The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

25 July 2023 via MS Teams

Minutes

NAME	TITLE
MEMBERS	
Ms Maxine Mawhinney	Co-Chair
Dr Catriona McMahon	Co-Chair
Mrs Louise Barnett	Chief Executive
Ms H Flavell	Director of Nursing (Trust)
Professor Trevor Purt	Non-Executive Director & Chair of Audit & Risk Committee
Dr John Johns	Medical Director
ATTENDEES	
Dr Mei-See Hon	Clinical Director – Obstetric & Maternity Services
Ms Carol McInnes	Divisional Director of Operations (Women and Children's) (Trust)
Ms Jo Jacques	Specialist Midwife, Lighthouse Service
Ms Annemarie Lawrence	Director of Midwifery
Ms Kim Williams	Deputy Director of Midwifery
Ms Cristina Knill	Senior Project Manager – Maternity Transformation Programme
Mr Mike Wright	Programme Director Maternity Assurance (Trust)
Mr Andrew Sizer	Divisional Medical Director (Women & Children's)
Ms Sharon Fletcher	NHS Shropshire, Telford & Wrekin ICB – Senior Quality Lead & Patient Safety Specialist
Ms Charlotte Robertshaw	Communications Lead - Maternity
Mr Keith Haynes	Independent Governance Consultant
APOLOGIES	

No.	ITEM	ACTION
45/23	**Welcome, introductions and apologies**. Ms Maxine Mawhinney welcomed everyone to the meeting. No apologies were received.	
46/23	**Declarations of Conflicts of Interests** There were no declarations of interest notified.	
47/23	**Minutes of the previous meeting and matters arising** The minutes of the meeting of the 27th of June 2023 were accepted as an accurate record.	

48/23	**Informed Birth Choices** Dr Mei-See Hon began her presentation by outlining her previous intention that the presentation should be retitled “informed consent” and explained the GMC definition of good medical practice is that giving consent is about an exchange of information between doctor and patient, which is the process of information sharing, education, listening and facilitating choice. The actions in the first Ockenden Report relating to informed consent are: • IEA 2.4 – CQC inspections much 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 7.1 – Provide women with accurate and contemporaneous evidence-based information per national guidance. To include all aspects of maternity care throughout antenatal, intrapartum and postnatal periods of care. • IEA 7.2 – Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care. • IEA 7.3 – Women’s choices following a shared and informed decision-making process must be respected. • LAFL 4.55 – Provide women with accurate, in-date information; enabled participation in decision-making and informed choice. Choice must be respected. And from the final report: • 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. • 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. Dr Hon reminded the meeting that all of the actions relating to this theme had been evidenced and assured with the one outstanding action (IEA 2.4) being a ‘de-scoped’ action requiring CQC inspections to include an assessment of whether women’s voices are truly heard by the maternity service. Dr Hon explained that service improvements linked to Ockenden actions included the following:	

	• Personalised care planning meetings in place • Birth Options Clinic in place • Consultant midwife service (birthing outside guidance) • Birth preferences card (version 2) in use Ms Jo Jacques, Specialist Midwife, presented slides on the Lighthouse Service which is the maternal mental health service. This is a collaborative working partnership between SaTH and Midlands Partnership Foundation Trust. It provides a tailored package of support where a range of evidence-based trauma informed psychological interventions are used to support local families. The Lighthouse Service team includes seven psychologists, a psychotherapist, a peer support worker and a specialist midwife. One more psychologist will be joining at the end of year. The criteria for referral is a service user, partner or other family member who is experiencing moderate to severe mental health difficulties following a pregnancy or neonatal loss or bereavement, or a traumatic maternity experience occurring in the past five years, or to be experiencing symptoms of tocophobia. Service users must live or be registered with a GP in Shropshire, Telford and Wrekin. Dr Hon described the Birth Options Clinic which is a weekly clinic 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 and collaborative working to formulate individualised birth plans, recognise and plan for triggers, control what can be controlled and acknowledge psychological indications. Two videos were played giving service user feedback in which service users described their experience of the Birth Options Clinic. Dr Hon extended her thanks to the two service users for agreeing to share their stories. In summary: • All of the Ockenden actions linked to informed consent have been delivered and focus remains on ensuring that the green actions remain evidenced and assured. • There is still work to do to ensure continuous improvement (e.g. a 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.	
49/23	**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 July 2023 the projected position was 113 evidenced and assured, 59 delivered not yet evidenced and 38 not yet delivered. The actual position in July 2023 is 152 evidenced and assured, 28 delivered not yet evidenced and 30 not yet delivered.

