The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 February 2021

Agenda item	030/21			
Report	The Ockenden Report			
Executive Lead	Interim Executive Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1 BAF 2 BAF 8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√	CRR 16 CRR 18 CRR 19 CRR 23 CRR 27 CRR 31	
	For noting			
	For information			
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon (if applicable)**:**				
Executive summary:	This report presents the first full version of the Trust's Ockenden Report Action Plan. Good progress is being made with most of the required actions, with three yet to start. These relate to ongoing work that is required with and the Local Maternity and Neonatal System (LNMS), and these will be progressed in February. The position against each action is provided, along with a description of how each is progressing. This report also provides an update on actions that were required following the Board of Directors meeting in Public on 7th January 2021.			

	The Board of Directors is requested to: • Receive and review the first version of the Ockenden Report Action Plan at **Appendix One,** and sample project management documentation at **Appendix Two** • Decide if any further information, action and/or assurance is required.
Appendices	**Appendix 1. -** Ockenden Report Action Plan **Appendix 2. -** Sample Project Management Plans

1. PURPOSE OF THIS REPORT

1.1 This report presents the first full version of the Trust's Ockenden Report Action Plan and provides updates on actions since the last meeting of the Board of Directors in Public on 7th January 2021.

2. THE OCKENDEN REPORT (IMR)

2.1. The Board of Directors received the first Ockenden Report[1] - Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews, at its meeting in public on 7th January 2021.

2.2. The report sets out the following actions for the Trust to implement:

2.2.1. Twenty-seven Local Actions for Learning (LAFL), which are specific 'Must Do' actions for this Trust, and;
2.2.2. Seven Immediate and Essential Actions (IEA) for all NHS providers of maternity care, which apply to this Trust, also. These seven themes comprise 25 related actions.
2.2.3. In total, there are 52 specific actions for the Trust to implement.

2.3. All of the Ockenden actions (LAFL and IAE's) have been cross-referenced to the Trust's Maternity Improvement Plan (MIP) and the Maternity Transformation Plan (MTP). However, due to the significance of the first Ockenden Report, it was agreed with the Board of Directors that all 52 required actions should be available as a 'stand-alone' Ockenden Report Action Plan, also. Therefore, the current position against all 52 actions is presented at **Appendix One – Ockenden Report Action Plan** for the Board's consideration (Note: Glossary and Index are at the back of the plan).

2.4. The action plan has been structured to give a summary overview of the position of each of the 52 actions as at January 31st 2021, along with the accountable executive and delivery person for each. Also, many of the actions comprise a number of sub-actions/component parts, which are provided in more granular detail in the supporting project management software that is being used to support this. This is available to review on request. However, two draft 'screenshot' examples of what this looks like are provided at **Appendix Two.**

3. STATUS OF REQUIRED ACTIONS

In order to apply rigour to the Ockenden Action Plan, a simplified RAG system has been applied, as follows:

Colour	Delivery Status	Description
	Not Yet Delivered	Action is not yet in place; there are outstanding tasks to deliver (Recommendations will stay 'Red' until they are in place)

[1] www.gov.uk/official-documents. (2010) Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our First Report following 250 Clinical Reviews.

	Delivered, Not Yet Evidenced	Action is in place, but has not yet been assured/evidenced as delivering the required improvement(s)
	Evidenced and Assured	Action is in place, with assurance/evidence that the action has been/continues to be addressed

The **'Delivery Status'** position of each of the 52 actions as at 31st January 2021 is summarised in the following table:

	Total Number of Actions	Not Yet Delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	24	3	0
IEA	25	23	2	0
Total	**52**	**47**	**5**	**0**

Whilst this is helpful in providing an overall 'Delivery Status' rating, it does not tell you if the action is on track to deliver or not. For example, an action might not yet have been delivered but good progress is being made against it, so this needs to be recognised. Therefore, a 'Progress Status' column has been included in the action plan to provide the following additional information:

Colour	Progress Status	Description
	Not started	Work on the task(s) required to deliver this action has not yet started
	Off track (see exception report)	Achievement of the action has missed or may miss the scheduled deadline. Where this is the case, an exception report must be created. This will explain why this is the case along with mitigating actions, where possible, and a description of its likely delivery status.
	At risk (see exception report)	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but where the action owners judges that this can be remedied. However, where this is the case, an exception report must be created to describe the current assessment.
	On track	Work to deliver this action is underway and expected to meet deadline and quality tolerances
	Complete	The work to deliver this action has been completed and there is assurance/evidence that this action is being delivered and sustained.

