Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

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Jenny Hughes
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18th December 2020

Dear Jenny,

Response to Ockenden Review – Buckinghamshire Healthcare NHS Trust

I am writing as requested to outline the position of the Trust in response to the Ockenden Review.

The report is a difficult read. We welcome this opportunity to work together with the national and regional teams to reflect and improve collectively on the quality of services we provide, but most importantly to do this along side our many stakeholders and the public we serve.

In response to the Immediate and Essential Actions (IEAs);

1) Enhanced Safety
a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

All perinatal deaths are currently reviewed using the perinatal mortality review tool from MBBRACE on a monthly basis. Quarterly maternity safety reports to the Trust Board include the perinatal maternity review tool summaries. We will implement the new Perinatal Clinical Quality Surveillance Model once made available, in partnership with our LMS, ICS and local stakeholders and MVP.

Serious incidents are reviewed at the Trust's monthly Serious Incident Group; these are then reported at the same frequency to the Trust Board. We will do more to strengthen the visibility of the maternity incidents, and the depth to which they are reviewed at our Quality Committee. I am aware that the LMS is also reviewing the BOB wide process. All HSIB reportable cases are reported and noted appropriately.

2) Listening to Women and their Families
a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named nonexecutive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

Buckinghamshire has an active and effective MVP that has regular meetings with both the maternity team and the CCG, as well as the LMS Board. In recent months we have co-produced user leaflets and other communication tools and we are currently working together designing an engagement project to reach out to women from our BAME community. Regular user surveys are conducted through the MVP social media pages, and they have been both constructively challenging and helpful over the events of the last year in shaping our response to the pandemic. We have a dedicated user experience midwife and a summary of feedback and actions is presented through a quarterly report.

Karen Bonner, our Chief Nurse, is our executive lead for maternity, supported by Dr. Dipti Amin, our nominated Non-Executive lead.

3) Staff Training and working together
a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place.
c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

We have scheduled and job planned consultant led ward rounds three times daily, seven days a week.

We established an MDT emergency skills training programme that has met all CNST requirements in years 1 & 2. All mandatory training is provided in house by an MDT faculty and all colleagues are allocated study time to attend. Compliance with training is tracked on our monthly maternity dashboard. Just before the pandemic, compliance for midwives was at 96.6% and doctors 97.9%. Currently this is 84% and 76.9% respectively, with plans in place to recover to pre-pandemic levels.

The department has an allocated training fund and non-recurrent transformation funding has been used in the last two years to provide supplementary training. CNST refund allocations will be protected for this use and other safety initiatives. Over the last two years the department has been an active member of the Oxford Academic Health Science Network maternity patient safety collaborative.

4) Managing complex pregnancy
a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

All antenatal clinics have an appropriate subspecialty named consultant lead and have done so since 2016. We are putting in place immediate actions to audit this.

BHT is part of the Thames Valley Maternal Medicine Network with Oxford University Hospitals as our specialist centre. There are agreed and followed network referral criteria and guidelines. Work is underway to formalise a regional specialist MDT.

5) Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

All women are risk assessed at booking, 28 weeks and if any change in pregnancy is reported. It is documented on the front of the woman's notes if she is on a midwife or consultant led pathway. If a pathway is changed, this is documented with a reason for the change. All women are risk assessed on admission to labour, with continuous risk assessments during labour and additionally hourly if in midwife led care. Personalised care plan usage is documented on our electronic record system, and compliance tracked and reported through to the BOB LMS Board. In September 2020, PCP recorded at booking was 68% compliant, with plans in place to improve.

6) Monitoring Fetal Wellbeing
a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

There is both a lead midwife and a lead consultant already in place for fetal monitoring. These leads run weekly fetal monitoring training sessions. Fetal monitoring training is included in the department's mandatory study days and compliance with this training is regularly tracked; compliance for midwives is currently 93% and doctors 88%.

We are on trajectory to complete the implementation of the Saving Babies Lives care bundle 2 in line with CNST requirements with the refresh of one outstanding guideline (to be formally signed off at our next guideline meeting) the only action outstanding.

7) Informed Consent
a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.

We have a dedicated section on our website for the Trust's maternity services, including care options, available support and detail of care pathways. Our whole website is currently undergoing a complete rebuild to make more user friendly.

We are therefore asking Trust Boards to confirm that they have a plan in place to implement the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

We will review this at Board alongside the workforce implications for the Continuity of Carer programme on the 27th January 2021.

We will complete the assurance assessment tool and report this through the LMS and the regional team by the 15th January 2021, with a review of the tool and the full report in our public Board meeting on the 27th January 2021.

I can confirm this response has been signed off by our LMS Chair.

We are very proud of our maternity services and look forward to learning more about how we can become even better for the women we serve.

If you have any further questions, please do not hesitate to contact me.

Yours sincerely

Neil Macdonald
Chief Executive
Buckinghamshire Healthcare NHS Trust

Cc: Hattie Llewelyn-Davies, Chair, BHT
Dipti Amin, NonExecutive Director and Maternity Champion Board Lead, BHT
Karen Bonner, Chief Nurse, BHT
Heidi Beddall, Head of Midwifery, BHT
Debbie Simmons, Chair BOB LMS
James Kent, Accountable Officer, BOB ICS
Sue Manthorpe, Director for Governance, BHT
David Williams, Deputy Director Quality, Bucks CCG
Fiona Dite, Co-Chair Bucks MVP
Helen Discombe, Co-Chair Bucks MVP
Aparna Reddy, SDU Lead, Obs and Gynae, BHT
Ian Currie, Divisional Chair, Women and Children, BHT
Ed MacFarlane, Divisional Director, BHT
Dan Gibbs, Chief Operating Officer, BHT
Tina Kenny, Medical Director, BHT
Lisa Cook, Care Quality Commission