Ockenden Report Assurance Committee (ORAC)

Position of the 210 Ockenden Report Actions

JULY 2023

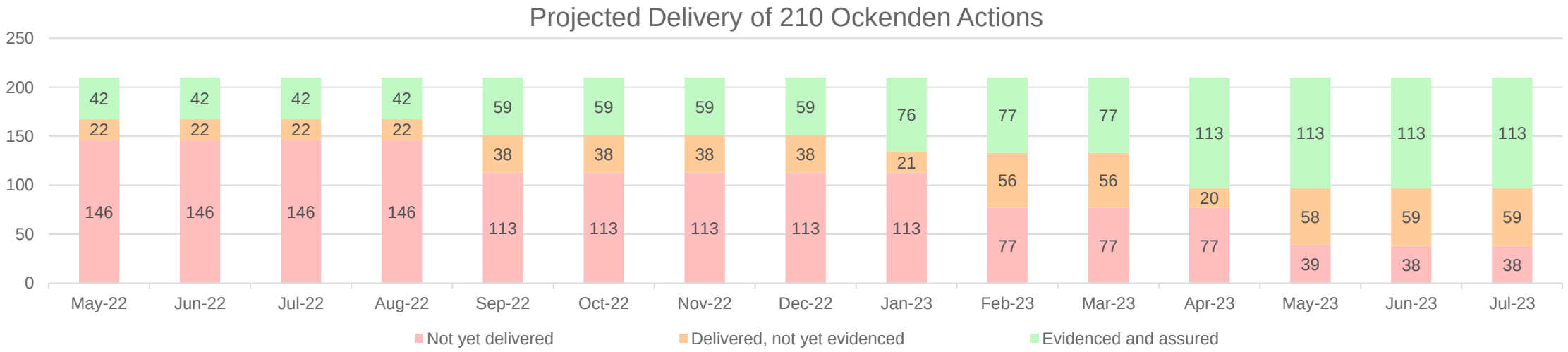
Presenter:

- Annemarie Lawrence – Director of Midwifery

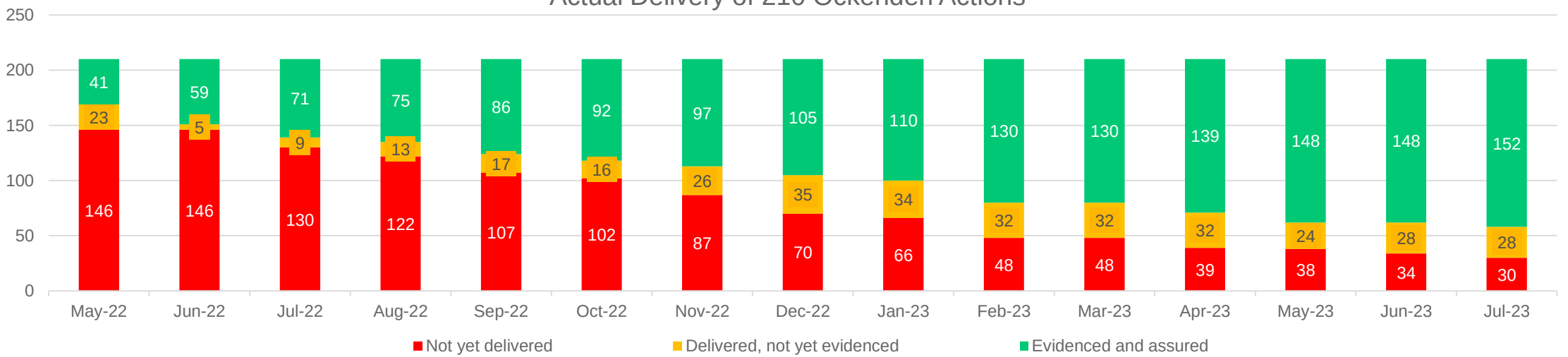
Delivery against Actions from the Ockenden Reports (First and Final)

