The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

28 November 2023 via MS Teams

Minutes

NAME	TITLE
MEMBERS	
Ms Maxine Mawhinney	Co-Chair
Ms Catriona McMahon	Co-Chair
Mrs Hayley Flavell	Director of Nursing (Trust)
ATTENDEES	
Dr Mei-See Hon	Clinical Director – Obstetric & Maternity Services
Mrs Carol McInnes	Divisional Director of Operations (Women and Children's) (Trust)
Ms Kim Williams	Head of Midwifery
Dr John Jones	Medical Director (Trust)
Mr Mike Wright	Programme Director Maternity Assurance (Trust)
Ms Vanessa Barrett	Chair of Healthwatch Shropshire
Ms Angela Loughlin	Maternity Voices Partnership (MVP) Development Co-ordinator
APOLOGIES	
Mrs Annemarie Lawrence	Director of Midwifery
Mrs Louise Barnett	Chief Executive

No.	ITEM	ACTION
59/23	**Welcome, introductions and apologies**. Maxine Mawhinney welcomed everyone to the meeting. Apologies were received from Louise Barnett and Annemarie Lawrence.	
60/23	**Declarations of Conflicts of Interests** There were no declarations of interest notified.	
61/23	**Minutes of the previous meeting and matters arising** The minutes of the previous meeting were accepted as an accurate record. Dr John Jones asked that the minute 52/23 should state that "the invited review of the service, is being led by the Royal College of Physicians and supported by the Royal College of Paediatrics and Child Health".	

62/23	**Progress position of the 210 actions arising from the Ockenden Reports** Ms Kim Williams, Head of Midwifery, presented slides to the meeting showing projected versus actual delivery of the 210 Ockenden actions. For October 2023, the projected position at this time was expected to be: • 153 'evidenced and assured' • 20 'delivered not yet evidenced'; and, • 37 'not yet delivered'. The actual position in October 2023 is: • 164 'evidenced and assured' • 25 'delivered not yet evidenced'; and, • 21 '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 are 'not yet delivered'. Completion rates of the actions from the final Ockenden Report are: • 143/158 (91%) actions implemented. Of these, 123 (78%) are 'evidenced and assured' • 20 (13%) are 'delivered not yet evidenced'. • 15/158 (9%) actions not yet delivered. Actions that received a status change at the October and November 2023 Maternity Transformation Assurance Committee meetings were: Changed from 'not yet delivered' to 'delivered, not yet evidenced': • 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 changed. • LAFL 14.30 – The Trust must ensure parents receive appropriate information in all COMPLEX cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for the 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. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

- LAFL 14.57 – As the Trust has benefited 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.

Changed from 'delivered, not yet evidenced' to 'evidenced and delivered':

- IEA 4.1 – Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.

- IEA 11.6 – Obstetric anaesthesia staffing guidance to include: the full range of obstetric anaesthesia workload including, elective Caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training and governance activity.

- IEA 11.7 – Obstetric anaesthesia staffing guidance to include: the competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.

- IEA 13.2 – All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.

- LAFL 14.24 – The Trust Board must review the progress of the maternity improvement and transformation plan every month.

Status change rejected:

- 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 available of consultant anaesthetist input to the maternity service.

Mrs Carol McInnes, Divisional Director of Operations, presented slides showing outstanding actions. There are 41 actions (19%) that are not yet 'green'. Work is underway to deliver the actions before the March 2024 completion date; however, ten were 'descoped' as lying outside the Trust's scope of work and control.

Mrs McInnes advised that there are a further eight actions that require additional recurrent investment. A business case has been developed outlining these requirements, which is supported by the Trust's Executive team. There is some ringfenced national funding that will contribute to the funding of this case.

The 'descoped' actions are as follows, and these are reviewed at MTAC on a quarterly basis:

- 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.

- IEA 1.1 – The investment announced following our 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. The bodies must include as a minimum NHSE, RGOG, RCM and 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.

- 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.

A further slide was presented showing a summary of the actions being worked on, and outlined in the business case for these that has been

submitted for recurrent funding:

- IEA 4.3 – Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.

- IEA 8.1 – Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.

- IEA 11.1 – Conditions that merit further follow up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.

- LAFL 14.32 – The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

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

- LAFL 14.59 – 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.

- IEA 14.8 – Neonatal providers must ensure sufficient numbers of appropriate 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.