The **'Progress Status'** position of each action as at 31st January 2021 is summarised in the following table:

	Total Number of Actions	Not Started	Off Track (see exception report)	At Risk (see exception report)	On Track	Completed
LAFL	27	0	0	0	27	0
IEA	25	3	0	0	22	0
Total	**52**	**3**	**0**	**0**	**49**	**0**

There are three actions that have not yet started. These all relate to the Trust being a single-organisation Local Maternity and Neonatal System (LMNS) and, also, about

what should be reported to the LNMS going forward. These actions will be progressed during February 2021.

Going forward, it is proposed that progress against this action plan is reported to each Board of Directors' meeting, when it meets in public.

4. AN UPDATE ON ACTIONS FROM THE BOARD OF DIRECTORS' MEETING IN PUBLIC ON 7TH JANUARY 2021

4.1. IEA Return to NHS Midlands on delivery of the Immediate and Essential Actions

4.1.1. At its meeting of The Board of Directors on 7th January 2021, the Board was asked to approve the signing off of a return to the NHSE/I Midlands region that contained the Trust's assessment against all seven Immediate and Essential Actions. The Board approved for this to be undertaken on its behalf by Tony Bristlin - Non-Executive Director lead for maternity, the Director of Nursing, the Chief Executive, supported by Mike Wright – Programme Director for Maternity Assurance. Initially, this return was due to be submitted by 15th January 2021; however, due the pressures trusts are under as a result of the Coronavirus pandemic, this has been deferred nationally to the 15th February 2021. The Board of Directors will be sent a copy of this signed return prior to its meeting on 11th February 2021, so that it has sight of it. In any event, the current position against all of the IEA's is repeated in the fuller Action Plan at **Appendix One**.

4.2. Patient/Family Engagement

4.2.1. The first draft of a Maternity Services Communication and Engagement Plan was presented to the Board of Directors' meeting on 7th January, also. Key to the delivery of this plan were two actions, as follows:

5.1 Continue work with the Expert External Advisory Panel, chaired by Dr Bill Kirkup and the Trust's Communications Support team to develop an engagement/involvement strategy and plan for women and families, including those that have been impacted by care at SATH.

A meeting with Dr Kirkup took place between the Chief Executive and the Programme Director for Maternity Assurance on Wednesday 3rd February 2021. This was a positive discussion and it was agreed that the Terms of Reference for this panel will be revised for it to become an independent reviewer/critical friend in relation to the Trust's progress against the Ockenden Report Actions. At this stage, it is anticipated that the panel will meet with members of the service to undertake this work four times a year. The Programme Director for Maternity Assurance will progress this work with the panel to finalise the Terms of Reference and reporting arrangements.

5.2 Establish Communication and Engagement Liaison Group comprising membership including Maternity Voices Partnership and Service User representation. This group is being established to work with the Trust on developing its overall approach and plan to ensure that women and families are involved in their care, are listened to and are involved in service developments and service evaluation.

The inaugural meeting of the Communication and Engagement Liaison Group took place on 6th January 2021. Membership of this group includes the Maternity Voices Partnership (MVP) Chair, the MVP Vice Chair, the MVP Co-ordinator, an MVP Service User Volunteer, a Maternity Liaison Health Visitor Volunteer, along with SATH maternity, neonatal and communications staff.