Assurance: Projected vs. Actual Delivery

The Shrewsbury and Telford Hospital NHS Trust



Position as of Jul-23 MTAC (11.07.23)



Ockenden Actions – Completion Batteries

Ockenden Reports - Completion Rates

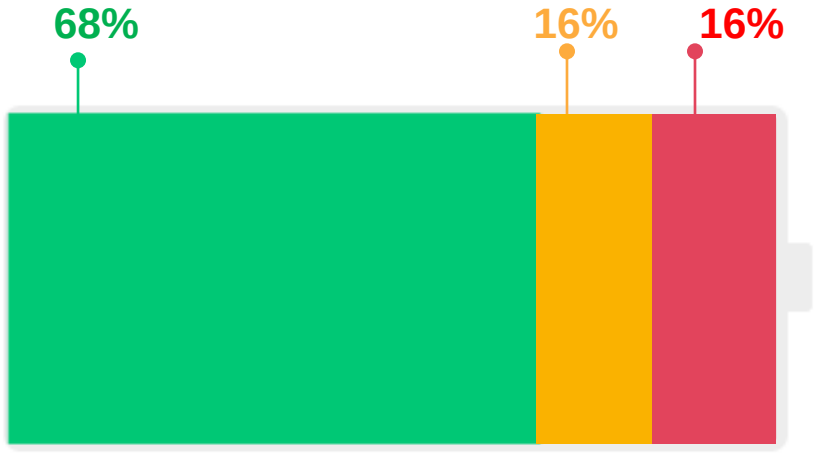
The Shrewsbury and Telford Hospital NHS Trust

First Report - Delivery Battery

47/52 Actions Implemented (90% overall):

- 45 actions (87%) ‘Evidenced & Assured’
- 2 actions (3%) ‘Delivered, Not Yet Evidenced’
- 5 actions (10%) ‘Not Yet Delivered’

Final Report - Delivery Battery



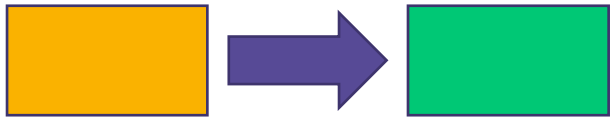
133/158 Actions Implemented (84% overall):

- 107 actions (68%) ‘Evidenced and Assured’
- 26 actions (16%) ‘Delivered, Not Yet Evidenced’
- 25 actions (16%) ‘Not Yet Delivered’

Position as of Jun-23 MTAC (13.06.23)

First Ockenden Report – Status Change Proposals Approved at July-23 MTAC

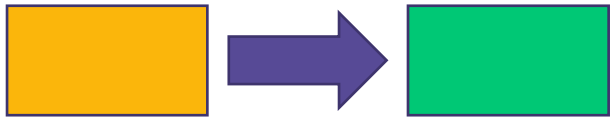
Actions proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description		Evidence
LAFL 4.88	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.		Updated Calling on a Consultant SOP
			Updated Escalation Guidelines
			Guidelines included in Induction
			Audit demonstrating compliance

Actions proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

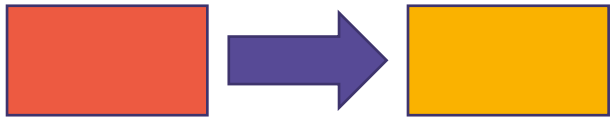
ID	Description		Evidence
IEA 4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.		Maternal medicine centres up and running
			Referral to the Maternal Medicine Network guideline – demonstrating that the process is set up

Note: The regional criteria and process for referral to a specialist centre has only just been published in the last month, and only 1 case has met the criteria for referral. Therefore, we propose the system to be audited in 12 months-time to be of more value – This can be incorporated into the MTAT.

MTPG is confident that there is sufficient assurance evidence to satisfy IEA 4.3 to be ‘green’.

