The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date **Tuesday 25 July 2023**
Time **14.30 – 17.00**
Location **Via MS Teams – to be live streamed to the public from 14.30 hrs.**

Note 1: The session will be opened at 14.00 hrs. to enable members to log in, but the meeting will start promptly and 'go-live' at 14.30 hrs.

Note 2: The meeting will be recorded to enable the full and accurate transcription to take place. The recording will be deleted when this has been completed.

AGENDA

Item No.	Agenda Item	Paper / Verbal	Lead	Required Action	Time
2023/45	Welcome Apologies Welcome to any new members/observers	Verbal	**Maxine Mawhinney Co-Chair**	Noting	14.30 (15 min)
2023/46	Declarations of Interest relevant to agenda items	Verbal	**Maxine Mawhinney Co-Chair**	Noting	
2023/47	Minutes of meeting on 27 June 2023	Enc. Verbal	**Maxine Mawhinney Co-Chair**	Approval	
2023/48	Progress position of the 210 actions arising from the Ockenden Reports	Presentation	**Annemarie Lawrence Director of Midwifery**	For information	14:45 (45 mins)
2023/49	Informed Birth Choices	Presentation	**Dr Mei-See Hon Consultant Obstetrician & Clinical Director – Obstetrics**	Discussion/ For Assurance	15.30 (45 mins)
2023/50	Discussion and reflection on the meeting and one year on from the	Verbal	**Maxine Mawhinney Co-Chair**	Discussion	16.15 (20 min)

	publication of the final Ockenden Report: • Key messages from the meeting for the Board of Directors • Reflections one year on from publication of the final Ockenden Report • Feedback from Stakeholders on progress to date • Key messages for service users - women and families Any other steps we need/wish to take.		**All**		
2023/51	Any other Business Meeting closes. **Date of Next Meeting:** **No meeting in August** **Tuesday 26 September 2023 @ 14:30-17:00 hrs.** **Meeting will open to members to log in from 1400 hrs.** **Via MS Teams – to be live. streamed to the public**	Verbal	**Maxine Mawhinney Co-Chair/All**		16.35 (5 min)

1. **Enclosures: Minutes from ORAC meeting on 27 June 2023**

2. **For Information: Proposed Future ORAC Dates and meeting topics - 2023:**

26 September 2023	Topics TBC
~~31 October 2023~~	~~No Meeting~~
28 November 2023	Topics TBC
~~December 2023~~	~~No Meeting~~

Topics yet to be included:

- MBRRACE Data 2020 & 2021
- Maternity & Neonatal Safety Champions – role and observations
- Learning from Investigations

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

27 June 2023 via MS Teams

Minutes

NAME	TITLE
MEMBERS	
Ms Catriona McMahon	Co- Chair
Ms H Flavell	Director of Nursing (Trust)
Professor Trevor Purt	Non-Executive Director & Chair of Audit & Risk Committee
ATTENDEES	
Mr M Wright	Programme Director Maternity Assurance (Trust)
Ms Angela Loughlin	Maternity Voices Partnership (MVP) Development Co-ordinator
Ms Kim Williams	Deputy Director of Midwifery (part meeting)
Ms Claire Roche	Executive Director Nursing & Midwifery, Powys Health Board (part meeting)
Dr Patricia Cowley	Consultant Neonatologist and Clinical Director Neonatal Services
Dr Jennifer Brindley	Consultant Neonatal Paediatrician
Ms Annemarie Lawrence	Director of Midwifery
Ms Cristina Knill	Senior Project Manager – Maternity Transformation Programme
Mr Keith Haynes	Independent Governance Consultant
APOLOGIES	
Ms Maxine Mawhinney	Co-Chair
Dr Mei-See Hon	Clinical Director – Obstetric & Maternity Services
Ms Carol McInnes	Divisional Director of Operations (Women and Children's) (Trust)

No.	ITEM	ACTION
38/23	**Welcome, introductions and apologies**. Dr Catriona McMahon welcomed everyone to the meeting. Apologies were noted as above.	
39/23	**Declarations of Conflicts of Interests** There were no declarations of interest notified.	
40/23	**Minutes of the previous meeting and matters arising** The minutes of the meeting of the 30th May 2023 were accepted as an accurate record.	

41/23	**Safe and effective care – Neonatal care** Dr Patricia Cowley began her presentation with an explanation of the difference between neonates and paediatrics, which she felt is best simply explained that neonates are babies who have never been discharged home. A video was presented to the meeting attendees of parents who have babies on the neonatal unit, along with information about the staff who make up the Nursing and Medical Teams on the unit. Dr Cowley explained that the work carried out by the staff in the Unit includes new-born resuscitation, intensive care, high dependency and special care. Dr Cowley went on to remind the meeting of the Ockenden actions from the first report which are as follows: • LAFL 4.97 - Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed. • LAFL 4.98 - There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care. • LAFL 4.99 - The neonatal unit should not undertake even short-term intensive care, if they cannot make arrangements for 24h on site, immediate availability at either tier 2 or tier 3, with sole duties on the neonatal unit. • LAFL 4.100 - There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit. And from the final report: • IEA 14.1 - Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided. • IEA 14.2 - Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly. • IEA 14.3 - Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	

- IEA 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.

