with the aim of providing 24/7 residential consultants.
- ✓ Ongoing liaison with new regional specialist maternal medicine centres to inform referral pathways.
- ✓ SaTH successful early adopter of Perinatal Mental Healthcare Clinic; successful bid and ongoing rollout achieved by Transformation Midwife.

IEA 5

- ✓ Bespoke audit tool in development to monitor compliance with risk assessment processes at antenatal appointments and during intrapartum phase.
- ✓ First bookings commenced via Badgernet EPR system in August 2021.

Dr Mei-See Hon
Clinical Director, Obstetrics

IEA Theme 6 – Monitoring Fetal Wellbeing

Ms Becky (Surname)
Midwife

IEA 6

- ✓ Named consultant plus two specialist midwife champions in post.
- ✓ Active delivery of training and improving practice.
- ✓ Multiple places booked for clinical staff on Baby Lifeline's 'CTG Masterclass' course.
- ✓ Ongoing audits of compliance with CTG guidelines.

IEA Theme 7 – Informed Consent

IEA 7

- ✓ Promotion of BabyBuddy app v2.0 in partnership with MVP; co-production of ‘My Personal Care and Support Plan’
- ✓ Co-produced MVP / SaTH ‘User Experience (UX) System’ yielding significant service user and staff input
- ✓ New Badgernet system is providing digitalised content and provides prompts where information has not been accessed, triggering staff to offer additional support
- ✓ Birth Options clinic up and running

Actions currently off-track

Actions that have missed their (internally imposed) deadlines, the reasons for this delay, the mitigations put in place and the plans to get them back on track

Actions Currently Off-track (1 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description	Reason for delay	Mitigation / Recovery Plan
LAFL 4.59	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	Recent staff turnover in the divisional clinical governance team put back the delivery of this action.	The Trust has appointed a new Head of Clinical Governance. The divisional Clinical Governance team has appointed a new Risk and Governance lead midwife, with two specialist deputies – funded by NHSE/I.

Actions Currently Off-track (2 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description	Reason for delay	Mitigation / Recovery Plan
LAFL 4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	The initial internally-set deadline for this action did not allow for the complexity of its implementation.	SaTH is compliant with Safety Action 1 of CNST and working towards full compliance with Safety Action 10. The divisional clinical governance team has been enhanced with the inclusion of three specialist midwives. A governance review, partnered with Sherwood Forest Hospitals NHS Foundation Trust is underway.

Note: LAFL 4.73 is also Off Track: this is covered in the 'External Dependencies' section of this presentation.

Next steps

Next steps

The Shrewsbury and Telford Hospital NHS Trust

Milestone	Area affected	Date
Completion amendments to the Case Notes Audit tool, and launch second audit round	All workstreams	Oct 2021
Implementation of split Tier 2 rotation and first round of observational attachments at Tier 3 Units Oct	Neonatal staff	Oct 2021
Sands review, to inform National Bereavement Care Pathway adoption	Bereavement Care	Nov 2021
Prepare to receive and plan the implementation of the Final Ockenden Report	All workstreams	Winter 2021
Review of Ockenden actions related to integration of Obstetric Anaesthesia in wider maternity team, to test level of completion	Obstetric Anaesthesia	Mar 2022
Evidenced completion of the partnered Governance Review	Governance & Risk	Spring 2022

Ockenden Actions with external dependencies

These actions are not within SaTH's control to implement independently.

Further clarity / action is needed from external parties in order to proceed.

Any sub-actions that can be completed internally, are underway

Ockenden Actions with External Dependencies (1 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description
LAFL 4.73	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.
IEA 1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.
IEA 1.4	An LMS cannot function as one maternity service only.
IEA 2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

Ockenden Actions with External Dependencies (2 of 2)

Reference	Description
IEA 2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
IEA 2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.
IEA 4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.

Thank you