

Ockenden (2022)

Findings, conclusions and essential actions from the independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

A Self – Assessment CTMUHB May 2022

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Background

- 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
- 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.

- A national focus group was held on 13th April 2022 to consider recommendations across Wales
- The Royal College of Midwives Briefing paper was shared with all staff on 16th April 2022.
- The multi-disciplinary team met on 28th April 2022 to discuss the report and begin self-assessment.
- National learning event planned for 7th July 2022
- National safety summit planned for 6th September 2022.

Assessment

7 Immediate and Essential Actions

	Standard Required	Where we are currently		Our Plan
<p>Clinical Governance</p>	<p>Health Boards must work collaboratively to ensure serious incidents are investigated thoroughly and the Board must have oversight of these</p>	<p>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.</p>		<p>Continue to work closely with the Wales Maternity and Neonatal Network to identify and share learning from incidents.</p> <p>Working with the MatNeoSSP to develop safety champions within maternity and neonatal services</p>



Assessment

Listening to Women and their families

Maternity Service must ensure women and their families have their voices heard



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

Assessment


	Standard Required	Where we are currently	Our Plan
Staff Training and Working Together	<p>Staff who work together must train together and MDT ward rounds must take place</p>	<p>All staff across all acute and community settings now attend annual PROMPT training. 2021 compliance 97% across all staff groups.</p> <p>Twice-daily huddles collaboratively with neonatal colleagues.</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div>	<p>Continue to implement community PROMPT Wales training across the Health Board</p> <p>Strengthen local PROMPT MDT Faculty (further train the trainer dates planned)</p> <p>Strengthen MDT working with neonatal colleagues through MDT joint training ie NLS.</p>

Assessment

<p>Managing complex pregnancies</p>	Standard Required	Where we are currently	Our Plan	
	<p>There must be robust pathways in place for managing women with complex pregnancies.</p>	<p>Antenatal Care Guideline updated with enhanced care pathway for women with complex needs.</p> <p>Dedicated Consultant Obstetrician specialising in caring for women with diabetes in pregnancy- weekly held with nurse specialists</p> <p>Diabetic Specialist Midwife in post.</p> <p>Public Health Specialist Midwife in post</p>	<p>Continue programme of Guideline review against national guidance and local update, with associated staff training and resource considerations.</p>	



Assessment

	Standard Required	Where we are currently		Our Plan
<p>Risk assessment through pregnancy</p>	<p>Staff must ensure that women undergo risk assessment at booking and at each pregnancy contact.</p>		<p>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.</p> <p>This is audited via annual documentation audit, clinical risk review and clinical supervision for midwives.</p>	<p>Continue to monitor compliance with risk assessments via documentation audit and feedback learning for continuous improvement.</p>

Assessment

<p>Monitoring fetal wellbeing</p>	<p>Dedicated lead for Fetal Monitoring who champion best practice in fetal surveillance.</p>	<p>Fetal Surveillance Lead Midwife in post.</p> <p>Programme of staff training developed to national standards, inclusive of multidisciplinary team working.</p> <p>Training needs analysis developed inclusive of all statutory and mandatory training.</p> <p>Compliance reported to our maternity service senior clinical leaders during monthly assurance meetings.</p>		<p>Introduction of computerised Antenatal CTG across sites, supported by an educational masterclass for all staff who will be using the system.</p> <p>Continue to monitor, and further develop programme of training in response to our changing service and population needs.</p> <p>Introduce central monitoring systems at Prince Charles and Princess of Wales Hospitals</p> <p>Introduce Intelligent Intermittent Auscultation assessment criteria within training</p> <p>Support staff to develop enhanced knowledge via National Learning Events and Masterclasses</p> <p>Develop a learning needs analysis to identify any further knowledge skills gaps from themes and trends</p>
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Assessment

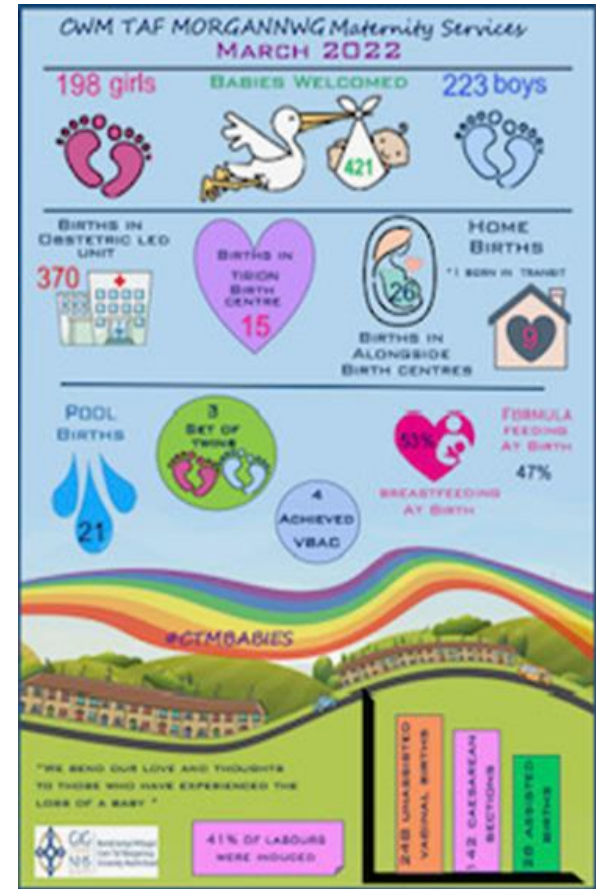
<p>Informed consent</p>	<p>Women must have access to accurate information to enable informed choice.</p>	 <p>Labour and Birth</p>  <p>Women's and families experiences</p>	<p>In January 2022, we launched a brand new maternity website, and were supported by women and families to populate the site with helpful information that matters to them.</p> <p>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.</p>	<p>Continuously review, develop and add to the information available.</p> <p>Plans underway to include neonatal service and other early years information to provide timely, accessible and evidence-based information for families.</p> <p>Develop leaflet for women to share transfer rates from the MLUs based on national (Birthplace Study 2013)) and local data.</p>
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Key Risks

- Transition arrangements to continue Floor to Board Governance to support business as usual following MNIP/MSOP de-escalation
- Sustainable workforce plan to be developed within the next 2-3 months to ensure continued learning through QI, triangulation of data and 'closing the loop'

Recommendations

- 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





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