- IEA 14.5 - Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.

- IEA 14.6 - Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real time dialogue to take place directly between the consultant and the resuscitating team if required.

- IEA 14.7 - Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.

- IEA 14.8 - Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

- LAFL 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.

- LAFL 14.57 - As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention, and training of ANNPs.

- LAFL 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.

	• LAFL 14.59 - The number of neonatal nurses at the Trust who are "qualified in specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review. Dr Cowley confirmed that the majority of actions from both the first and final Ockenden reports had been actioned and evidenced, and she referenced some of the service outcomes/improvements seen as a consequence, as follows: • Two trainee ANNPs (Advanced Neonatal Nurse Practitioners) (video presented to the meeting) • Hosted an ANNP away afternoon • Extended the time that consultants are resident to deliver 7 day working • Consultant Neonatologists are continuing to rotate to other NICUs to help maintain their competencies • Tier 2 ANNPs are due to start rotating in September to visit NICUs to strengthen training Dr Cowley advised that there are four actions from the first and final Ockenden Reports that are not yet delivered related to neonatal staffing, these are: • LAFL 4.100 - There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit. • IEA 14.8 - Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications. • IEA 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. • LAFL 14.57 - As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention, and training of ANNPs. Dr Cowley confirmed the plan to meet the outstanding Ockenden actions, as follows: • Separation of the Tier 2 rota	

	• Rotation of ANNPs • Rotation of Nurses • Achievement of QIS numbers In discussion, it was explained that the limiting factor was often the ability to be able to send staff to other units without a reciprocal return of staff to cover for the loss of a staff member(s). Dr Cowley confirmed the final Ockenden report had recommended reciprocal rotation arrangements between units and that this was the aim which would make it easier to rotate staff. Dr Cowley went on to give some further examples of other improvements on the Neonatal Unit as follows: • Pulse Oximetry Screening • PERIPrem national programme, Life Start Trolley, Probiotics, and a positive outlier for optimal cord clamping • Allied Health Professionals working in the Unit include Occupational Therapists, Psychologists, Dieticians, Speech and Language Therapist, Physiotherapists. Dr Cowley explained that in summary: • Delivered most of the Ockenden actions linked to Neonatal care and remain focused on delivering the outstanding ones. • Staffing remains the biggest challenge to completing the remaining Ockenden actions. A plan is in place to address this. • Improving the care delivered to babies is the highest priority and the team has been busy working on improvements linked and not linked to Ockenden. Examples are the PERIPrem initiative, AHPs and pulse oximetry screening. • Acknowledge that there is much work to maintain and build on the high-quality care already provided. Ms Angela Loughlin notified the meeting that the MVP will soon be rebranding to the MNVP, Maternity and Neonatal Voices Partnership and they are looking for a new service user champion which will be a remunerated role for two days a week.	
42/23	**Progress position of the 210 actions arising from the Ockenden Reports** Ms Annemarie Lawrence, Director of Midwifery, presented slides to the meeting showing projected versus actual delivery of the 210 Ockenden actions. For June 2023, the projected position was 113 evidenced and assured, 59 delivered not yet evidenced and 38 not yet delivered. The actual position in June 2023 is 148 evidenced and assured, 28 delivered not yet evidenced and 34 not yet delivered. Ms Lawrence went on to advise that completion rates of the actions from the first Ockenden Report were as follows:	

	• 47/52 (91%) actions implemented, of these 43 (83% are evidenced and assured, 4 (8%) are delivered not yet evidenced. • 5/52 (10%) actions not yet delivered. Completion rates of the actions from the final Ockenden Report were as follows: • 129/158 (82%) actions implemented, of these 105 (67%) are evidenced and assured, 24 (15%) are delivered not yet evidenced. • 29/158 (18%) actions not yet delivered. Ms Lawrence confirmed that actions approved as 'amber' delivered not yet evidenced at the June 2023 Maternity Transformation Assurance Committee (MTAC) were as follows: • IEA 1.9 - All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7. • LAFL 14.17 – All staff involved in preparing complaint responses must receive training in complaints handling. • 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. • 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. In order to achieve sustainability, the Maternity Transformation Assurance Tool (MTAT) has been developed: • The Ockenden Reports comprise 210 Ockenden Actions. Each action has a Reverse RAG © status assigned to it, approved by the Maternity Transformation Assurance Committee (MTAC). • To make sure a green action remains green the team are using a bespoke Maternity Transformation Assurance Tool (MTAT). • The MTAT is group of audits/ reviews which are linked to the Ockenden actions. The aim is to utilise the tool on a quarterly basis to ensure that the action remains 'evidenced and assured' and does not revert back to 'not yet delivered'. • The MTAT has been included within the Maternity Forward Audit Plan, which is presented and reviewed at Maternity Governance and Divisional committee on a monthly basis. • Moving forward, MTAC will receive updates from the MTAT on a quarterly basis, alongside the descoped actions.	

