The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Ockenden Report Action Progress

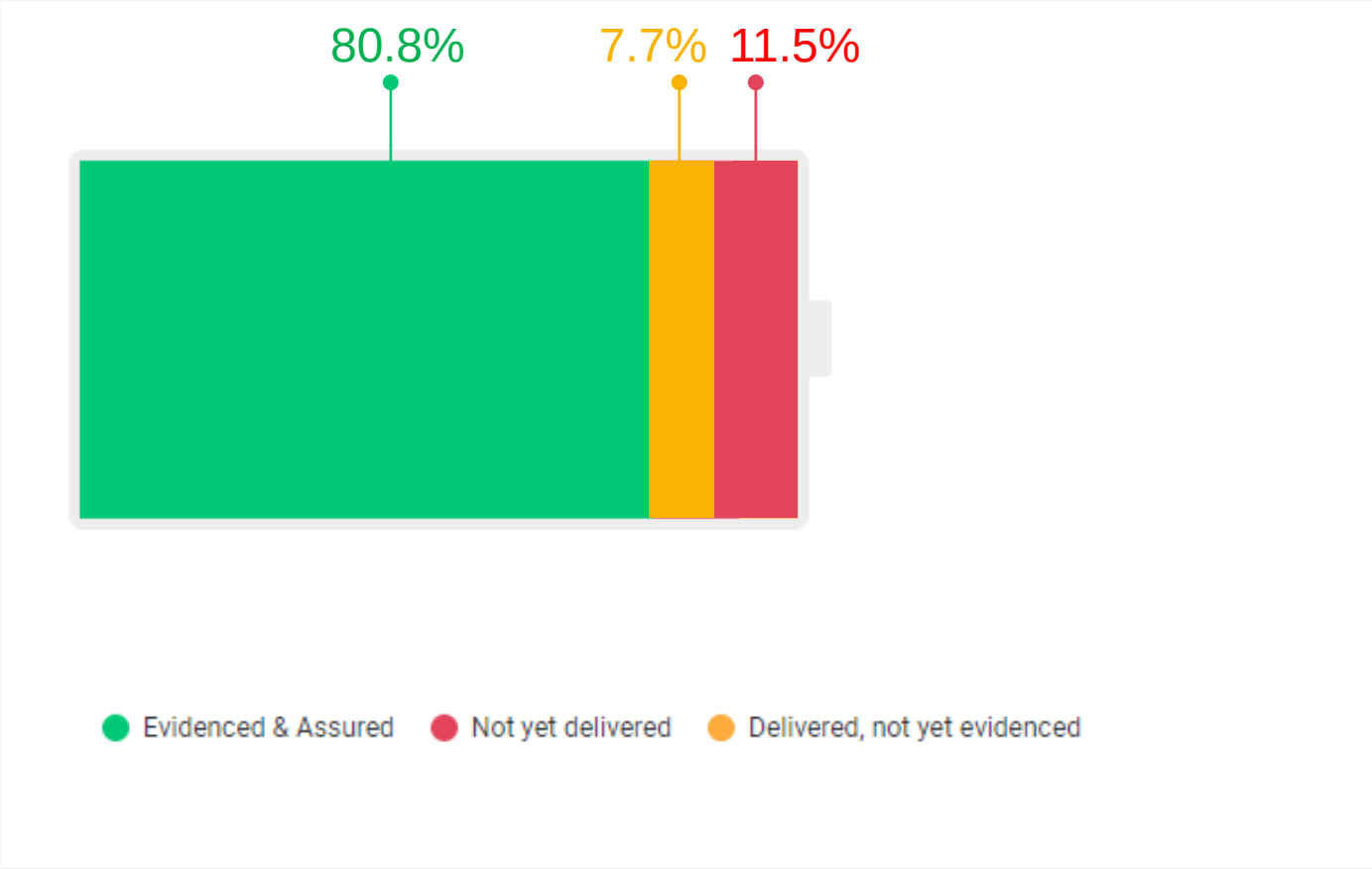
Date: 19.07.2022

Presenter:

- Annemarie Lawrence – Director of Midwifery

Ockenden action plan (1st report) – completion rates

Completion battery: Ockenden I actions



Progress the same as last month

46/52 Actions Implemented (88.5% overall), comprising:

- 42 (80.8%) Evidenced & Assured
- 4 (7.7%) Delivered, Not Yet Evidenced

6 (11.5%) Actions ‘not yet delivered’. Of these 5 are ‘on track’ and 1 is ‘off track’.

