AGENDA ITEM
6.1.2

QUALITY & SAFETY COMMITTEE

MATERNITY SERVICES SELF-ASSESSMENT AGAINST OCKENDEN 2022 RECOMMENDATIONS

Date of meeting	24/05/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Suzanne Hardacre, Director of Midwifery
Presented by	Suzanne Hardacre, Director of Midwifery
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CTG	Cardiotocograph (used to monitor fetal well-being)
CTMUHB	Cwm Taf Morgannwg University Health Board
IMSOP	Independent Maternity Services Oversight Panel
MNIP	Maternity and Neonatal Improvement Programme
MatNeoSSP	Maternity Neonatal Safety Support Programme
MDT	Multi-Disciplinary Team

MLU	Midwife Led Unit
MMMW	My Maternity My Way
NLS	Newborn Life Support
PREMS	Patient Reported Experience Measures
PROMPT	**PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
QWE	Quality of Women's Experience

1. SITUATION/BACKGROUND

1.1 This paper sets out the current position against the publication of the final report outlining the findings, conclusions and essential actions from the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, published on 30th March 2022.

1.2 The Ockenden Review was commissioned following a review at The Shrewsbury and Telford Hospital NHS Trust. This was prompted by a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS England Improvement to commission a review assessing the quality of investigations relating to maternal and newborn harm at that Trust

1.3 Following publication and receipt of the report, maternity services at Cwm Taf Morgannwg University Health Board (CTMUHB) has welcomed the opportunity to consider all immediate, essential actions and completed an evidence-based self-assessment.

1.4 The multi-disciplinary team met on 28th April to consider the report recommendations.

1.5 Maternity services have undertaken a review of the Ockenden report and key recommendations to ensure safety in maternity services. The Health Board is compliant with the majority of the recommendations in the report and action plans have been developed where further work is required.

1.6 The evidence accompanying each of the immediate and essential actions is held securely within secure files within with the Maternity and Neonatal Improvement Programme and Risk and Governance team.

1.7 Multi-disciplinary team representation from the maternity & neonatal service recently contributed to a national focus group in response to Ockenden (2022) hosted by the Maternity and Neonatal Network on 13th April 2022.

1.8 Two national learning summits are scheduled for 7th July 2022 & 6th September 2022. These further summits aim to:

- Progress development of a national assurance framework for maternity and neonatal services in Wales
- Share the learning from the invited RCOG/RCM review of Cwm Taf Morgannwg University Health Board Maternity and Neonatal Services
- Review and progress recommendations from Ockenden (2022).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Due to the comprehensive work already undertaken by the Maternity and Neonatal Improvement Programme Team to progress against RCOG/RCM Recommendations, all 7 immediate and essential actions as identified within Ockenden (2022) are being addressed.

2.2 The self-assessment document which provides context to this paper is attached as Appendix A

2.3 An infographic highlighting progress against the 7 actions also provides a pictorial overview of the current position Appendix B

2.4 A further gap analysis is being undertaken by the maternity risk and governance team to benchmark against Ockenden 'local' recommendations which were not featured within the RCOG/RCM invited review of former Cwm Taf University Health Board.

2.5 The self-assessment document and outstanding actions will be monitored through ILG and Service Wide Governance and Assurance Forums.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Transition arrangements to continue robust Floor to Board governance to be developed at pace to support business as usual following disaggregation of the Maternity Improvement Programme Team

3.2 Sustainable workforce plan to be developed within the next 2-3 months to ensure that actions and learning from both the RCOG/RCM recommendations and Ockenden (2022) are embedded in practice through continuous improvement, audit plans and reflective practice.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: • Governance Leadership and Accountability • Individual Care • Timely Care • Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to recommend Board note the progress against the Ockenden (2022) recommendations, national multi-disciplinary engagement and acknowledge the ongoing work to ensure that the conditions for sustainability and the agreed milestone plan are being progressed.