In summary:

- Over the coming months, the focus will be on those larger, more complex actions, that now need to be delivered.

- The team are ahead of schedule for delivery and have focused on those actions with higher risk scores initially, as part of the prioritisation process

- The Divisions can provide assurance that work continues at pace to deliver the rest of the programme.

- From the first report, 47/52 actions 'delivered' (91%). The team 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)

- From the final report, 129/158 actions 'delivered' (82%). From the 18% 'not yet delivered', over two thirds of these are underway.

A summary of improvements was presented to the meeting from the first Ockenden report:

- IEA 1 – Safety
  - Dashboard/Data sharing
  - Robust reporting for data oversight/sharing
  - LMNS Buddying up agreement
  - SI reports shared with LMNS

- IEA 2 – Women's voice
  - Independent Senior Advocate Role created
  - NED co-chairing safety champions
  - CQC working with MVP

- IEA 3 – Learning
  - PROMPT training
  - Multidisciplinary ward rounds
  - Funding allocated strictly for training
  - Incidents investigated and learning shared timely

- IEA 4 – Complex Pregnancies
  - Named consultant leads
  - Guidelines benchmarked against national standards
  - Clinical risk assessments at every appointment
  - Maternal medicine specialist clinics in place

- IEA 5 – Risk Assessments
  - Use of Badgernet standardising risk assessment
  - Personalised care planning meetings for individualised care
  - Clear pathways for changes in risk assessment

- IEA 6 – Fetal monitoring
  - Foetal monitoring leads in place
  - Mandatory Electronic Foetal monitoring training
  - Evidenced delivery of saving babies lives care bundle v2

- IEA 7 – Informed Consent
  - Information leaflets and website updated
  - Maternity personalised care and support planning meeting
  - Birth preferences cards produced

- LAFL Theme 1 – Maternity Care
  - 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

- LAFL Theme 2 – Maternal Death
  - Audits against escalation policy
  - Women with pre-existing comorbidities seen by specialist MDT
  - Named consultant for high-risk women
  - Early referrals to Maternal Medicine Specialist Centre
  - All guidelines benchmarked against national standards

- LAFL Theme 3 – Obstetric Anaesthesia
  - 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

- LAFL Theme 4 – Neonatal Services
  - 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

A summary of improvements was presented to the meeting from the final Ockenden report:

- Pillar 1 – Antenatal care
  - Multiple pregnancy specialist recruited
  - My birthplace choices leaflet
  - Investment in diabetes service
  - Guidelines reviewed:
    - Multiple pregnancy
    - Diabetes

- Gestational hypertension
- Preterm birth
- EFM
- In-utero transfer
- Foetal growth assessment

- Pillar 2 – Intrapartum care
  - 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

- Pillar 3 – Postnatal care
  - Follow up appointments
  - Psychological support
  - Patient feedback audits
  - Pregnant women attending hospital policy
  - Postnatal readmissions audit
  - National bereavement care pathway followed

- Pillar 4 – Governance
  - Named consultant leads
  - Guidelines benchmarked against national standards
  - Clinical risk assessments at every appointment
  - Maternal medicine specialist clinics in place

- Pillar 5 – Workforce
  - 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

- Pillar 6 – Learning
  - 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

- Pillar 7 – Neonates
  - Neonatal workforce plan
  - TNA for ANNPs
  - Increase in numbers of qualified in speciality nurses to align with BAPM standards

	Ms Hayley Flavell informed the meeting of an education session that will be happening on 25th July and invited any stakeholders at this meeting to join this meeting to see where Ockenden fits into the broader scope of maternity transformation at SaTH.	
43/23	**Discussion and reflection on the meeting and one year on from the publication of the final Ockenden Report:** In discussion, it was agreed that the following items from the meeting should be shared with the Board: • The current progress in implementing the Ockenden actions based on the projected and actual delivery of completed actions • Confirmation that any progress in relation to de-scoped items continue to be reviewed by the Committee • The part that the Maternity Transformation Assurance Tool will play in ensuring the ongoing sustainability of improvements made • An update regarding the now bi-monthly meetings and the rationale for this	
37/23	**Date of Next Meeting: Tuesday 25th July 2023 @ 14:30 – 17:00 Hrs** The next meeting will take place on the 25th of July, with no meeting scheduled for August.	