Early feedback from this meeting was that it was well attended and was a very positive start. Members were described as building a good rapport with one another, where they were able to speak freely and honestly. The group agreed its collective aims and are now developing a work-plan in order to manage these more effectively. Some of the early topics discussed, included:

- The use of language by clinical professionals not always resonating well with women, for example: they would prefer use of the term 'birth' instead of 'delivery', and the use of the term 'chance' (of something happening) instead of risk
- How to get partners and wider families involved in service development and feedback processes
- How to help staff to accept and learn from criticism
- How to enable the service to show that it listens to women and families and improves services as a result. The use of 'you said, we did' mechanisms was a first suggestion.
- The group discussed having better access to the maternity safety champions so that they can discuss issues with them directly
- Some suggested 'quick wins' were around the greater use of social media by the organisation. For example, dedicated Facebook/Instagram pages for STAH Maternity services and updates, as many women use these as key methods of obtaining and sharing information.

This group has got off to a really positive start and more feedback on its progress will be provided to the Board of Directors in due course.

4.3. <u>Board Assurance Development Day</u>

Also, at the meeting on 7th January, the Board of Directors committed to undertake a Board seminar session to reflect on whether the assurance mechanisms are effective and provide sufficient evidence of action and learning, and report back to the next board of directors meeting in public. This session was scheduled to take place on Friday 5th February 2021, after this paper was written. The session is also due to consider the overall governance arrangements for managing the Ockenden Report Action Plan. Therefore, a verbal update on the session's outcomes will be provided at the meeting on 11th February 2021.

5. WORKFORCE PLAN, INCLUDING BIRTHRATE PLUS ASSESSMENT

The Board of Directors will recall that, in a letter to all NHS Trust providers of maternity services of 14th December 2020 from NHS England/Improvement, it requested for Trust Boards to: *"….confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation."* An update on the position against this requirement is provided by the Director of Midwifery in the separate maternity paper on this meeting's agenda.

6. SUMMARY

Good progress is being made against the required actions from the first Ockenden Report (2020). Three actions relating to the LMNS have not yet started to be addressed but these will be progressed during February.

Discussions in relation to Patient and Family Engagement and Board assurance are scheduled to take place after this report was written; therefore, verbal updates will be provided on these to the Board of Directors meeting in Public on 11th February 2021.

7. ACTION REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to:

- Receive and review the first version of the Ockenden Report Action Plan at **Appendix One,** and sample protect management documentation at **Appendix Two**
- Decide if any further information, action and/or assurance is required.

Hayley Flavell
Interim Executive Director of Nursing

Mike Wright
Programme Director - Maternity Assurance

February 2021

Appendix One - Ockenden Report Action Plan
Appendix Two - Sample Project Management Documentation

SHREWSBURY AND TELFORD NHS TRUST
MATERNITY SERVICES - OCKENDEN REPORT ACTION PLAN (as at 31 Jan 2021)

The Shrewsbury and Telford Hospital NHS Trust

LOCAL ACTIONS FOR LEARNING (LAFL): The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 1: Maternity Care													
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.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Revised risk assessment form introduced (at booking); audit pending. Consider making risk assessment mandatory field in Medway (and Badgernet). Handheld notes include planned place of delivery and risk category (at each appt), but audit needed to confirm this.		30/06/21		Hayley Flavell	Mei-See Hon	
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Ongoing antenatal care pathway development under way. Videos and leaflets available plus BabyBuddy app. Access to/utilisation of these needs to be determined. Key info also provided in handheld notes. Method to be introduced to confirm mother's understanding / receipt of info.		30/06/21		Hayley Flavell	Mei-See Hon	
4.56	The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Named obstetrician and midwife in place as leads for fetal monitoring. Long term resourcing to be secured and confirmation of appropriate training to be evidenced.		31/08/21		Anna Milanec	Nicola Wenlock	
4.57	These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Dedicated SBL project midwife in post, progress against Saving Babies' Lives (SBL) v2 monitored within scope of Maternity Transformation Plan (MTP). Peer review to be undertaken with Sherwood Forest Hospitals NHS Foundation Trust (SFH). Plan to lead on the development of a West Midlands dashboard and database of good practice for SBL.		15/07/21		Anna Milanec	Nicola Wenlock	
4.58	Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.	Y	10/12/20	30/04/21	Not Yet Delivered	On Track	FIGO (International Federation of Gynaecology and Obstetrics) guidelines implemented (as opposed to NICE and supported by NHSI/E improvement advisor in 2020) SATH Fetal Monitoring guideline, approved by the Clinical Network, recommends that there should be further internal review given the action for the report. This is being progressed.		30/06/21		Anna Milanec	Nicola Wenlock	
4.59	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Review of Governance team structure underway.		30/09/21		Anna Milanec	Nicola Wenlock	