Final Ockenden Report – Status Change Proposals Approved at July-23 MTAC

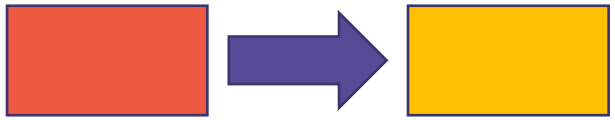
Actions proposed to ‘go amber’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
IEA 1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Gap analysis Strategy paper
IEA 7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMNS.	PROMPT Training content includes Human Factors and Civility Civility Training Content LMNS colleagues part of faculty meeting where training is agreed PROMPT Compliance (>90% - CNST) Civility Training Compliance (>90% for non clinical staff)

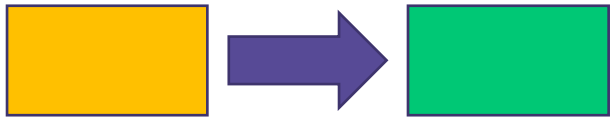
Actions proposed to ‘go amber’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
LAFL 14.12	The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.	Workshop held with MVP re family engagement with incident investigations Minutes and Action plan produced following workshop Example of improvement made via MVP co-production – Duty of Candour Letter Action plan fully implemented
LAFL 14.50	In view of the relatively high number of direct maternal deaths, the Trust’s current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.	Relationship with external units established PROMPT review reports PROMPT review presentation to LMNS LMNS monitoring process

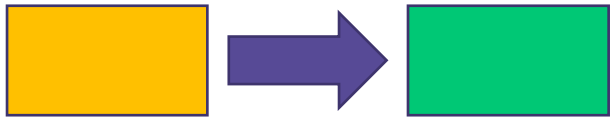
Actions proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
LAFL 14.40	The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.	Coordinators Development Programme including: - Behaviours and Value training - Roles and Responsibilities Standardised 360 Assessments undertaken Preceptee feedback

Actions proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
LAFL 14.44	All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care	FTSU summary report for Maternity Maternity and Neonatal Safety Champions AAAA and TOR Conflict of Clinical Opinion policy PMA Quarterly Report DOM drop in invite list Staff Survey Results Summary

Descoped Actions Quarterly Review (Jul-23) presented at Jul-23 MTAC

Next review due in Oct-23

De-scoped actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Status	Position
IEA 2.4 (First report)	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.	De-scoped	Remains the same (CQC and National MVP)
IEA 1.1 (Final report)	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	De-scoped	Remains the same (External funding)
IEA 1.4 (Final report)	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH	De-scoped	Remains the same (National bodies)
IEA 1.7 (Final report)	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	De-scoped	Remains the same (Nationally recognised module)

De-scoped actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Status	Position
IEA 1.11 (Final report)	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	De-scoped	Remains the same (External training programme)
IEA 6.1 (Final report)	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings. NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death	De-scoped	Remains the same (NHSEI, Royal colleges and chief coroner)
IEA 11.4 (Final report)	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	De-scoped	Remains the same (Resources from anaesthetic bodies)
IEA 14.5 (Final report)	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace. Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	De-scoped	Remains the same (Neonatal network)

De-scoped actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Status	Position
LAFL 14.1 (Final report)	Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.	De-scoped	Remains the same (PSIRF)
LAFL 14.64 (Final report)	There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.	De-scoped	Remains the same (External funding)

Position Statements

Summary

The Shrewsbury and Telford Hospital NHS Trust

- Over the coming months, our focus will be on those larger, more complex actions, that we now need to deliver
- We are ahead of schedule for delivery and have focused on those with higher risk scores initially, as part of our prioritisation process
- The Divisions can provide assurance that work continues at pace to deliver the rest of the programme

First Report

- 47/52 actions ‘Delivered’ (90%). We are carrying out audits to ensure that the actions rated as green-green, sustain those ratings
- 5 actions ‘Not Yet Delivered’, 4 lying outside of SaTH’s direct control (external dependency linked to LMNS, CQC and NHSEI)

Final Report

- 133/158 actions ‘Delivered’ (84%). From the 16% ‘not yet delivered’, over two thirds of these are underway