‘Not Yet Delivered’ (Red) Actions

The Shrewsbury and Telford Hospital NHS Trust

Action	Dependency	Reasons	Due date
LAFL 4.73	External	National/ regional dependency on the establishment of the Maternal Medicine Specialist Centres (go live date: April-22)	Oct-22
IEA 1.4	External	The action states that ‘an LMNS cannot function as one maternity service only’. LMNS colleagues to present updated exception report at August 2022 MTAC	Apr-22
IEA 2.1	External	This action relates to Trusts creating an independent senior advocate role which reports to both the Trust and the LMNS Boards. These roles are being developed, defined and recruited nationally. It is understood that this process in underway.	TBC
IEA 2.2	External	The action states that 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. Once in post, methodology for this is to be developed. Action linked to 2.1.	TBC
IEA 2.4	External	This action indicates that CQC inspections must include an assessment of whether womens’ voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership (MVP). The rests with the CQC to deliver.	Mar-22
IEA 4.3	External	National/ regional dependency on the establishment of the Maternal Medicine Specialist Centres (go live date: April-22)	Oct-22

Note: Action 1.4 ‘off track’. LMNS colleagues to present exception report to Aug MTAC

‘Delivered, not yet Evidenced’ (Amber) Actions

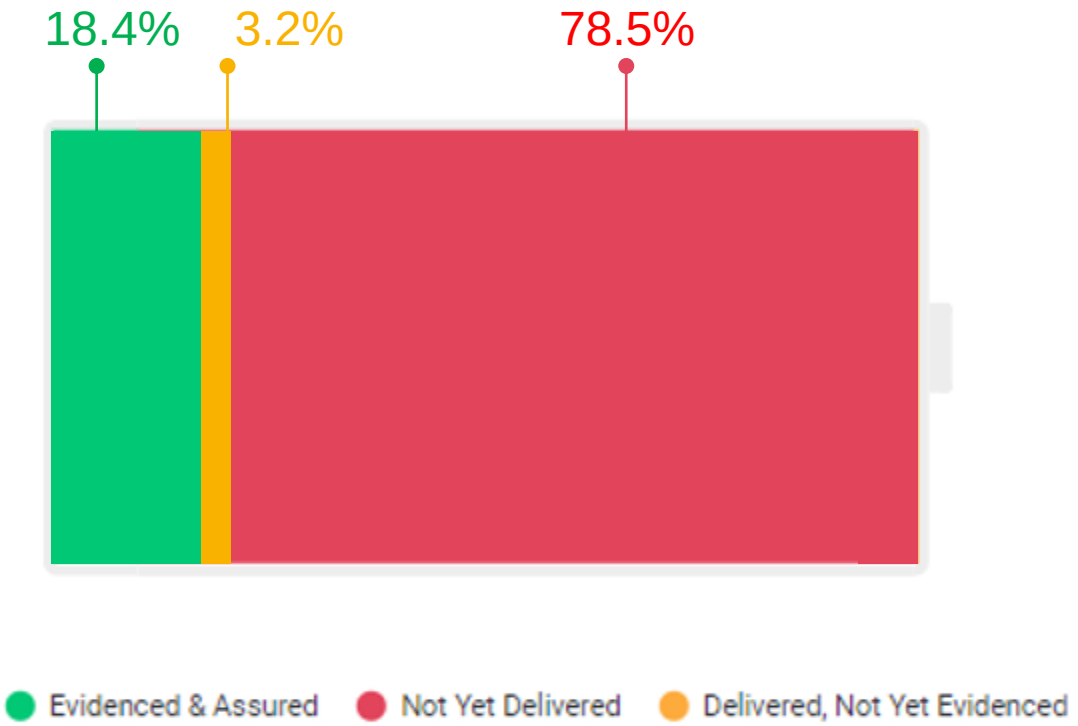
The Shrewsbury and Telford Hospital NHS Trust

Action	Dependency	Reasons	Due date
LAFL 4.87	Internal	Obstetric anaesthesia action. Review of current clinical guidelines to ensure best practice, and adherence, audits and training to teams. Guidelines have been reviewed and updated, audits are underway. Action on Track for October 2022.	Oct-22
LAFL 4.88	Internal	Obstetric anaesthesia action. Review of existing guidelines for escalation to the consultant on-call. The guideline was updated to include the phrase ‘…the consultant should attend’. However caused dismay amongst some anaesthesia consultants who felt this could put them in an unfair situation if they are tending to another (non-maternity) patient at the time. MTAC requested to approve a deadline extension to Dec-2022 to allow time for the Surgery, Anaesthesia and Cancer division to resolve the rota issue. Action on track for December 2022.	Dec-22
LAFL 4.89	Internal	Obstetric anaesthesia action. Quality improvement methodology used to audit and improve clinical performance of obstetric anaesthesia services. Although much audit and QI work has been conducted in connection with this guideline, there is currently insufficient evidence of this having used ‘approved QI’ techniques, this will go into workstream 7. Action on track for October 2022.	Oct-22
LAFL 4.100	Internal	Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit. Although this has been achieved for Neonatal Consultants, there are currently too few ANNPs to allow these staff to be freed up for attachments at other units. Action on Track for October 2022.	Oct-22