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Review of Governance team structure underway.		30/09/21		Anna Milanec	Nicola Wenlock	
4.61	Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	All women with complex pregnancies are seen by an obstetrician, but an audit is required.		31/05/21		Anna Milanec	Nicola Wenlock	
4.62	There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Consultant ward rounds at 08:30 and 20:30 in place 7 days per week since September 2019, handover sheets in place, weekly MDT in-situ simulation training in place. Liaison with Anaesthesia department required to ensure inclusion on rounds (see section 'Obstetrics Anaesthesia'). Current simulation training package under review.		30/06/21		Hayley Flavell	Mei-See Hon	
4.63	Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Currently achieved. Need to be able to provide on-going evidence, Retrospective audit of notes and ongoing audit to be conducted.		30/06/21		Hayley Flavell	Mei-See Hon	
4.64	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.	Y	10/12/20	30/04/21	Not Yet Delivered	On Track	Current guideline regarding use of oxytocin is in line with national guidance, including continuous CTG monitoring. 'Fresh eyes' initiative and regular reviews by obstetricians is in place Guideline to be enhanced beyond required standards, e.g. 4 hourly review by doctor if oxytocin is being used. Standard operating process for documentation of obstetric reviews to be developed.		30/06/21		Anna Milanec	Nicola Wenlock	
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Two bereavement midwives in place. Business case submitted for additional 90 hrs of consultant time for delivery of bereavement care. Need to appointment obstetrician to co-lead on bereavement care.		30/06/21		Hayley Flavell	Mei-See Hon	
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Bereavement pathway adopted partially and commitment in place to embed it fully. Implemented the maternity bereavement experience measure. SANDS (Stillbirth and Neonatal Death Society) online training modules mandated for clinical staff, which will need to be evidenced over time. SANDS review scheduled for Feb 2021.		31/08/21		Anna Milanec	Nicola Wenlock	

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Escalation policy already in place. Updated November 2020 to describe situations where Consultants must be in attendance. Process in place to assess competencies of all middle grade doctors, not just O&G trainees. Compliance with escalation process to be audited.		30/06/21		Hayley Flavell	Mei-See Hon	
4.73	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	The risk assessment process at booking has been redesigned with an early referral for women with pre-existing medical conditions. These women are seen in multidisplinary clinics. Where there is not a relevant MDT clinic they are seen by an Obstetrician with an interest in matenal medicine for assessment and referral to a local or tertiary Physician. The development of specialist Maternal Medicine Centres is a National priority that is being led by each Clinical Network. In the West Midlands; the centre is yet to be determined but will not be SaTH. This is not within the control of SaTH to determine timescales for implementation. A business case has been submitted to allow the appointment of a Maternal Medicine Lead Obstetrician. Relevant guidelines to be reviewed to formalise local and tertiary referral processes, supported by on-going engagement with the Clinical Network		30/06/21		Hayley Flavell	Mei-See Hon	
4.74	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Named consultant is already identified for all high risk pregnant women antenatally. If risk status changes during labour, the on-call consultant assumes responsibility and becomes their named consultant. The on-call consultant attends the antenatal ward daily and reviews all inpatients. They also go to the postnatal ward daily between 1100-1200 for a handover of complex postnatal patients. This will be evidenced by an “attendance” audit and by using the the handover sheets whereby complex postnatal and antenatal cases have an “indirect” handover. Further clarity to be sought of specifics of this requirement ie: what constitutes demonstrated expertise?		30/06/21		Hayley Flavell	Mei-See Hon	

