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	

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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	

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

The Shrewsbury and Telford Hospital NHS Trust

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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	

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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	

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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	

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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	

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Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight													
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Y	10/12/20	31/10/21	Not Yet Delivered	Not Started	Review at LMNS Board in order to consider what data is required and in what format Work being scoped with NHSEI to develop national maternity dashboard with SaTH as a key stakeholder				Hayley Flavell	Nicola Wenlock	
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Not Yet Delivered	On Track	This is achieved in some cases currently. Arrange formal agreements between Trusts in order to achieve fully. Joining with a larger LMNS will support this process All cases which fulfil PMRT criteria currently reviewed with external panel member present.		31/07/21		Hayley Flavell	Nicola Wenlock	
1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	Review underway into levels of accountability and responsibility for maternity services held by this LMNS Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate and effective oversight				Hayley Flavell	Hayley Flavell	
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	SATH currently a single trust LNMS. Issue raised with NHSI/E regional office Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate effective oversight				Hayley Flavell	Hayley Flavell	
1.5	The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	This is in place but is not yet evidenced				Hayley Flavell	Hayley Flavell	
1.6	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.	Y	10/12/20	30/04/21	Not Yet Delivered	On Track	Review and strengthen SI reporting process to Trust Board and LMNS. Discussions commenced on how best to do this. Quarterly report to Trust Board using peer as example of reporting process to be developed		30/06/21		Anna Milanec	Nicola Wenlock	

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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	These roles are being developed, defined and recruited to nationally. It is understood that this process in underway				Hayley Flavell	Hayley Flavell	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Once in post, methodology for this is to be developed				Hayley Flavell	Hayley Flavell	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Non-Executive Safety Champion in post with oversight of Maternity Services Executive Safety Champion in post – Trust Executive Medical Director Work to be undertaken to ensure that women's voices are represented at Board level. Report to be taken to Board of Directors (frequency to be agreed)		30/04/21		Anna Milanec	Nicola Wenlock	
2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	SaTH has ongoing engagement with MVP for all MTP workstreams. Evidence that active and meaningful involvement is in place is required. Action to be discussed with CQC at relationship meeting				Hayley Flavell	Nicola Wenlock	

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Immediate and Essential Action 3: Staff Training and Working Together Staff who work together must train together													
3.1	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	New Multi Discilpinary leadership Team in post in the last 12 months, leading the Care Group (Doctor, Midwife and Manager) MDT Practical Obstetric Multi-Professional Training (PROMPT) training in place and occurring monthly (doctors and midwives) Weekly MDT simulation exercises take place on delivery suite with ad hoc sessions on Midwifery Led Unit Work underway within Maternity Transofrmation Plan (MTP) to develop further best practice in this area. Twice weekly Cardiotocograph (CTG) learning and feedback sessions on Delivery Suite – MDT delivered by CTG midwife and/or consultant Weekly risk management meetings in place, which are MDT, with Lead Obstetrician, Clinical Director, midwifery managers and maternity risk manager in attendance Identified Obstetric anaesthetic lead with Human Factor specialist interest attends MDT training Attendance reporting to commence using the CNST reporting template for all aspects; MDT skills drills to take place out of hours, to include an escalation scenarios, anaesthetic attendance at training sessions.				Arne Rose	Will Parry-Smith	
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	There is a twice-daily ward round on the delivery suite with the delivery suite midwifery coordinator, duty anaesthetist and obstet ric consultant in attendance. These occur at 08:30 and 20:30.If there is a change of consultant, there is an additional ward round at 17:00. 7-day working of consultant in place within maternity services; 7-day rota in place to ensure obstetric consultant cover meeting Consultant to sign a daily sheet that records the ward round Monthly audit of attendance at Ward Rounds to be introduced. Recruit 6 x additional consultant obstetricians to offer 24/7 cover by Summer 2021 Achieve compliance with CNST Maternity Improvement Scheme (MIS) safety action 4. Multidisciplinary Simulation (SIM) training and PROMPT courses already take place.		30/06/21		Hayley Flavell	Mei-See Hon	

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3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	This is not in place currently. MTP Workstream 4 has in scope proposals regarding how much time is required by clinical staff in order to complete their training and an uplift may be required. Identify which funding streams need to be ring-fenced including money from Health Education England (HEE) for students Mechanism for this yet to be established with the Executive Director of Finance				Hayley Flavell	Hayley Flavell	

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.