APPENDIX A Cwm Taf Morgannwg UHB Maternity and Neonatal Services Assurance Offered Against Ockenden Report Actions for Learning

1. Clinical Governance

Recommendation	CTM Current Position
Safety must be strengthened by increasing partnerships with local networks (for Wales this would be the WMNNN).	Team members attend the Wales' Maternity and Neonatal Network's Mortality Review Meetings, utilising the PMRT support All Wales sharing and learning from cases. CTM is represented within each of the WMNNN work streams.
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.	Introduction of CTM 'Serious Incident Tool Kit' to ensure all incidents are managed appropriately and to the highest standard.
The executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.	All obstetric consultants have SPA time (1.5 core in PCH/RGH) according to BMA and RCOG. This SPA time includes participation in risk management and incident review investigations
All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession	Introduction of CTM 'Serious Incident Tool Kit' to ensure all incidents are managed appropriately and to the expected standard. Our multi-professional reviews of care now have joint attendance of both the Neonatal and Obstetric colleagues. Care from pregnancy through to admission to the neonatal unit is reviewed and discussed jointly.

	They now also attend the senior multi-professional meeting to provide senior oversight and identify any joint learning to be shared back with clinical teams. All incidents are reviewed in timely manner in incident MDT on Wednesday pm with team including LW lead, anaesthesia lead, operational midwives and neonatology then these incidents are reviewed by senior MDT on Friday afternoon to ensure two layers of assessment
Correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.	Introduction of CTM 'Serious Incident Tool Kit' to ensure all incidents are managed appropriately and to the highest standard
Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.	Women and families are integral to the review process and are sent a letter at the start of the investigation to inform them a review of their care is beginning and to invite them to participate. In this letter, keeping in touch information is also provided so that the family can stay as involved as they wish. Once an investigation is complete, the reports are shared with the family by the appropriate member of the team, which may include an obstetrician, paediatrician and/ or a senior midwife/nurse. The Governance team requests statements from all clinical staff who are involved in the incident and the relevant evidence is provided to the team investigating the case. The team responsible for the investigation are not involved in the clinical management of the case. This is taken into consideration when allocating and appointing an Investigating Officer
All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Board.	Work has now completed to ensure all historic SI's have now been reviewed and submitted for sign off by the senior team. The Health Board is now supported by the Delivery Unit to ensure all serious incidents are accurately reported and investigated in a timely manner.

All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy.	Staff who undertake investigations have completed appropriate levels of training. This continues to be supported by the Patient Safety Team.
The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms.	The Health Board is committed to ensuring comprehensive investigation, learning, action planning and quality assurance takes place, in response to all serious incidents. Integral to this is compassionate consideration and involvement of the families affected. The Health Board have been actively engaged in improvements in relation to serious incident reporting, timely investigation and robust assurance processes. A 'key' is added to explain any acronyms or medical terminology in each investigation report.
Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	The clinical cabinet has not completed the 'lookback exercise' and all historic SIs have been completed. A thematic analysis is due to be undertaken as outlined within Welsh Government's Quality and Safety Framework. In accordance with the requirements of the Maternity and Neonatal Safety Support Programme, a series of national learning events are being planned where the learning from CTMUHB will be shared. Local learning is shared through clinical audit sessions, PROMPT multi professional training, clinical supervision for midwives, themes from concerns and investigations.

1.2 Patient and Family Involvement	
Recommendation	**CTM Current Position**
The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.	CTM has now developed and integrated a robust process to inform families when a review of their care is being undertaken. Families are sent a letter at the start of the investigation process. Families are provided with the opportunity to request particular areas of their care that they would like to be looked at and provided with a 'keeping in touch' contact number.