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20		Not Yet Delivered	On Track	Anaesthetists participating in some MDT ward rounds MDT emergency obstetrics course run in the SIM centre approx. 3 x per year Lead obstetric anaesthetist key facilitator in weekly in situ simulation training Obstetric anaesthetists to complete online Prompt course by 31/3/21 Include obstetric education section in each Anaesthetic governance meeting Regular obstetric anaesthesia meetings with a learning section Involvement of anaesthetists in PROMPT – both as facilitators and participants.				Anna Milanec	Nicola Wenlock	
4.86	Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.	Y	10/12/20	30/09/21	Not Yet Delivered	On Track	Good engagement with anaesthetics department. Consultant Anaesthetic Lead working closely with Clincal Director for obstetrics to ensure that anaesthetics staff are fully-embedded in the delivery of safe and effective care.				Rhia Boyode	Janine McDonnell	
4.87	Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA. Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.	Y	10/12/20	30/09/21	Not Yet Delivered	On Track	Annual audit cycle in regards to Royal College of Ananesthetists (RCoA) Guideline audit currently in place (covers theatre and epidural practice). Trust Guidelines last reviewed in 2016; new review underway. Regular guidelines review to be implemented as standing agenda item of bi-monthly obstetrics anaesthetic meeting. Audit method for compliance with the guidelines to be devised.		30/09/21		Anna Milanec	Nicola Wenlock	
4.88	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.	Y	10/12/20		Not Yet Delivered	On Track	Middle grade rota is staffed by experienced obstetric anaesthetists only. Continuous Professional Development (CPD) for consultants that cover obstetrics at night but who do not have regular sessions in obstetrics is in place. SOP/Guideline: "W*hen to Call a Consultant*" being developed. Compliance of completed CPD sessions to be collated. 'Cappuccini' audit underway and will be repeated: will demonstrate contactability of anaesthetic consultants.				Anna Milanec	Nicola Wenlock	

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Review of effectiveness of application of the ACSA (RCoA) – 189 standards is underway. In place as standing agenda item at the Obstetric Anaesthesia meeting.				Anna Milanec	Nicola Wenlock	
4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20		Not Yet Delivered	On Track	Obstetric Anaesthetist expertise is incorporated to regular Datix reviews. Regular input to 'Human Factors' investigations, also. Anaesthetics consultants to dedicate SPA time to Obstetrics in addition to current service lead in order to progress this. Will require audit evidence.				Anna Milanec	Nicola Wenlock	
4.91	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Currently working towards compliance with Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, safety action 8. Simulation course held 3 x per year In situ simulation training conducted weekly All obstetric anaesthetists to submit evidence of completion of the online PROMPT course by 31/3/21				Arne Rose	Will Parry-Smith	