Summary of Improvements made from the Ockenden Reports

First Ockenden Report Summary of Improvements: IEAs

The Shrewsbury and Telford Hospital NHS Trust

IEA 1: Safety	IEA 2: Women's voice	IEA 3: Learning	IEA 4: Complex Pregnancies	IEA 5: Risk Assessments	IEA 6: Fetal Monitoring	IEA 7: Informed Consent
Data/ Dashboards	Maternity Voice Partnership (MVP)	Training	Clear Pathways	Personalised Care Meetings	Fetal Monitoring Leads and Training	Accurate information
○ Dashboard/ Data sharing ○ Robust reporting for data oversight/ sharing ○ LMNS Buddying up agreement ○ SI reports shared with LMNS	○ Independent Senior Advocate Role created ○ NED co-chairing safety champions ○ CQC working with MVP	○ PROMPT training ○ Multidisciplinary Ward rounds ○ Funding allocated strictly for training ○ Incidents investigated and learning shared timely	○ Named consultant leads ○ Guidelines benchmarked against National standards ○ Clinical risk assessments at every appointment ○ Maternal medicine specialist clinics in place	○ Use of Badgernet standardising risk assessment ○ Personalised care planning meetings for individualised care ○ Clear pathways for changes in risk assessment	○ Fetal monitoring leads in place ○ Mandatory Electronic Fetal monitoring training ○ Evidenced delivery of saving babies lives care bundle v2	○ Information leaflets and website updated ○ Maternity personalised care and support planning meeting ○ Birth Preferences Cards produced

First Ockenden Report Summary of Improvements: LAFLs

The Shrewsbury and Telford Hospital NHS Trust

Theme 1: Maternity Care

Specific Improvements

- Accurate information provided (leaflets, website, videos, etc.)
- Clinical governance team well-resourced
- Consultant-led ward rounds
- Lead midwife and obstetrician for bereavement care
- National Bereavement care pathway adopted

Theme 2: Maternal Death

Avoiding Maternal Death

- Audits against escalation policy
- Women with pre-existing co-morbidities seen by specialist MDT
- Named consultant for high-risk women
- Early referrals to Maternal Medicine Specialist Centre
- All guidelines benchmarked against National standards

Theme 3: Obstetric Anaesthesia

Anaesthetic Improvements

- PROMPT attendance and teaching
- Ward round attendance
- Guidelines reviewed and audited
- Escalation to the on-call consultant guideline Quality improvement methods in place to improve service
- Learning from incident investigations alongside maternity colleagues

Theme 4: Neonatal Services

Neonatal Service Improvements

- Neonatologists and ANNPs visiting other NICUs for learning
- Medical and Nursing notes combined
- Neonatal exception reports shared with Network
- Business case produced to align with BAPM standards

Final Ockenden Report Summary of Improvements: IEAs & LAFLs

The Shrewsbury and Telford Hospital NHS Trust

Pillar 1: Antenatal care	Pillar 2: Intrapartum care	Pillar 3: Postnatal care	Pillar 4: Governance	Pillar 5: Workforce	Pillar 6: Learning	Pillar 7: Neonates
Specific Improvements	Specific Improvements	Specific Improvements	Systems and Processes	People and Culture	Training	Accurate information
○ My Birth Place choices leaflet ○ Investment in Diabetes Service ○ Mult. pregnancy specialist recruited ○ Guidelines reviewed: ➢ Multiple Pregnancy ➢ Diabetes ➢ Gestational Hypertension ➢ Preterm Birth ➢ EFM ➢ In Utero Transfer ➢ Fetal Growth Assessment	○ 24/7 consultant presence on labour ward ○ Induction of labour guideline reviewed ○ CTG monitoring in place ○ Staffing papers: red flags and supernumerary status ○ Duty of Candour followed ○ Established to BirthRate Plus	○ Follow up appointments ○ Psychological Support ○ Patient feedback audits ○ 'Pregnant women attending hospital' policy ○ Postnatal readmissions audit ○ National Bereavement Care Pathway followed	○ Named consultant leads ○ Guidelines benchmarked against National standards ○ Clinical risk assessments at every appointment ○ Maternal medicine specialist clinics in place	○ Culture work underway ○ Divisional workforce plan underway ○ DS and Triage coordinator orientation programmes ○ Mentors identified for B7 and above midwives ○ SLT 360 leadership assessments ○ Psychologist Team in place	✓ PROMPT ✓ EFM and emergency skills training ✓ Preceptor programmes ✓ Behaviours and Values training ✓ Civility, human factors and leadership training ✓ Maternity governance lead trained in HF ✓ Complaints handling training	○ Neonatal workforce plan ○ TNA for ANNPs ○ Increase in numbers of Qualified in Speciality Nurses to align with BAPM standards