	As part of the SI investigations, there is section about questions asked by the family and this is included in the report.
All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.	On completion of an investigation, all reports are fed back to families by the Clinical Director/Consultant Obstetrician, Consultant paediatrician (where applicable) and Head of Midwifery/Director of Midwifery
The maternity governance team must work with their relevant lay group to improve how families are contacted, invited and encouraged to be involved in incident investigations.	As above

1.3 Support for Staff	
Recommendation	**CTM Current Position**
There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.	Feedback to staff is provided via DATIX, newsletters, and individual one to one discussions with line managers / risk and governance team or clinical supervisors for midwives.
The Health Board must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.	CTM CSfM's and PROMPT leads are currently in the process of developing a support package to help support staff who are involved in any serious incidents. De-briefs are offered to all staff who are involved in an incident. CTM maternity now have close links with the CTM staff wellbeing service and psychologist Dr. Clare Wright Strategic Lead for Wellbeing and Employee Experience. Staff are encouraged to engage in all wellbeing services (where required).

1.4 Improving Complaints Handling	
Recommendation	**CTM Current Position**
Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.	The Women's Experience Lead / Consultant Midwife will ensure that this recommendation is included for discussion at the next My Maternity My Way Forum. The service is reviewing all template letters sent to families following a loss, ensuring the recommendations from MBRRACE and the Perinatal Maternity Review Tool are adhered to.
Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the lay group.	Merthyr and Cynon ILG & Bridgend ILG review concern themes and trends at CSG governance meetings. Monthly 'WeSee' Reports also monitor themes and trends which are shared with local multi professional teams.
All staff involved in preparing complaint responses must receive training in complaints handling.	A gap analysis is required to determine the level of training needs required for staff undertaking concern responses. Support will be sought from colleagues within the PTR team.

1.5 Improving Audit Processes	
Recommendation	**CTM Current Position**
There must be midwifery and obstetric co-leads for audits.	The development of the AmAT system for monitoring and documenting audits has been in place since 2021, with nominated Senior Midwifery and Obstetric Leads supporting the audit programme.
Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.	Audit and Governance meeting are multidisciplinary and all staff encouraged to attend and present.

Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred	Audits arising from change in practice are hosted within the AMAT system. Learning is shared through clinical supervision, audit and governance sessions.
Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.	As above. However the service recognises that further challenge and scrutiny may needed to provide assurance as the service transitions into 'business as usual'
Matters arising from clinical incidents must contribute to the annual audit plan.	Learning from the Historic 'Look Back' IMSOP case reviews has informed the forward audit plan. Learning from CTMUHB will be shared nationally across Wales and will also help inform the requirements for the national assurance framework for maternity and neonatal services in Wales.

1.6 Improving Guidelines Processes	
Recommendation	**CTM Current Position**
There must be midwifery and obstetric co-leads for developing guidelines.	Introduction of CTM UHB Multidisciplinary Maternity Service Guideline Group. The group are responsible for the co-ordination of the development and updating of new and existing policies in line with current evidence.
A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use	As above

1.7 Leadership and Oversight	
Recommendation	**CTM Current Position**

The Board must review the progress of the maternity improvement and transformation plan every month.	Regular meetings held with Board members to discuss progress of the Maternity Improvement Team • Monthly MNIB Huddle • Bi-Monthly MNIB meeting • Monthly MNIP highlight reports

2. Antenatal Care

2.1 Care of Vulnerable and High Risk Women	
Recommendation	**CTM Current Position**
The Health Board must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.	Updates Antenatal Care Guideline ratified and published Oct 2020. Includes information on appropriate risk assessment at booking. • Trigger list for referral to CLC at booking (page 25) Guideline on the correct path to follow when a woman's risk status changes in pregnancy (page 26)

2.2 Fetal Growth Assessment and Management	
Recommendation	**CTM Current Position**
The Health Board 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	CTM now has a Fetal Surveillance Lead Midwife who conducts GAP GROW training for all staff. Training attendance is reviewed every month. Training compliance have improved consistently for the multi-disciplinary team to over 90% compliance. CTM's detection levels for the identification of small for gestational age babies continues to be maintained at the GAP user average for the UK. The Fetal Surveillance Lead Midwife undertakes a regular programme of audit.

Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed.	Fetal Surveillance Lead Midwife conducts training regarding the importance of plotting all scan measurements on the GAP & GROW chart to effectively monitor growth. This training includes the correct action to take when findings are outside of the expected range. This standard is now audited regularly to ensure it is happening reliably. Training attendance is also closely monitored to ensure all staff are compliant with the training.

2.3 Fetal Medicine Care	
Recommendation	**CTM Current Position**
The Health Board must ensure parents receive appropriate information in all cases of fetal 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.	Improvements made referral to FMU when an abnormality is detected on scan/lab result. Referrals made to FMU immediately when fetal abnormality is suspected.
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.	As above

2.4 Diabetes Care	
Recommendation	**CTM Current Position**
The Health Board 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.	Preconception care service now available in the HB. This began with providing care and advice to women with known medical risk factors and then rolled out to all women discussing conception with their own GPs in order to optimise their health for pregnancy.

	CTM now have dedicated Consultant who specialise in caring for women with diabetes in pregnancy, and run weekly clinics jointly with nurse specialists. Diabetic Specialist Midwife in post whose role it is to provide support and education to women with diabetes as part of a multidisciplinary approach to provide care in which the woman feels valued and understood and has an opportunity to discuss any aspect of her care throughout her pregnancy. Dedicated Diabetes in Pregnancy Guideline in the final stages of ratification (Est publication Autumn 2022). Enhanced diabetic training developed by Diabetic Lead Midwife and delivered annually in Mandatory Professional Update.

2.5 Hypertension	
Recommendation	**CTM Current Position**
Staff working in maternity care must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.	Health Board now has an updated 'Hypertensive Disorders in Pregnancy' Guideline which is in line with national guidelines. The updated guideline includes advice on all appropriate investigations, including urine and blood tests, as well as the correct clinical observations required. Audit against the guideline is on the Forward Audit Plan.

2.6 Consultant Obstetric Ward and Clinical Review	
Recommendation	**CTM Current Position**
All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.	In order to ensure all women's care has appropriate senior oversight, there are sixty hours of Consultant presence within the labour ward each week at PPCH and 40 hours per week at POW. At least twice daily, a Consultant is present on the labour ward to ensure they review high risk patients and support care planning. To ensure the appropriate level of staff are present in

	emergency situations, roles and responsibilities of consultants have been defined, and are supported by the introduction of an Escalation Policy which enables staff to seek senior input if required.
All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.	Induction of Labour Guideline updated in line with national best practice. This supports the multi-professional team in making appropriate plans jointly with women and families and includes information on the frequency of Obstetric review. A working group has been set up to audit and review induction of labour pathways / rates / women's experience and outcomes.
The Health Board must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.	The 'Jump Call' Policy to support staff in being able to escalate their concerns has been updated. Additionally, our Health Board has a new 'Consultant Obstetrician Presence on labour ward Trigger List' guideline to ensure they are present when appropriate. SBAR is the expected means of communication between HCP's. This is supported by PROMPT Wales training.

2.7 Escalation of Concerns	
Recommendation	**CTM Current Position**
The escalation policy must be adhered to and highlighted on training days to all maternity staff.	Maternity Escalation policy updated. Monthly Governance Days provide an opportunity to highlight the policy and embed its use in clinical practice.
The maternity service 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.	As above

The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents. 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.	1) CTM are currently in the process of introducing the Dawes Redman Antenatal CTG package. In readiness for the arrival of the new equipment staff training is currently underway lead by the Fetal Surveillance Midwife and an SOP developed. 2) CTM Health Board now has a Fetal Surveillance Lead Midwife who delivers regular training for all staff on how to correctly perform and interpret CTG monitoring and to act appropriately on findings. CTG training also includes case studies for learning across the multi-professional team. 3) Completion of annual CTG training is mandatory for all staff involved in recording and interpreting CTG's. These standards are regularly audited to ensure high standards are met.