Note: New anaesthetics workstream devised to ensure embedding of Anaesthetic related actions

Ockenden action plan (final report) – completion rates

Final Ockenden report actions: Delivery



- 29 actions (18%) green – ‘Evidenced and Assured’
- 5 actions (3%) amber – ‘Delivered not yet evidenced’

21% implemented (34 actions) as of 12.07.22

Timeline of events since publication of final report

Timeline of events

The Shrewsbury and Telford Hospital NHS Trust

30.03.22 — Final Ockenden report published

Support to staff and families

05.04.22 — MDT Lessons Learnt exercise and delivery strategy agreed.

Strategy agreed

07.04.22 — MDT Workshop 1

25/158 deadlines agreed

29.04.22 — MDT Workshop 2

101/158 deadlines agreed

10.06.22 — MDT Workshop 3 + Risk stratification

127/158 deadlines agreed

17.06.22 — MTP relaunch (including LMNS & MVP)

New workstream structure

01.07.22 — Anaesthetics Ockenden actions workshop

135/158 deadlines agreed

13.07.22 — Confirm & Challenge session

MTAC

Acknowledgements

Apr MTAC

18 ✓ May MTAC

1 17 ✓ June MTAC

+4 +12

5 29 July MTAC

Proposed timeframes

Assurance of Positive Progress

The Shrewsbury and Telford Hospital NHS Trust

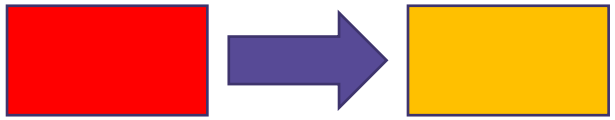
Size	Delivery date	Completion date	Number of actions
XS*	July-22	Sep-22	19
S	Sep-22	Jan-23	30
M	Dec-22	Apr-23	24
L	May-23	Aug-23	31
XL	Nov-23	Mar-24	31
YTBD	YTBD	YTBD	23

*Yet to be decided (YTBD). These actions have high complexities associated to them, or external dependencies which are pending further analysis.

Status changes approved as amber - ‘Delivered, Not Yet Evidenced’

(on 12.07.2022)

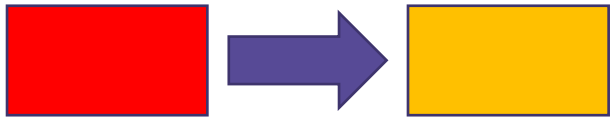
IEAs accepted as amber



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
10.2	Midwifery-led units must complete yearly operational risk assessments.	• Operational risk assessment
14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	• Communication with network re: requirement - Dr Wendy Tyler • Ock1 ANNP/Neonatologists observational attachments evidence from LAFL 4.100-Feedback and plans
14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	• Communication with network re the action – Dr Wendy Tyler • Ock1 ANNP/Neonatologists observational attachments evidence from LAFL 4.100-Feedback and plans

LAFL accepted as amber



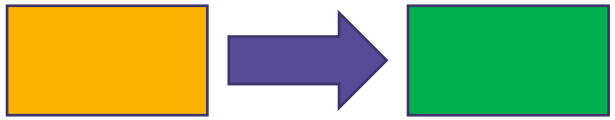
The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
14.63	Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.	• 2021 CQC Maternity Service User Survey (Scored above average in women feeling listened to in the intrapartum period) Action rejected as 'green' but accepted as 'amber' at July MTAC

Status change proposals accepted as green - 'Evidenced and Assured'

(on 12.07.2022)