Thank You. Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

JULY 2023

Informed Consent

Date: 25.07.2023

Presenters:

- Dr. Mei-See Hon – Clinical Director for Obstetrics
- Jo Jaques – Specialist Midwife, Lighthouse Service

Link to Ockenden Actions

From the First Report

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Status
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.	Not Yet Delivered
IEA 7.1	Provide women with accurate & contemporaneous evidence-based info per national guidance. To include all aspects of maternity care throughout antenatal, intrapartum & postnatal periods of care	Evidenced and Assured
IEA 7.2	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.	Evidenced and Assured
IEA 7.3	Women's choices following a shared and informed decision-making process must be respected	Evidenced and Assured
LAFL 4.55	Provide women with accurate, in-date info; enable participation in decision-making & informed choice. Choice must be respected.	Evidenced and Assured

From the Final Report

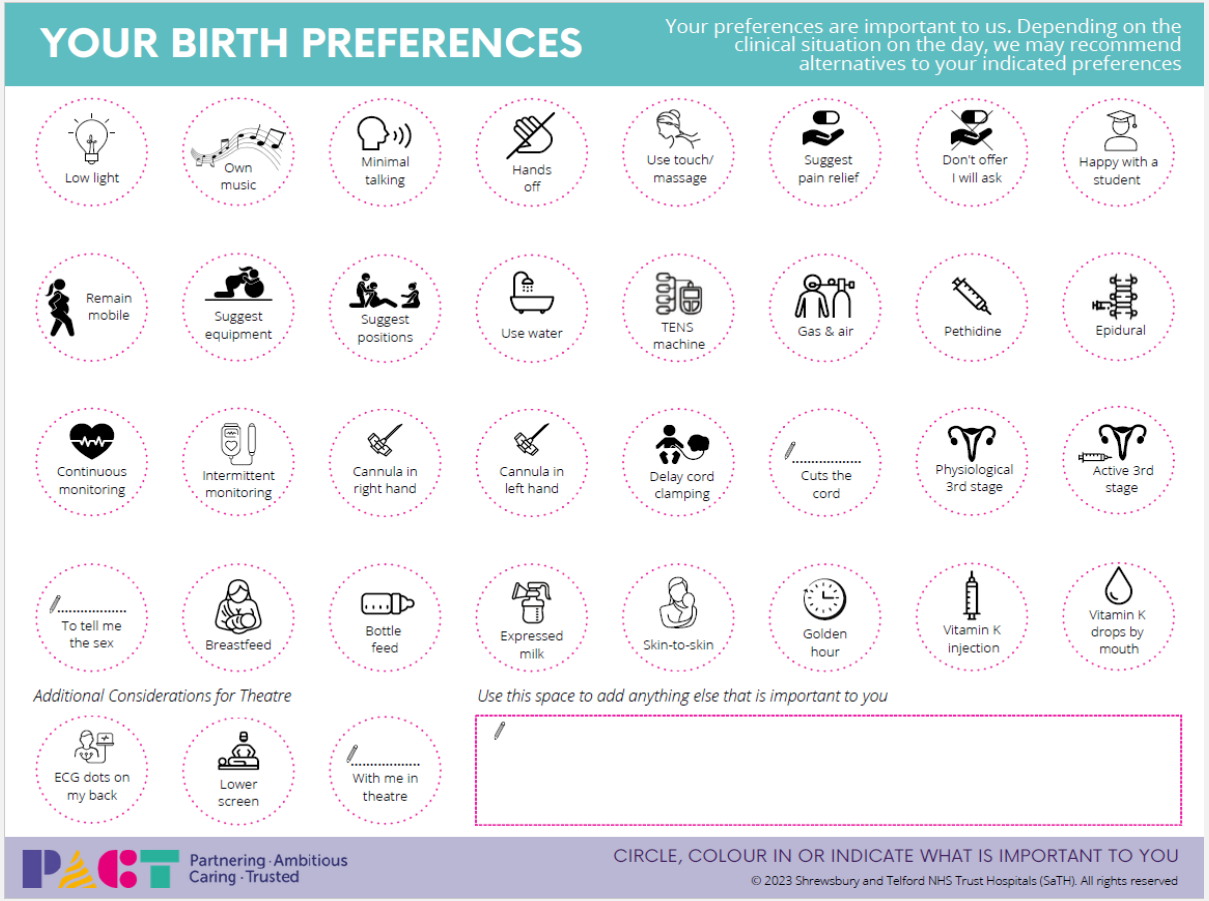
The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Status
IEA 10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Evidenced and Assured
LAFL 14.49	It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.	Evidenced and Assured