2.8 Managing Complex Pregnancy	
Recommendation	**CTM Current Position**
Women with complex pregnancies must have a named consultant lead.	Enhanced care pathway for women with complex needs included in the updated Antenatal Care Guideline 2020. Ensuring women have a full and thorough risk assessment completed at booking (physical and social) and offered CLC where necessary. Guideline also includes information and guidance when an early appointment with a consultant should be arranged.
Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	In conjunction with the new and updated Antenatal Care Guideline, the All Wales Pregnancy record has a trigger list to identify those pregnancies which need closer monitoring, including consultant review. Once the need for a consultant review is identified, a robust referral document is completed which ensures an appointment is made as soon as possible to support joint care planning.

3 Intrapartum Care

3.1 Multidisciplinary Working	
Recommendation	**CTM Current Position**
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.	Improvement in leadership within CTM maternity services. Human factors training, the importance of effective communication and leadership.
The labour ward coordinator must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.	The HB is currently working with Birth-rate Plus to ensure the appropriate work force planning within the maternity unit Birthrate Plus will help identify correct staffing levels required to ensure quality and safety of women's care
There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.	At least twice daily, a Consultant is present on the labour ward to ensure they review high risk patients and support care planning. Roles and responsibilities of consultants have been clearly defined, and are supported by the introduction of a Jump Call which enables staff to seek senior input if required. Robust MDT handover twice daily on labour ward that's includes attendance of Band 7 coordinator and on call obstetric consultant Consultant support available 24/7 with 60 hour consultant presence of Labour Ward and Jump Call Access to Advice Guideline
Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.	All staff now undertake annual PROMPT Wales Training, which is inclusive of Human Factors training.
All clinicians must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out and feel able to speak out when they have concerns about safe care.	Development of Human Factors presentation to be included in mandatory CTG study day and includes information on the importance of 'speaking out' and being empowered to escalate concerns.

3.2 Fetal Assessment and Monitoring	
Recommendation	**CTM Current Position**
Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.	New Fetal Surveillance Guideline awaiting ratification and will include information on guidance for FSE use and contraindications.
The Health Board must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.	Staff allocated protected time to attend all mandatory training and supported and encouraged to attend external study days. Demonstrated by training compliance report.
Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors	The Fetal Surveillance Lead Midwife delivers regular training for all staff on how to correctly perform and interpret CTG monitoring and to act appropriately on findings. Completion of annual CTG training is mandatory for all staff involved in recording and interpreting CTG's. These standards are regularly audited

3.3 Specific to MLUs and Out of Hospital Birth Settings	
Recommendation	**CTM Current Position**
Midwifery-led units must complete yearly operational risk assessments	An operational risk assessment has been completed for Tirion Freestanding Birth Centre and Tair Afon Alongside Birth Centre for 2022.
Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	All community based staff now undertake annual Community PROMPT Wales Training.
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	A patient information leaflet is in development facilitated by Consultant Midwife and Women's Experience Midwives. Due to be published by Summer 2022.

developed and agreed between maternity services and the ambulance trust.	

4 Postnatal Care

4.1 Postnatal Care	
Recommendation	**CTM Current Position**
Ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.	Enhanced communication between CTM maternity services and primary care. Postnatal Care Guideline ratified and published and includes information sent to GP at discharge from inpatient maternity care. Includes information on antenatal care, birth and postnatal continuum.
Ensure complete and accurate information is given to families after poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.	The Health Board now have a birth reflections clinic in place to offer all parents the opportunity to understand and ask questions about their care. Where applicable, this will be offered jointly between maternity and neonatal colleagues where appropriate. In accordance with the Duty of Candour, the governance team always liaise with families and ensure they form part of any review/investigation.