In summary, some of the key areas of improvement seen since the Ockenden Reports were published, are:

	• Listening to women • Birth options/risk management • Strong and sustainable leadership • Bereavement support • Up to date practices/techniques • Consultant obstetrician presence • Midwifery staffing levels • Management of patient safety incidents Over the coming months the focus will be on the delivery of the remaining actions. Discussions will be held with regional and specialised colleagues regarding sourcing of the remaining funding requirements as part of the business planning round for 2024/25. Notwithstanding these, delivery of the actions continues to be ahead of schedule and focus will be on those actions with a higher risk score as part of the prioritisation process. Questions and comments were invited from the meeting attendees. Ms Vanessa Barrett suggested that one of the significant improvements that has happened since the Ockenden Reports were published, is the investment in perinatal mental health, which was not particularly given focus in the Ockenden reviews, but has been of significant benefit to many women and families locally. Ms Angela Loughlin added that she had an opportunity to meet with the CQC inspectors recently and an honest and open conversation took place around the Ockenden actions.	
63/23	**Learning from Incidents** Ms Kim Williams, Head of Midwifery, presented slides to the meeting regarding the Trust's process for learning from incidents. Ms Williams described that a patient safety incident is an unintended or unplanned event or circumstance which could have resulted or did result in harm to a patient. Examples could be clinical, environmental, professional, or service issues. Any adverse incident that has the potential to produce unexpected or unwanted effects, or an incident which has a consequence or learning point, i.e. an event that causes a loss, injury or near miss to a patient staff or others should be reported. Reporting an incident creates an official record enabling the details to be recalled and referred to in the future. Analysing incidents allows learning from events, to develop and improve services and identify training needs. Ms Williams presented a slide showing a process map of when an incident occurs, how it moves through the system, and how learning from the incident is then disseminated. In summary, when an incident occurs it is captured on the Datix system and is given a category for the level of harm, this being no harm/low harm, moderate, severe or death. Incidents at the level of no harm/low harm are managed at ward level. Incidents at the other levels are reviewed at an incident review meeting, which is chaired by the Quality Governance team. Other groups also meet to review incidents, including the Divisional Oversight Assurance Group	

(DOAG) and the Review Action and the Trust-level Learning from Incidents Group (RALIG). Learning is captured and it is then disseminated through the following methods:

- Individual learning processes and systems
- Education and training
- PROMPT – (PRactical Obstetric Multiprofessional Training)
- Maternity Governance Meetings
- Maternity and Neonatal Voices Partnership and Governance team meetings
- Governance feedback meetings
- Daily huddles
- Ward manager meetings
- Appraisals
- Tea trolleys
- Clinical Gems/Newsletter

Ms Williams presented a slide showing the number of incidents by level of harm in maternity and neonatal over the last two years between October 2021 and October 2023.

There have been a total of 3,393 incidents, an average of 135.7 per month. The breakdown of the severity of these incidents during that time was:

- 60% no harm
- 38% low harm
- 2% moderate harm
- 0.1% severe harm; and,
- 0.03% death.

The top maternity incident themes are: 35% staffing, 34% intrapartum care, 17% communication and 14% other, which included care/monitoring/review delays, diagnosis delay/failure, appointment problems and notes/records.

The top neonatal incident themes are: 45% term neonatal admissions, 32% staffing, 18% other, which included medical devices, medication/prescribing errors and administration errors, care monitoring and review delays, patient admission, pressure ulcer/skin damage and diagnosis delay/failure. 5% involved communication between staff, teams, and departments.

In summary:

- Consistent levels of reporting of incidents over past two years for both neonatal and maternity services has taken place, providing a steady picture.
- There is a real drive to encourage staff to access the incident reporting system and to report incidents and ‘near misses’ at all levels.

- The top incident theme identified for maternity services is staffing levels, and the top incident theme for neonatal services is term neonatal admissions.
- 60% of the reported incidents assessed as ‘no harm’. However, learning is always exported and shared to improve overall practice and patient safety.
- 38% of the reported incidents assessed at ‘low harm’.
- 2% of the reported incidents assessed at ‘moderate’.
- <0.1% of the reported incidents assessed as ‘severe/death.’