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 4: Managing Complex Pregnancies There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.													
4.01	Women with Complex Pregnancies must have a named consultant lead.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	All women with complex pregnancies have a named consultant lead Appropriate risk assessment documented at each contact Implement a formal auditing process and report to respective local governance meetings Review of Midwifery led cases for appropriate referral onwards, to be undertaken.				Hayley Flavell	Mei-See Hon	
4.02	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Antenatal risk assessments to continually reassess care pathway incorporated and being further developed, including integration with Badgernet Fetal monitoring a priority, with specific leads in place to champion awareness Individual pathways incorporating pre-existing morbidities created Connections to be developed in order to achieve holistic solution. Process already in place including specialist antenatal clinics for diabetes and endocrine, haematology, cardiac disease, rheumatology, respiratory, gastro, neurology and mental health. Review of women with additional needs at monthly multidisciplinary meetings. This may include specific medical conditions but, also, for individualised birth plans. Business case submitted for additional consultant hours to staff an "Urgent" Antenatal clinic to see women developing complex obstetric conditions. Validate and document that these requirements are being fulfilled.				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.

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
4.03	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Exploration of specialist centres under way. Network identified, but connections yet to be put in place (see Local Action for Learning 4.73) Onward referral process to be developed Formalise connections with specialist maternal medical centres Obstetric Clinical Director engaged in discussions with network. This is an on-going discussion regionally and nationally in terms of how SaTH dovetails with these and connects to them. Pathways in place for transfer to specialist centres if required i.e. cardiac Gain an updated understanding of this across the region – regional leads are taking this forward. SaTH has determined that we do not wish to be a maternal medicine centre but we are currently awaiting further guidance.				Hayley Flavell	Mei-See Hon	
4.04	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Obstetric Clinical Director enagaged with network on this topic.				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.

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y LAFL 4.54	10/12/20	31/03/21	Not Yet Delivered	On Track	For Intrapartum care high risk women wil have risk re-assessed hourly throughut labour with "fresh eyes" review. A seperate risk assessment tool is being developed for women receiving low risk care in all birth settings to clearly document a regular review of risk status. Audit required to confirm ongoing assessment and reassessment, including during labour, is being observed Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact Manual audit underway as stop-gap; weekly feedback Formalised audit to be implemented Rapid Implementation of Badgernet EPR system to allow data extraction and analysis.		30/06/21		Hayley Flavell	Mei-See Hon	
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Place of birth revalidated at each contact as part of ongoing risk assessment Mother's choices based on a shared and informed decision-making process respected This is to be checked within the scope of the audit mentioned at LEA 5.01		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.
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IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.													
6.1	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: * Improving the practice of monitoring fetal wellbeing * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Raising the profile of fetal wellbeing monitoring * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Lead MW for fetal monitoring 0.4 WTE in place on secondment. Lead obstetrician in place with allocated time and job description – 1 SPA per week incorporating PROMPT, Fetal monitoring (0.5) & education and training. Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases. Job descriptions and personal specifications to be scoped to ensure they fulfil all of the required criteria Further recruitment underway Audit of guidelines underway Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases.		31/08/21		Anna Milanec	Nicola Wenlock	
6.2	The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Twice weekly training and review MDT meetings in place reviewing practice and identifying learning. Lead Midwife attends weekly risk meetings to ascertain if CTG is a key or incidental finding in any incident. K2 training for midwives and obstetricians in place Incidents reviewed for contributory / causative factors to inform required actions. Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases Audit compliance with new guideline.				Arne Rose	Will Parry-Smith	
6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Named project midwife responsible for Saving Babies Lives in place - 1.0 WTE secondment Ongoing implementation and reporting of progress of SBL Care Bundle in place CNST safey action 6 compliance reporting and SBL complaince reporting in place.		15/07/21		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.

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 7: Informed Consent All Trusts must 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.													
7.1	All maternity services must 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	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Patient information leaflets available on the Internet (SATH Homepage), including recently developed leaflet of choice for place of birth co-produced with the MVP. Also includes link to national PIL on Caesarean section (Tommy's) and Birth after previous caesarean section (RCOG). Work currently on-going as part Antenatal Care Pathway sub-project; videos, leaflet and Baby Buddy app available. Developing links for women to watch videos on relevant pregnancy topics such as IOL to assist in digesting information. Women who are requesting to have a caesarean section are referred to a consultant-led birth options clinic, where this is explored and management is individualised according to their choice. Patient feedback notice boards in place on inpatient areas. Translation services available for consultations.Through audit, need to confirm that the mother and partner / family have received and consumed the information as intended. Digitalisation of patient record through the implementation of the Badgernet system. The Communication and Engagement workstream includes MVP and patient representation. Review of other websites required to identify best practice. Link with local LMNS and units that also provide care to women from Shropshire to ensure consistent approach to information.		30/06/21		Hayley Flavell	Mei-See Hon	
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Work currently on-going as part Care Pathway sub-project Confirm that the mother and partner / family have received and consumed the information as intended A process for auiditing this will need to be established.		30/06/21		Hayley Flavell	Mei-See Hon	
7.3	Women's choices following a shared and informed decision making process must be respected	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	A mechanism for measuring and auditing this needs to be developed. Dedicated PALS officer to be appointed to Maternity Services to offer in-reach and provide real time feedback.		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.