5 Maternal Deaths

5.1 Maternal Deaths	
Recommendation	**CTM Current Position**
The Health Board's mandatory multidisciplinary team training for common obstetric emergencies must be reviewed to ensure they are fit for purpose.	As above 3.1 (Intrapartum Care- PROMPT)

6 Obstetric Anaesthesia

6.1 Obstetric Anaesthesia	
Recommendation	**CTM Current Position**
Urgently address consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be always in line with GPAS	CTM continually ensures job planning is in line with GAPS. (NB. On occasion, unachievable due to sickness absence) (CLW rota)
Supporting the anaesthetic department to ensure that job planning facilitates the engagement of consultant in maternity governance activity.	Lead Consultant Anaesthetist for Obstetrics has allocated job planning every Wednesday afternoon to facilitate engagement with maternity governance.
Providing written guidance to staff regarding events that require reporting.	CTM has improved its governance processes to ensure all incidents are reported and graded appropriately. A trigger list has now been developed and added to the Maternity Information Technology System (MITS) to ensure that all incidents that require a Daitx report to be submitted are captured.
Audit of compliance with guidelines to ensure evidence-based care is being embedded in day-to-day practice.	Although audits are not completed in an official capacity, assurance of compliance with evidence based care being embedded in practice, is assured in an alternative capacity. MDT clinical case review meetings are held weekly on labour ward. All 'moderate' incidents are reviewed to ensure compliance with evidence based practice. All identified learning fed back to staff in newsletters and governance days.

7 Neonatal Care

7.1 Neonatal Care	
Recommendation	**CTM Current Position**
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.	CTM Neonatal Services now have a local agreement with tertiary neonatal units for seeking support and advice when we have a sick and deteriorating infant in our care to help inform our clinical decision-making. In addition to this, the neonatal transport service now has a 24/7 service which enables teams to transfer babies to the correct levels of care in the appropriate timeframes. A Neonatal Audit plan has also been established that incorporates all aspects of neonatal audit activity including shared audits with Maternity services.
The number of neonatal nurses who are 'qualified-in-specialty' must be at recommended level, ensuring funding and access to appropriate training courses. Progress must be subject to annual review.	Our Neonatal QIS (Qualified in speciality) status is reviewed regularly with our Practice Development Nurse Team. CTM now have strong links with CAV and the ANUHB that allows us to access all courses and to ensure the nurses are offered places on the relevant courses as soon as they are ready to undertake the modules. Our robust TNA monitors the percentage of staff that are QIS, currently sat at 78%. BAPM recommends 70% of staff are QIS.
Ensuring there is clearly documented, early consultation with a tertiary NICU for babies who require continuing intensive care.	As previously noted, CTM Neonatal Services now have a local agreement with tertiary neonatal units for seeking support and advice.
Developing a strategy for continuing recruitment, retention and training of ANNPs.	CTM currently have one ANNP for the whole health board. Based at PCH and is given support and supervision from a consultant with neonatal interest. The senior neonatal team regularly discuss ANNP training with the staff during their annual reviews but have not had any interest expressed.
Ensuring sufficient resources to provide safe neonatal medical or ANNP cover at all times.	As above

8 Informed Consent	
Recommendation	**CTM Current Position**
Ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	Birth choice clinics are embedded into the service. 36 week birthplace discussions are held with community midwives (and / or obstetricians and documented within the All Wales Antenatal Records
Ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Updated patient information has been co-produced alongside families to ensure it fully meets the needs of service users.
Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	In January 2022, our updated annual Engagement & Experience plan was implemented, outlining the multiple methods being used by the service to engage and communicate with women and families. Through the continued work with service users via the My Maternity My Way groups (which include specific focus groups for birth partners and around infant feeding), we have continued to work with women and families to identify, discuss and agree priority areas.
Women's choices following a shared and informed decision making process must be respected.	As above. 'Birthrights' training is planned for Summer 2022. Sessions for staff include the use of appropriate language, informed decision making and choice.