Completion rates of the actions from the first Ockenden Report are:

- 47/52 (90%) actions implemented, of these 45 (87% are evidenced and assured, 2 (3%) are delivered not yet evidenced.
- 5/52 (10%) actions not yet delivered.

Completion rates of the actions from the final Ockenden Report are:

- 133/158 (84%) actions implemented, of these 107 (68%) are evidenced and assured, 26 (16%) are delivered not yet evidenced.
- 25/158 (16%) actions not yet delivered.

Actions proposed to 'go green' at the July 2023 Maternity Transformation Assurance Committee (MTAC) are as follows:

- 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

- 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.

It was explained that the regional criteria and process for referral to a specialist centre has only just been published in the last month and only one case has met the criteria for referral. Therefore, it is proposed the system should be audited in 12 months' time to be of more value. This will then be incorporated into the Maternity Transformation Assurance Tool.

- 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 and roles and responsibilities. ○ Standardised 360 assessments undertaken ○ Preceptee feedback • 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. ○ Freedom To Speak Up (FTSU) summary report for Maternity ○ Maternity and Neonatal Safety Champions AAA and Terms of Reference ○ Conflict of Clinical Opinion policy ○ PMA Quarterly Report ○ DOM drop-in invite list ○ Staff Survey results summary. Actions proposed to 'go amber' at the July 2023 MTAC: • 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 undertaken ○ Next step is a 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) ○ Next step is civility training compliance >90% for non-clinical staff) • 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. ○ Next step action plan is 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 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 ○ Next step PROMPT review presentation to LMNS and LMNS monitoring process. Ms Carol McInnes presented a slide showing the following descoped actions from the Ockenden actions along with their current position: • 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. ○ Remains the same (CQC and National MVP) • IEA 1.1 – The investment announced following our first report was welcomed. However, to fund maternity and neonatal services appropriately request a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. ○ Remains the same (external funding) • IEA 1.4 – 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 and RCPCH. ○ Remains the same (national bodies) • IEA 1.7 – 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. ○ Remains the same (nationally recognised module) • IEA 1.11 – 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. ○ Remains the same (external training programme)	

- IEA 6.1 – 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.
    - Remains the same (NHSEI, Royal Colleges and Chief Coroner)

- IEA 11.4 – 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.
    - Remains the same (resources from anaesthetic bodies)

- IEA 14.5 – 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.
    - Remains the same (neonatal network)

In summary, over the coming months the focus will be on those larger, more complex actions that need to be delivered. The team are ahead of schedule for delivery and have focused on those actions with a higher risk score initially as part of the prioritisation process. The Division can provide assurance that work continues at pace to deliver the rest of the programme.

From the first report, 47 of the 52 actions (90%) are delivered. Audits are being carried out to ensure that the actions rated as green-green sustain those ratings. Of the five actions not yet delivered, four lie outside of SaTH's direct control.

From the final report 133 of 158 actions (84%) are delivered. From the 16% not yet delivered, over two thirds are underway.

A summary of improvements was presented to the meeting by Ms Lawrence from the first Ockenden report as follows:

- 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
  - Fetal monitoring leads in place
  - Mandatory Electronic Fetal 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	
50/23	**Discussion and reflection on the meeting and one year on from the publication of the final Ockenden Report:** Ms Mawhinney asked what the measurement for success is when considering if women's voices are truly being heard. Dr Hon explained that there are many different metrics, from conversations, complaints and compliments received. Annemarie Lawrence added that there is a Friends and Family Test and also feedback loops with the MVP. Mrs Louise Barnett asked about the levels of referrals to the Maternal Medicine Centres. Dr Hon explained that this service is starting to be used utilised more now, but it won't be until the next audit cycle until the data can be analysed. Dr McMahon asked about those people who don't meet the criteria for referral to the Lighthouse service. Ms Jacques explained that people who come into the Birth Options Clinic have an opportunity to receive more input and this may be in the form of a telephone conversation or face to face chat. This engagement can also be made at maternity midwife appointments. Dr McMahon then asked a follow-up question about the upskilling of staff to deal with having such conversations. Dr Hon confirmed that this topic will be made part of the junior doctor induction programme. Annemarie Lawrence confirmed that it is part of the mandatory training programme for midwives. Professor Purt suggested that the two service user videos from the earlier presentation by Dr Hon on the Birth Options Clinics should be made available to a wider audience and presented to the Board. Items to take to Board: • Service user videos of feedback from Birth Options Clinics	
51/23	**Date of Next Meeting: Tuesday 26th of September 2023 @ 14:30 – 17:00 Hrs** The next meeting will take place in September, with no meeting scheduled for August.	