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

Colour	Status	Description
	Not yet delivered	Action is not yet in place; there are outstanding tasks to deliver.
	Delivered, Not Yet Evidenced	Action is in place with all tasks completed, but has not yet been assured/evidenced as delivering the required improvements.
	Evidenced and Assured	Action is in place; with assurance/evidence that the action has been/continues to be addressed.

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadine or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	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.

Accountable Executive and Owner Index

Name	Title and Role	Project Role	
Hayley Flavell	Executive Director of Nursing	Clinical Quality and Choice Executive Sponsor, Overall MTP Executive Sponsor	
Arne Rose	Executive Medical Director	Executive Sponsor, Learning, Partnership & Research	
Mei-See Hon	Clinical Director, Obstetrics	Co-Lead, Quality and Choice Workstream	
Guy Calcott	Obstetric Consultant	Co-Lead, Quality and Choice Workstream	
Rhia Boyode	Workforce Director	Executive Sponsor, People and Culture Workstream	
Janine McDonnell	W&C Divisional Director	Lead, People and Culture Workstream	
Anna Milanec	Director of Governance	Executive Sponsor, Governance & Risk and Comms & Engagement	
Nicola Wenlock	Director of Midwifery	Lead, Risk and Governance Workstream	
William Parry-Smith	Obstetric Consultant	Lead, Learning, Partnerships and Research	
Kirsty Walker	Director of Communications	Lead, Communication and Engagement Workstream	

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting
11 February 2021

Agenda item	039/21			
Report	Ockenden Report Governance Arrangements – Chief Executive's Report of Board Seminar 5th February 2021			
Executive Lead	Chief Executive			
	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	√	BAF1, BAF4	
	For decision / approval		**Link to risk register:**	
	For review / discussion	√	970, 1083, 1930, 2027, 2065	
	For noting	√		
	For information	√		
	For consent			
Presented to:	Matters discussed at a board seminar on 5th February 2021			
Dependent upon (if applicable)**:**	n/a			
Executive summary:	This brief report provides a summary and overview of the Board. Seminar held on 5th February 2021 to consider the governance. arrangements in support of the plans to implement in full the recommended actions arising from the First Ockenden Report (December 2020). The report should be read in conjunction with the two accompanying reports on the Board agenda dealing in more detail with the Ockenden Report Action Plan and Governance Arrangements. **Recommendation:** The Board is asked to note the contents of this report that should be read in conjunction with the accompanying reports dealing with the Ockenden Report Action Plan and Governance Arrangements.			
Appendices	N/A			

1.0 Introduction

1.1 The first Ockenden Report was published on 10th December 2020 and at its meeting on the 7th January 2021 the Trust's Board of Directors formally accepted the report, its findings, and recommended actions in their entirety and without reservation. Importantly, having considered the report in detail and its many examples of poor practice, behaviours, and outcomes the Board of Directors put on record its unreserved apology to the women, babies, and families whose unacceptable treatment and care is highlighted in the report.

1.2 However, it is fully recognised that this is not enough. The Trust has failed to learn lessons from individual cases and internal reviews of its services. The Ockenden Report says exactly this (paragraph 1.13) and goes on to make a "call to action" demanding that there must be an end to investigations, reviews and reports that do not lead to meaningful change. This is the challenge for the Trust which it must not fail to deliver. Our objective, through the implementation of the Ockenden Report actions, is to improve safety and quality of maternity services and restore the confidence of women and families in our maternity services. In rising to this challenge, we cannot rely on approaches that have been used before and which have clearly not worked. Our approach must be different and engaging. It cannot be confined to the boardroom and the hospital. We must work with and engage service users in making real change and improving safety in maternity services. Through our work and commitment we must demonstrate real and lasting improvements.

