

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC 26 September 2023 via MS Teams

Minutes

|  |  |
| --- | --- |
| **NAME** | **TITLE** |
| **MEMBERS** | |
| Ms Maxine Mawhinney | Co-Chair |
| Ms Catriona McMahon | Co-Chair |
| Ms H Flavell | Director of Nursing (Trust) |
| Dr John Jones | Medical Director |
| Professor Trevor Purt | Non-Executive Director & Chair of Audit & Risk Committee |
| Dr Tim Lyttle | Associate Non-Executive Director & Maternity Safety Champion |
| **ATTENDEES** | |
| Dr Mei-See Hon | Clinical Director – Obstetric & Maternity Services |
| Ms Annemarie Lawrence | Director of Midwifery |
| Ms Jacqui Bolton | Midwifery Matron |
| Ms Kim Williams | Deputy Director of Midwifery |
| Dr Patricia Cowley | Clinical Director Neonatal Services |
| Ms Kate Evans | Powys Teaching Health Board – Women’s & Children’s Services |
| Mr Mike Wright | Programme Director Maternity Assurance (Trust) |
| Ms Katie Steyn | Digital Communications Lead (Maternity) |
| Ms Cecile Pollitt | Assistant Project Manager |
| Ms Sara Bailey |  |
| Ms Charlotte Robertshaw | Communications Lead - Maternity |
| Mr Keith Haynes | Independent Governance Consultant |
| Mr Billy Roberts | Lodestone Communications |
| **APOLOGIES** |  |
| Ms Carol McInnes | Divisional Director of Operations (Women and Children’s) (Trust) |
| Mrs Louise Barnett | Chief Executive |
| Ms Cristina Knill | Senior Project Manager – Maternity Transformation Programme |

|  |  |  |
| --- | --- | --- |
| **No.** | **ITEM** | **ACTION** |
|  | | |
| 52/23 | **Welcome, introductions and apologies**.  Ms Maxine Mawhinney welcomed everyone to the meeting. Apologies were noted as above.  Dr John Jones was invited to speak to the meeting about a paper that was recently presented to the Integrated Care Board (ICB) dealing with system-wide mortality data and, in particular, mortality rates for children (neonates, infants and children). Dr Jones stated that all child deaths are tragedies and explained that the Trust always seek to understand what has happened. He reminded the meeting that the Saving Babies Lives care bundle has been fully embedded and all ten safety actions in year four of the Clinical Negligence Scheme for Trusts (CNST) have been completed. He highlighted the improvement work that was taking place in the Trust’s neonatal services, including an invited review of the service, led by the Royal College of Paediatrics and Child Health and supported by the Royal College of Physicians. Once completed the results of this review will be reported to the Board of Directors. |  |
| 53/23 | **Declarations of Conflicts of Interests**  There were no declarations of interest notified. |  |
| 54/23 | **Minutes of the previous meeting and matters arising**  The minutes of the previous meeting held on 25th July 2023 were accepted as an accurate record. |  |
| 55/23 | **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 September 2023 the projected position was 151 evidenced and assured, 21 delivered not yet evidenced and 38 not yet delivered. The actual position in July 2023 is 164 evidenced and assured, 21 delivered not yet evidenced and 25 not yet delivered.  Completion rates of the actions from the first Ockenden Report are:   * 48/52 (92%) actions implemented, of these 46 (88% are evidenced and assured, 2 (4%) are delivered not yet evidenced. * 4/52 (8%) actions not yet delivered.     Completion rates of the actions from the final Ockenden Report are:   * 137/158 (87%) actions implemented, of these 118 (75%) are evidenced and assured, 19 (12%) are delivered not yet evidenced. * 21/158 (13%) actions not yet delivered.   From the first report, 92% of the actions have been implemented, the following four actions are still to be delivered:   * IEA 1.4 - An LMS cannot function as one maternity service only.   + This is an external action which remains off track. There continue to be on-going discussions with the ICB to resolve this outstanding matter. On a positive note Ms Lawrence reported that a stakeholder engagement meeting had been held involving stakeholders from across the region and agreement had been reached the develop a region-wide performance dashboard to enable benchmarking. * IEA 2.2 - 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.   + This is an external action which is on track. There is a person in post in this role, however to evidence there needs to be tangible outcomes from the implementation of that role. * 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.   + This is an external action which has been descoped. This action will only move forward when SaTH receives a CQC inspection. * 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.   + This is an internal action, and it is on track to deliver. It was noted there have been staffing challenges which have impacted on the delivery of this action.   