Outcomes Linked to Ockenden Actions/ Improvements

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Personalised care planning meetings in place
- ✓ Birth Options Clinic in place
- ✓ Consultant midwife service (birthing outside guidance)
- ✓ Birth preferences card (version 2) in use



Outcomes Linked to Ockenden Actions/ Improvements

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Updated website (New website being built)
- ✓ Induction of Labour Video
- ✓ Updated birth choices leaflet published on badgernet (with transfer times)
- ✓ Comprehensive leaflet library available on Badgernet

Focus on Lighthouse Service and Birth Options Clinic

Maternal Mental Health Service – The Lighthouse Service

The Shrewsbury and Telford Hospital NHS Trust

- A collaborative working partnership between SaTH & MPFT (Midlands Partnership Foundation Trust)
- Provides a tailored package of support, where a range of evidence-based trauma informed psychological interventions are used to support local families

Lighthouse Service Team

- Psychologists
- Psychological Therapists
- Peer support worker
- Specialist Midwife (Jo Jaques)

Lighthouse

Bringing a beacon of hope and healing for families experiencing birth anxiety, birth trauma and pregnancy and neonatal bereavement in Shropshire and Telford & Wrekin

Who to refer

The Shrewsbury and Telford Hospital NHS Trust

A service user, partner or other family member who is experiencing moderate to severe mental health difficulties following:

- a pregnancy or neonatal loss/bereavement
- or traumatic maternity experience occurring in the past 5 years,
- or be experiencing symptoms of tocophobia.

- Service Users must live or be registered with a GP in Shropshire, Telford & Wrekin.

Birth Options Clinic

- The weekly clinic is run by the Consultant Obstetrician and the Specialist Midwife
- The clinic is committed to supporting women's choices
- There is a close link with the Lighthouse service ie: tocophobia, birth trauma and loss (Rainbow clinic)
- Collaborative working to:
  - ✓ Formulate individualised birth plans
  - ✓ Recognise and plan for triggers
  - ✓ Control what can be controlled
  - ✓ Acknowledge psychological indications

Service User Feedback

Permission given by the service users for stories to be used and videos to be produced for this presentation

Anonymised Service User Story

Jess' Story

Summary and Next Steps

Summary and Next Steps

The Shrewsbury and Telford Hospital NHS Trust

- We have delivered all of the Ockenden actions linked to informed consent, and remain focused on ensuring that the green actions remain ‘evidenced and assured’
- However, we acknowledge that there is still work to do to ensure continuous improvement (e.g., new website)
- Next steps are being explored as to the feasibility of expanding the Birth Options Clinic
- The team remains determined and motivated to continue to improve the services to deliver high quality care

Thank you. Any questions?