APPENDIX B

Cwm Taf Morgannwg Maternity Services
Learning and Actions from the Ockenden Report
Position as at 9th May 2022

Clinical Governance	**Standard Required**	**Where we are currently**		**Our Plan**
	Health Boards must work collaboratively to ensure serious incidents are investigated thoroughly and the Board must have oversight of these	Board have had close oversight of the IMSOP clinical reviews and the resulting improvement action plan via reporting mechanisms including monthly reporting and bi-monthly MNIP Board meetings.		**Continue to work closely with the Wales Maternity and Neonatal Network to identify and share learning from incidents.** **Working with the MatNeoSSP to develop safety champions within maternity and neonatal services**
Listening to Women and their families	**Standard Required**	**Where we are currently**		**Our Plan**
	Maternity Service must ensure women and their families have their voices heard	 **My Maternity My Way**	QWE work stream overseeing activity relating to Experience and Engagement January 2022, updated Engagement & Experience plan implemented, including methods to engage and communicate with women and families. PREMS launched in September 2021.	**Continue to work closely with service users via the My Maternity My Way (MMMW) groups to identify, discuss and agree priority areas.** **Strengthen partnerships with service users.** **Thematically analyse emerging data from the PREMS survey to inform service design** **Support MMMW Chair development with Welsh Government**
Staff Training and Working Together	**Standard Required**	**Where we are currently**		**Our Plan**
	Staff who work together must train together and MDT ward rounds must take place	All staff across all acute and community settings now attend annual PROMPT training. 2021 compliance 97% across all staff groups. Twice-daily huddles collaboratively with neonatal colleagues.		**Continue to implement community PROMPT Wales training across the Health Board** **Strengthen local PROMPT MDT Faculty (further train the trainer dates planned)** **Strengthen MDT working with neonatal colleagues**

				through MDT joint training ie NLS.
Managing complex pregnancies	**Standard Required**	**Where we are currently**	**Our Plan**	
	There must be robust pathways in place for managing women with complex pregnancies.	Antenatal Care Guideline updated with enhanced care pathway for women with complex needs. Dedicated Consultant Obstetrician specialising in caring for women with diabetes in pregnancy- weekly held with nurse specialists Diabetic Specialist Midwife in post. Public Health Specialist Midwife in post	**Continue programme of Guideline review against national guidance and local update, with associated staff training and resource considerations.**	
Risk assessment through pregnancy	**Standard Required**	**Where we are currently**		**Our Plan**
	Staff must ensure that women undergo risk assessment at booking and at each pregnancy contact.		All Wales Pregnancy record trigger list identifies pregnancies requiring closer monitoring. If consultant review required, referral document completed and appointment made as soon as possible. This is audited via annual documentation audit, clinical risk review and clinical supervision for midwives.	**Continue to monitor compliance with risk assessments via documentation audit and feedback learning for continuous improvement.**
Monitoring fetal wellbeing	**Standard Required**	**Where we are currently**	**Our Plan**	
	Dedicated lead for Fetal Monitoring who champion best practice in fetal surveillance.	Fetal Surveillance Lead Midwife in post. Programme of staff training developed to national standards, inclusive of multidisciplinary team working. Training needs analysis developed inclusive of all statutory and mandatory training. Compliance reported to our maternity service senior clinical leaders during monthly assurance meetings.		**Introduction of computerised Antenatal CTG across sites, supported by an educational masterclass for all staff who will be using the system.** **Continue to monitor, and further develop programme of training in response to our changing service and population needs.** **Introduce central monitoring systems at Prince Charles and Princess of Wales Hospitals** **Introduce Intelligent Intermittent Auscultation assessment criteria within training** **Support staff to develop enhanced knowledge via**

				National Learning Events and Masterclasses **Develop a learning needs analysis to identify any further knowledge skills gaps from themes and trends**
Informed consent	**Standard Required**	**Where we are currently**		**Our Plan**
	Women must have access to accurate information to enable informed choice.	 Labour and Birth My Maternity My Way Women's and families experiences	In January 2022, we launched a brand new maternity website, and were supported by women and families to populate the site with helpful information that matters to them. Women's Experience Lead is developing a suite of written information for women, including leaflets on induction of labour and what to expect on the maternity wards.	**Continuously review, develop and add to the information available.** **Plans underway to include neonatal service and other early years information to provide timely, accessible and evidence-based information for families.** **Develop leaflet for women to share transfer rates from the MLUs based on national (Birthplace Study 2013)) and local data.**