

# Ockenden Assurance Committee

## Local Actions for Learning (LAFL)

### Theme 1: Maternity Care (13 Actions)

Date: 25<sup>th</sup> March 2021

Presenters:

**Dr Mei-See Hon,**

Clinical Director, Maternity Services

**Mr Martyn Underwood,**

Medical Director, Women and Children's Division



# LAFL Theme 1: Maternity Care (1 of 13)

## 4.54 – A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate

- Delivered, Not Yet Evidenced
- On track
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021

### Risks to delivery

- Any delays to Badgernet rollout will hamper our ability to digitalise the process

### Summary:

- ✓ RAST disbanded and Clinical Referral Team established to ensure referral to correct pathway.
- ✓ Risk assessment completed at each antenatal appointment
- Carry out audit of compliance
- Further checks to ensure ongoing assessment and re-assessment incl. during labour. Design method to measure and audit this.
- Confirmation that assessment has been made will be a compulsory field in Badgernet

# LAFL Theme 1: Maternity Care (2 of 13)

**4.55 – All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women’s Choices following a shared decision-making process must be respected.**

- Not Yet Delivered
- On track
- Due to be in place by 31/03/2021 and evidenced by late summer

## Summary

- ✓ Provision of videos and leaflets on SaTH website
- ✓ Provision of on-line antenatal classes
- ✓ BabyBuddy App available and promoted (including new business cards with QR links to relevant info)
- ✓ Roll out of redesigned Personalised Care and Support Plan records
- ✓ MDT place of birth meeting held monthly and minuted
- Digitisation of Handheld Notes (Badgernet)
- Method to be introduced to confirm mother's understanding / receipt of info.

# LAFL Theme 1: Maternity Care (3 of 13)

**4.56 The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.**

- Not Yet Delivered
- On track
- Due to be in place by 30/06/2021 and evidenced by 31/08/2021

## **Risks to delivery**

1. We may not find a midwife who has the appropriate experience.
2. Risk of funding not being allocated (business case has been submitted to Innovation and Investments Committee, due to be discussed 9th April)

## **Summary**

- ✓ Lead obstetrician in post
- ✓ Post for substantive midwife advertised
- Confirmation of appropriate training to be evidenced (target date: June-August 2021)
- Long term funding for the midwife post is to be sourced (see second risk outlined above)

# LAFL Theme 1: Maternity Care (4 of 13)

**4.57** These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.

- Not Yet Delivered
- On track
- Due to be in place by 30/06/2021 and evidenced by 15/07/2021

## Summary

- ✓ Elements 1.5, 1.7, 1.8, 2.3, 2.5, 2.6, 2.7, 2.8, 2.10, 2.11, 2.15 and 2.16 were moved from 'Not Yet Delivered' to 'Delivered, Not Yet Evidenced' status during March 2021
- Elements 2.4, 3.4, 3.5, 4.1, 4.7, and 5.17 are due to be moved to 'Delivered, Not Yet Evidenced' status during the next reporting period.
- Peer review to be undertaken with regional maternity network, and partnering with Sherwood Forest Hospital (SFH)
- All elements not yet validated to 'evidenced and assured' status will be reviewed by the appropriate forum during Spring and early Summer.
- Plan to lead on the development of a West Midlands dashboard and database of good practice for SBL.

# LAFL Theme 1: Maternity Care (5 of 13)

**4.58 Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.**

- Not Yet Delivered
- On track
- Due to be in place by 30/04/2021 and evidenced by 30/06/2021

## Summary

- ✓ FIGO (International Federation of Gynaecology and Obstetrics) guidelines implemented (as opposed to NICE and supported by NHSI/E improvement advisor in 2019, prior to implementation in 2020).
- ✓ The guidelines have been validated by CQRM & CCG
- SATH Fetal Monitoring guideline, approved by the Clinical Network, recommends that there should be further internal review given the action for the report. This is being progressed:
- FIGO guidelines have been presented to MQOC in March meeting, and will be presented to QSAC week beginning 29 March
- Audit tasks to evidence this action have been agreed, including confirmation that EFM continues during insertion of epidural and mobilising.