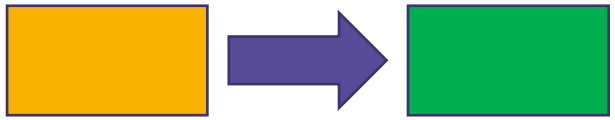
LAFLs proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
14.19	Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.	• ToR – Monthly audit meetings • Minutes – Monthly audit meeting showing MDT attendance
14.22	There must be midwifery and obstetric co-leads for audits.	• Appointment of midwifery lead for audits (job plan) • Appointment of obstetrics lead for audits (job plan)
14.28	The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.	• SFH Training in place • Clinical risk and SGA guideline • SFH Training compliance • Audit of training compliance • Audit of guideline

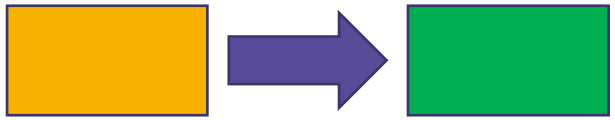
LAFLs proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
14.39	The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.	• EFM Guideline • EFM Training Content showing local discussions • EFM Training Compliance

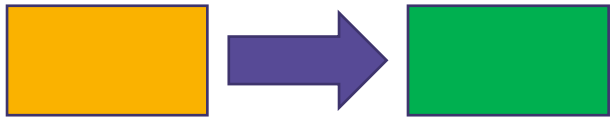
LAFLs proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
14.42	There must be a clear line of communication from the duty obstetrician and co-ordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.	• Staffing paper (CNST SA4) • On call rota for consultant obstetrician • CNST SA4 Standard a) Part 1 paper
14.46a	The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work	• CNST safety action 6 and 8 evidence • Agreement of advanced training uplift
14.48	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	• Training plan TNA for midwifery • Latest Training compliance records (CNST)

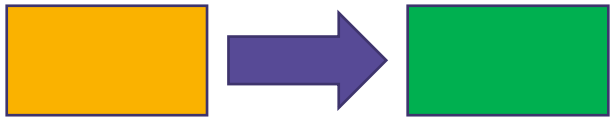
LAFLs proposed to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
14.56	The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.	• CNST SA 4c –Neonatal Medical Workforce • Audit registration
14.58	The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.	• CNST SA standard C paper • CNST SA standard C paper

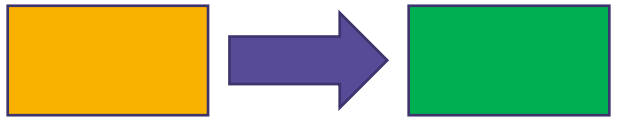
IEA proposals to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
2.2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at Board level	• On-call rotas • Roles and Responsibilities of on-call consultants • Business Continuity Management Plan
7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	• CNST SA8 evidence (PROMPT compliance records)

IEA proposals to ‘go green’



The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Evidence
13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	• Fetal Loss and Early Neonatal Death Guideline • Mandatory Bereavement training compliance for midwifery and medical staff • Bereavement care provision presentation - ORAC (Sands review included) • Badgernet bereavement checklist

Next steps

Conclusion and next steps

The Shrewsbury and Telford Hospital NHS Trust

1. From the first Ockenden report, we have delivered 100% of the actions within our control. Our system partners have informed us that work is underway to deliver the remaining 6 actions.
2. From the final Ockenden report, we have delivered 21% of the actions. The team is working to deliver the actions at pace.

Next steps:

1. To assign delivery and completion dates for remaining 23 Ockenden actions with system stakeholder partners.
2. To develop and implement an exciting and innovative communication and social media strategy for maternity.
3. Focus on delivering meaningful change to service users, following robust governance and assurance mechanisms to meet agreed timescales.

Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee

Service User Feedback

Date: 19.07.2022

Presenter:

- Claire Eagleton – Deputy Director of Midwifery

Bereavement Care – Feedback Focus

Link to Ockenden

The Shrewsbury and Telford Hospital NHS Trust

First report		
ID	Summary	Progress
LAFL 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.	Complete
LAFL 4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Complete

Final report		
ID	Summary	
Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.		
IEA 11.1	Bereavement care services must be available daily, not just Monday to Friday.	Complete
IEA 11.2	All trusts must ensure adequate staff numbers are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48h of birth. They should be trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Work underway
IEA 11.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Complete
IEA 11.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Complete

Service User Feedback

Sources of feedback

The Shrewsbury and Telford Hospital NHS Trust

- Maternity Voice Partnership (MVP) social media
- MVP quarterly service user feedback survey
- Trust website
- Patient Advice and Liaison Service (PALS)
- Complaints services
- Friends and Family
- Care Quality Commission (CQC) National Maternity Survey
- Direct contact with clinicians
- Commissioned reviews (e.g., SANDS)
- Perinatal Mortality Review Tool (PMRT) Families Involvement Feedback
- Healthwatch
- Primary care

Feedback 1

The Shrewsbury and Telford Hospital NHS Trust

‘…I just wanted to pass on my thanks for your wonderful midwives at the delivery suite at PRH last Friday. They looked after us so well, and with amazing compassion.