In brief, the actions from the Ockenden Reports that are linked to incident reporting include:

- IEA 1.6
- LAFL 4.60
- LAFL 4.85
- LAFL 4.90
- IEA 5.2
- IEA 5.3
- IEA 5.4
- IEA 5.5
- IEA 6.3
- LAFL 14.1 (not yet delivered)
- LAFL 14.7
- LAFL 14.9
- LAFL 14.21b
- LAFL 14.39
- LAFL 14.55 (not yet delivered)

Those not yet delivered in detail are:

- 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 (linked to Patient Safety and Incident Reporting Framework). This action is awaiting the full implementation of the new PSIRF before it can be delivered.

- 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.

Outcomes linked to Ockenden actions:

- Professional Development Programmes (e.g., coordinators’ programme, enhanced maternal care programme, Birmingham Symptom Specific Obstetrics Triage System (BSOTS) training programme, managers,’ and matrons’ handbooks)
- PROMPT
- ‘Helicopter’ training

	• Civility and human factors training • Each Baby Counts – Conflict of Clinical Opinion • Investigation training at Cranfield University A further slide was presented on the Birmingham Symptom Specific Obstetric Triage System (BSOTS) training package. This is a system which categorises women into 'red,' 'orange,' 'yellow' or 'green' risk categories, based on the woman's presenting symptoms and level of clinical urgency when they arrive into the department. All service users must be seen within 15 minutes of arrival by a BSOTS trained midwife who will commence the triage assessment by allocating a risk category (colour). The colour system is graded as follows: • Red – Obstetric emergency. Must be transferred to labour ward/theatre for 1:1 care. • Orange – Urgent review. Must be seen within 15 minutes and remain in the triage room. • Yellow – Can remain in the waiting area, but must be reviewed by an obstetrician within 60 minutes and receive ongoing care within 30 minutes. • Green – Can remain in the waiting area, but must be reviewed by an obstetrician within four hours and re-assessed if any clinical concerns arise. A video clip was played to the meeting showing Lauren Taylor, Deputy Head of Midwifery, who explained examples of learning from incidents. Ms Williams continued to explain that all new midwives to the triage area will have a supernumerary period in the first two weeks and, during this time, they undertake the triage orientation programme. This is a robust competency handbook, which equips the midwives with all the necessary skills to fully understand the BSOTS tool, and to ensure women are effectively triaged to obtain the best care possible. Compliance with BSOTS training is 100%. In summary, and next steps: • Learning from incidents is essential for the provision of safe, effective, and high-quality maternity care. It helps address and identify safety issues before they become serious incidents. • The Patient Safety Incident Response Framework (PSIRF) will be launched soon. This system supports the development and maintenance of an effective patient safety response and integrates compassionate engagement and involvement of those affected. • The majority of Ockenden actions specifically linked to learning from incidents have been delivered and focus is now on ensuring that the 'green' actions remain 'evidenced and assured,' along with the delivery of the outstanding actions. Questions and comments were invited from the meeting attendees. Ms Vanessa Barrett asked how families are supported during the time when serious incidents (SI) are being resolved. Mrs Hayley Flavell responded	

	that the gold standard for SI investigations is sixty days. The patient safety team and the investigating officer work with the families during this time, along with a family liaison officer. There is also a national pilot taking place, which SaTH will be involved in, for the appointment of independent senior advocacy roles in maternity services. This is currently ongoing.	
64/23	**Discussion and reflection on the meeting** Dr John Jones was invited to comment on the improvements and achievements within the service. He added that there are increasingly positive comments being received both within the service at the Princess Royal Hospital and, also, within the midwife led units around the county. Ms Angela Loughlin agreed that, when taking part in walkabouts around the service, there is a really positive feeling of a change in culture in maternity services.	
65/23	**Any other business** **Date of next meeting is 27 February 2024 at 14:30-17:00**. Topics for discussion include: • How do we know our maternity services are safe? (outcome measures) • Latest CQC survey and/or inspection reports (if available) Ms Catriona McMahon asked if it would be possible to have a draft outline of what the future governance pathway will be, to enable the committee to have input into this ahead of the final meeting. **The final ORAC meeting will take place on 30 April 2024**. Topics for discussion include: • Round up of the overall learning from the Independent Maternity Review • Latest CQC Survey/Inspection (if available) • Celebration of successes • Rolling programme of audit - sustainability • Work still to do – transition to existing assurance arrangements	