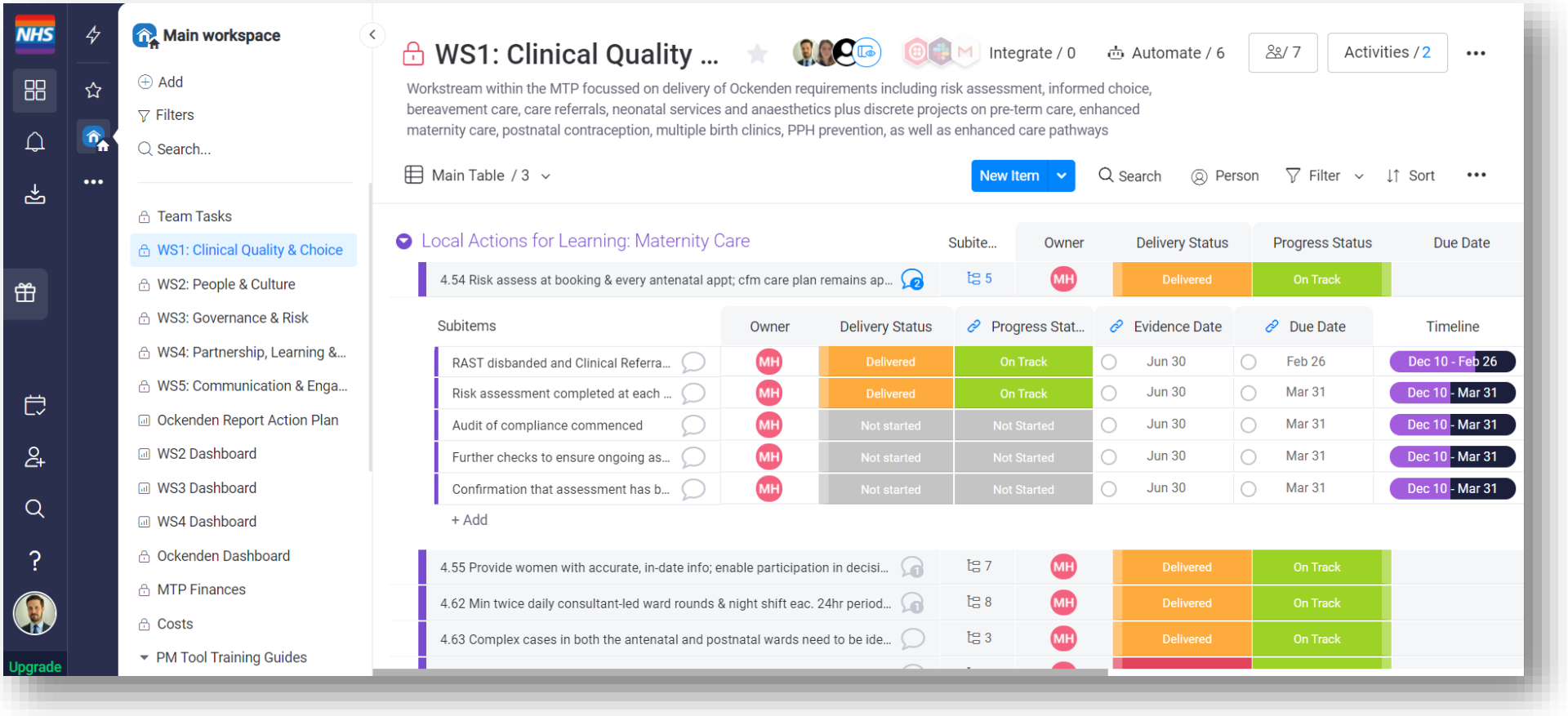
Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Roll out of combined medical and nursing notes to Neonatal Unit (NNU) planned for Q4 2020/2021. A structured 'daily notes guidance' exists already in the Neonatal Handbook Adopt combined records approach in NNU by 31/01/2021. Implement a system and problem-based recording of daily notes for babies receiving intensive and high-dependency care Ensure information on joint medical and nursing note keeping held on all staff induction Check adherence to above through audit Prepare a business case for Neonatal Badgernet EPR and explore the feasibility of using the existing summary record for daily entries in the interim.		30/04/21		Anna Milanec	Nicola Wenlock	
4.98	There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Policy for escalation already in place with audits taking place every three months by a senior Neonatologist. Adherence to exception reporting and escalation policy in line with service specification and Network requirements – to be monitored on monthly basis Recording and filing of discussions with NICUs outside of the exceptions to be implemented Review and revise the existing SOP for escalation by tier 2 staff/senior nurses to on call consultant		30/04/21		Anna Milanec	Nicola Wenlock	
4.99	The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.	Y	10/12/20	31/10/21	Not Yet Delivered	On Track	1. Business case completed and approved for additional senior clinicians to offer increased clinical presence on neonatal unit - meeting the dedicated 24 hour on-site tier 2 presence. 2. Recruitment to commence in Feb 2021 for anticipated start date of October 2021	12/01/21	31/10/21		Rhia Boyode	Janine McDonnell	
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.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Plans underway to enable observation of other NICUs Develop Job Plans to enable neonatal consultants to spend 2 weeks/year at the Network NICUs.				Arne Rose	Will Parry-Smith	

Colour	Status	Description
	Not yet delivered	Recommendation is not yet in place; there are outstanding tasks.
	Delivered, Not Yet Evidenced	Recommendation is in place with all tasks complete, but has not yet gone through the assurance and sign-off process.
	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

APPENDIX TWO: Ockenden Action Plan – Draft Screenshots of the Supporting Project Management Software Detail

Screenshot 1: The live planning environment



APPENDIX TWO: Ockenden Action Plan – Draft Screenshots of the Supporting Project Management Software Detail

Screenshot 2: Draft Ockenden Report Action Plan dashboard, showing completion rates for delivery and progress