Sadly, our baby had Edwards syndrome, so we had to deliver him there last Friday at 16 weeks. It was obviously devastating, and traumatic, for us, but your staff cared for us so well. Our midwife, Amanda, was brilliant.’

(Source: letter sent to Midwifery team, 2022, July)

Feedback 2 (1/2)

The Shrewsbury and Telford Hospital NHS Trust

‘Thank you for all your help and support leading up to and the weeks after the birth of our twins. You showed such compassion and care during a very difficult time for us both.

… We wanted to especially thank Jasmine (our midwife) who delivered our twins, for being so professional and calm, and I had absolute trust in, when things changed so quickly during early hours of the morning.

…Thank you to Dr Charlesworth for your compassion and assistance during a very difficult night and a few weeks later when I had a second trip to delivery suite, and for Mr Gornall’s expertise for overseeing my extended aftercare.’

(Source: letter sent to bereavement team, 2022, January)

Feedback 2 (2/2)

'…The memory boxes from 4Louis are lovely, and we wanted to especially thank Steph (midwife) for supporting us for the day and helping us create something we can always treasure. Our friends and family have made donations to the charity.

…We saw so many of the midwifery team during and afterwards who were all so very kind and caring to us both. We did not catch everyone's name, but a few were, Dr Mohajer, Nicky (midwife), Sally (midwife), Gail (midwife), Dan and Pesh in theatre'.

…Thank you to Jan and Charlotte, who compassionately assisted and guided us both through some very difficult decisions. The photographs you organised will help keep those very precious moments with us forever.'

(Source: Letter sent to bereavement team, 2022, January)

Feedback 3

The Shrewsbury and Telford Hospital NHS Trust

‘We were introduced to the whole team with midwife Hannah, providing our main care overnight through labour. Dr Smith & Dr Awe provided initial care and scan confirming the baby had passed and explained the next process in detail answering everyone's questions brilliantly. They also checked in on us several times which made us feel a priority. We also noted the incredible care of both Ruth, Paula and the rest of the team in supporting all 3 of us and our support network through the toughest time in our lives.

Sarah (surrogate) would like to mention the support she received in the run up to labour from Paula as she provided a mantra to get her through the following trauma which has stuck with her. Every midwife and doctor that provided care answered all queries, questions and concerns and alleviated all fears making the whole experience easier and at times even positive despite the horrible circumstance. All the staff made an effort to get to know us personally to tailor our care and this was greatly appreciated by all involved.

Hannah delivered our baby so gently, with great care and respect. She coached the babies Dads through that immediate care and handling of their baby as well as providing the best care to the surrogate through labour. The high level of care received by Hannah will never be forgotten and we hope she knows the positive impact she made on all of us. As a surrogate, Sarah would also like to note that every member of staff treated her with great dignity and respect, as well as tailoring their usual care specifically for her situation, for example, never referring to her as mum/mother. Due to our unique situation accommodations were made to include a support person for every party involved. Despite the horrendous outcome of the situation we were made to feel as special as any other person who would enter the unit. Each aspect of our care through the loss of our baby was thought through incredibly thoroughly, down to making sure the Dads had an exit out of the ward that didn’t force them pass rooms of ladies with new babies.’

(Source: PMRT Feedback, July, 14)

Next steps and work underway

Sands recommendations

The Shrewsbury and Telford Hospital NHS Trust

- Ensure that **parent feedback is at the heart of service development**, be that co-creating new developments such as the design for the new build in Shrewsbury or for continuous improvement through a more consistent approach to capturing feedback.
- Ensure that **parent view / feedback is systematically collected** and informs all services, not just in maternity but across the trust, ensuring mechanisms for doing this in EPAS and Neonatal Team are also developed.
- Ensure **MVP collaboration** is maximised; this should come from the top down to ensure that this collaboration is truly co-production and not just consultation / observation, and that these voices are heard and valued by all staff.
- Continue to raise at the highest level the need for **faster turnaround times of Post Mortems.**
- Neonatal leadership team to follow Maternity and EPAS in completing and regularly reviewing the **NBCP self-assessment.**
- Make **improvements to bereavement suite** in maternity, e.g. soft furnishings (including soundproofing as required) and establish private access to bereavement suite (a greater need than soundproofing).

Any Questions?