# LAFL Theme 1: Maternity Care (6 of 13)

**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.**

- Not Yet Delivered
- On track
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021

## Summary

- Review of Governance Structure is underway
- New associate director of governance recruited in order to conduct a gap analysis of our governance structures and identify any changes that are required

# LAFL Theme 1: Maternity Care (7 of 13)

**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.**

- Not Yet Delivered
- On track
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021

## **Summary**

- Review risk meeting structure to conduct review of incidents
- Introduce new oversight group - Divisional Oversight Group
- Provide SOP / ToR for the group



# LAFL Theme 1: Maternity Care (8 of 13)

## 4.61 Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.

- Not yet delivered
- On track
- Due to be in place by 31/03/2021 and evidence by 31/05/2021

### Summary

- ✓ Checked Clinical Risk Assessment Guideline and Operational Policy for Delivery Suite
- ✓ Guideline recently updated; evidence of this will be appended to the Ockenden Report Action Plan. (CRT) – this links in with ward rounds mentioned at LAFL 4.62
- Conduct audit to check whether consultant obstetricians are involved in 100% of complex pregnancies

# LAFL Theme 1: Maternity Care (9 of 13)

**4.62 There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.**

- Not yet delivered
- On track
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021

## Summary

- ✓ Consultant ward rounds at 08:30 and 20:30 in place 7 days per week since September 2019; handover sheets in place; weekly MDT in-situ simulation training in place.
- ✓ Current simulation training package under review.
- In situ training to be formally recorded
- Purchase of PROMPT training simulators for in-situ training, including out-of-hours
- Anaesthetic guidelines to be updated to specify participation in ward rounds

# LAFL Theme 1: Maternity Care (10 of 13)

**4.63 Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.**

- Delivered, Not Yet Evidenced
- On track
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021

## **Summary**

- ✓ Every patient, regardless of complexity, is already reviewed daily on the consultant-led ward round
- ✓ We have a mechanism for patients who require review on the Postnatal ward, and a daily ward round for those patients with complex cases takes place.
- The attendance registers of the daily PN consultants board round huddles are being scrutinised to audit adherence to this
- Need to be able to provide on-going evidence
- Retrospective audit of notes and ongoing audit to be conducted.

# LAFL Theme 1: Maternity Care (11 of 13)

**4.64 The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.**

- Not Yet Delivered
- On track
- Due to be in place by 30/04/2021 and evidenced by 30/06/2021

## Summary

- ✓ 4-hourly reviews implemented.
- ✓ Immediate audit of 10 cases underway and due for completion this month.
- SOP for documentation of obstetric reviews to be developed.
- Guideline to be enhanced beyond required standards, e.g. 4 hourly review by doctor if oxytocin is being used. Standard operating process for documentation of obstetric reviews to be developed.
- Updated guidance to go to guidelines committee for ratification
- Audit of adherence to new guidelines

# LAFL Theme 1: Maternity Care (12 of 13)

**4.65 The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.**

- Not Yet Delivered
- On track
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021

## Summary

- ✓ Two bereavement midwives now in place. Business case submitted for additional 90 hrs of consultant time for delivery of bereavement care.
- ✓ Second midwife appointed
- ✓ Appoint obstetrician to co-lead on bereavement care: business case submitted for additional 90 hrs of consultant time plus SPA time for delivery of bereavement care

# LAFL Theme 1: Maternity Care (13 of 13)

## 4.66 The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

- Not Yet Delivered
- On track
- Due to be in place by 30/06/2021 and evidenced by 31/08/2021

### Summary

- ✓ Bereavement pathway adopted partially and commitment in place to embed it fully. Implemented the maternity bereavement experience measure.
- ✓ Delivery of the NBCP is on track
- ✓ In addition, the Trust is working on Stillbirth and Neonatal Death Society (SANDS) online training modules - clinical staff have begun this training. Some interactive SANDS training was begun before the release of the Ockenden Report.
- Provide evidence of training modules completion rates
- SANDS review had been scheduled for February 2021, now postponed due to Covid.