From the final report, 87% of the actions have been implemented. The following eight actions have been descoped because they are not within the gift of SaTH to be able to deliver:   * IEA 1.1 - The investment announced following the 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. * 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, RCPCH. * 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.   + It should be noted that SaTH undertake their own in-house training which is likely to be part of the national programme that is offered. * 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. * 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. * 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. * LAFL 14.1 - 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. * LAFL 14.64 - 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.   The following 12 actions are not yet delivered, but are on track:   * IEA 2.6 - The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.   + The medical leadership team are currently working through these requirements. * IEA 4.3 - Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.   + Job descriptions are currently being worked through. * 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.   + Staff will soon begin to undertake these training days. * 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 14.30 - The Trust must ensure parents receive appropriate information in all cases of foetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases. * LAFL 14.31 - Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records. * LAFL 14.38 - The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Foetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.   + Waiting for the audit to be able to evidence the progress against this action. * LAFL 14.52 - The Trust’s executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust’s services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service. * LAFL 14.53 - The Trust’s executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020. * LAFL 14.55 - The Trust’s department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting. * 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 14.62 - The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.   + Currently participating in the CNST year five survey, the results of this should enable this delivery status to move forward.   Ms Lawrence presented slides on the Maternity Transformation Assurance Tool (MTAT) which is presented and reviewed at Maternity Transformation Assurance Committee (MTAC) on a quarterly basis. The Ockenden Report comprises 210 actions, and each action has a Reverse RAG© status assigned to it. The MTAT is a group of audits which are linked to the Ockenden actions. The tool will be used on a quarterly basis to ensure that the actions remain evidenced and assured. A list of audits that will link into the MTAT were presented.  In summary:   * Over the coming months the focus will be on those larger, more complex actions that now need to be delivered. * The actions are ahead of schedule for delivery. * Divisions can provide assurance that work continues at pace to deliver the rest of the programme. * From the first report 47/52 (92%) actions are delivered, 4/52 are not yet delivered, 3 lie outside of SaTH’s direct control. * From the final report 137/158 (87%) actions are delivered. From those actions not yet delivered, over two thirds of these are underway.   Mrs Hayley Flavell asked for explanation on the process of descoping an action. Ms Lawrence explained that descoped actions were out of the control of SaTH to deliver. These actions are reviewed on a quarterly basis and brought to MTAC.  Ms Mawhinney asked if there was a timescale in place for delivering IEA 1.4. Mr Wright confirmed that there was not a definitive date for delivery on this action. |  |
| 56/23 | **Community Midwifery Services**  Ms Jacqui Bolton, Midwifery Matron, gave a presentation on the role of Maternity Community Services.  Ms Bolton explained that the Community Team comprises seven community bases within Shropshire for maternity care:   * Telford – Princess Royal Hospital * Shrewsbury – Royal Shrewsbury Hospital * Bridgnorth – Community Hospital * Ludlow – Community Hospital * Oswestry – Robert Jones and Agnes Hunt Orthopaedic Hospital * Whitchurch – Community Hospital * Market Drayton – GP Surgery   These services are attended by over 70 staff members including midwives, maternity support workers and women’s service assistants.  Ms Bolton explained that care in the community includes antenatal care, labour and birth and postnatal care. Other aspects of the community midwife role include:   * Safeguarding * Ongoing risk assessments and appropriate referral to other services * Antenatal education * Infant feeding information and support * Mental health support * Pelvic health support   Specifically, the following Ockenden actions are linked to these roles and all of these actions are delivered, evidenced and assured:   * IEA 5.1 - All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. * IEA 5.2 - Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. * LAFL 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. * IEA 2.9 - All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. * IEA 10.2 - Midwifery-led units must complete yearly operational risk assessments. * IEA 10.3 - Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. * LAFL 14.47 - Midwifery-led units must complete yearly operational risk assessments. * LAFL 14.48 - Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. * 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.   Outcomes linked to the Ockenden actions:   * Operational risk assessments for MLUs in place * 2022 staff survey * Consultant midwife service (birthing outside guidance) * Birth preferences card (v.2) in use that starts at the community. * Manager of the Day * Safety champions walkabouts (to the community)   Ms Bolton focused next on the Safety Champions’ role:   * Monthly Maternity and Neonatal Safety Champions meetings in place, co-chaired by an Executive Director and Non-Executive Director, Dr John Jones and Dr Tim Lyttle respectively. * Bimonthly walkabouts in place focusing on specific areas. * Recent walkabout focused on community/outlying units. * “You said, we did” feedback system in place to demonstrate areas of improvement. * Maternity Voices Partnership (MVP) involvement   A video was shown outlining the role of the Safety Champion within Maternity Services which featured a discussion with the Maternity Safety Champions about their roles  In summary:   * All of the Ockenden actions specifically linked to community services have been delivered and the team remain focused on ensuring that the green actions remain evidenced and assured. * Acknowledgement that there is still work to do to ensure continuous improvement. * The team remains determined and motivated to improve the services to deliver high quality care. |  |
| 57/23 | **Discussion and reflection on the meeting**  Dr John Jones commented that there is a lot of focus on percentage completion of the actions, but providing and improving care is a continuous process, and although numbers are being presented it is often more about the experiences of the community, which is where the Safety Champions role comes to the fore.  Mr Wright commented that at the outset it was important for the Trust to be honest and open about how it delivered the improvement works. It was important that once an action had turned green, that it was still reviewed regularly to ensure performance did not deteriorate over time. The feedback from service users and what the improvements have had on them is very impactful.  Mrs Kim Williams commented on the importance of the senior leadership team being visible in all situations. There were culture issues at the beginning of the process, but the teams are now changing and evolving and there is continuous work in progress in this area.  Dr Tim Lyttle commented on the importance for staff to feel empowered to speak up, he felt there was no hint of any culture in place where a member of staff would suppress any comments about safety.  Mrs Flavell commented on the position Maternity Services now finds itself in with regards to staff vacancies and with the stability of the senior leadership team. Mrs Bolton echoed this in that applications both internally and externally have improved and the stability of having an established senior leadership team in post.  In summary, Ms Mawhinney explained that she felt that the following items and points of discussion should be drawn specifically to the attention of the Trust Board:   * It was acknowledged that when the Committee started its work in 2021, there was a significant amount of external participation in the meetings, including public participation. This is now falling off, and so there is a need to ensure that we remain extra vigilant in our challenge of the information shared.   + It continues to be a priority to re-establish the trust and confidence of our local communities in our services.   + We heard positive feedback about improvement recruitment to maternity services and how midwives wished to come and work for the Trust.   + As ever, there was a recognition that service improvement is a continuous journey and there could be no room for complacency. It is encouraging to note, therefore, that the service has an approach to ensure the sustainability of the changes/improvements that have been made so far. |  |
| 58/23 | **Date of Next Meeting: Tuesday 28th of November 2023 @ 14:30 – 17:00 Hrs**  The November meeting will cover investigations, complaints, and service user feedback.  Ms Mawhinney confirmed that the final meeting of ORAC will take place in April 2024. |  |
|  | | |