1.3 With this in mind, and to start the process, we agreed that there would be benefit in holding a short Board seminar on the approach to the governance arrangements that the Trust should consider putting in place to support delivery of the Ockenden Report actions. The Board Seminar was held on 5th February and my brief report summarises some key outcomes. The session started with a reminder of the details of some of the cases reported in the Ockenden Report. There are more detailed reports on the agenda which describe the Trust's proposed approach to the Ockenden Report governance arrangements and current progress in implementing the fifty-two actions.

1.4 This will not be the only such session held and as we embark on this journey, we plan other similar sessions and engagement events.

2.0 Ockenden Report Action Plan

2.1 A separate Board report is on today's agenda that provides a summary of the Trust's delivery of the fifty-two Ockenden Report actions. At the seminar focus was on the real need to ensure that each of the actions is implemented, sustained, and embedded. With this in mind Mike Wright (Programme Director, Maternity Assurance) explained a revised approach to the progress RAG rating approach (red, amber, green) that would result in recommendations staying red until they are implemented. The intention being that the Trust should not lose sight of the task and remain focussed on the work still to done to ensure implementation of all actions.

3.0 Ockenden Report Governance Arrangements

3.1 The main focus of the seminar was to consider the governance arrangements that

the Trust should put in place to ensure the delivery of the Ockenden Report actions.

3.2 However, I would emphasise a few points. It is clear that previous approaches to delivering and implementing internal enquiry reports have not worked and a different approach is needed which is visible to women and families and that provides for meaningful engagement with them. A time-limited Board Committee is proposed that will have a dedicated chair with the requisite skills and experience and that will work in a different way – it will not be the usual Trust Board assurance committee.

3.3 The governance arrangements also include an external expert advisory panel that will provide an advisory role to the Board of Directors, utilising its expertise as a "critical friend". The panel will be chaired by Dr Bill Kirkup who chaired the Morecambe Bay Inquiry, and the Trust must take full advantage of his and his panel's expertise to enable it to get this right.

4.0 Conclusion

4.1 Finally, the seminar was reminded that families did not feel listened to and of the failure to respect the views of women and families. This was recognised as the cornerstone of what the Trust needs to deliver without which there can be no improvement and change. Consequently, I was able to confirm the Trust's plans to develop an engagement strategy with the intention of holding a further seminar on this critical theme.

Louise Barnett
Chief Executive
February 2021

Board of Directors' Meeting
11 February 2021

Agenda item	039/21			
Report	Ockenden Report Governance Arrangements			
Executive Lead	Director of Governance & Communications			
	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	√	BAF1, BAF4	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√	970, 1083, 1930, 2027, 2065	
	For noting	√		
	For information	√		
	For consent	√		
Presented to:	Board Seminar 5th February 2021			
Dependent upon (if applicable)**:**	N/A			
Executive summary:	1. The report describes the proposed governance arrangements that are being recommended to the Board of Directors in order to deliver the recommendations and actions of the First Ockenden Report. Specifically, it proposes a set of governance arrangements which offer a different approach to what has gone before, acknowledging that these have not served the organisation well to date. 2. A time-limited Ockenden Report Assurance Committee is proposed which offers a different approach. Primarily, a difference in approach that is about ensuring its work involves representative stakeholders and that enables the organisation's progress in implementing the Ockenden actions to be presented through an engaging narrative. The aim is that the work of the Committee is not simply confined to the walls of the organisation. The key task is to implement all the actions in the Ockenden Report and as a result to re-establish confidence in the Trust's Maternity Services. The key features in the			

	approach and working of the Committee are aimed at achieving this objective and are described in the report. 3. The report also sets out a number of other features of the proposed governance arrangements including the relationship to the External Expert Advisory Panel with the intention of ensuring consistency between each committee's roles. 4. Terms of reference of the Ockenden Report Assurance Committee are attached at Appendix 1 together with diagrammatic representation of the governance arrangements. 5. **Recommendations** The Board of Directors is asked to: • Agree to the establishment of the Ockenden Report Assurance Committee and its terms of reference; • Note the proposal to ensure consistency with the terms of reference of the External Expert Advisory Panel; • Note that further consideration is to be given to the most appropriate mechanism for ensuring effective Executive Director delivery and oversight of the implementation of the Ockenden Report actions.
Appendices	Appendix 1: Terms of Reference of Ockenden Report Assurance Committee Appendix 2: Diagram of Ockenden Report Governance Arrangements

First Ockenden Report Governance Arrangements

Background

1. The first Ockenden Report (December 2020) makes a "call to action" – there must be an end to investigations, reviews and reports that do not lead to meaningful change (pragraph1.13). The Board of Directors needs to demonstrate that it has understood and "gets it". In order to rise to this necessary challenge, consideration needs to be given to the governance arrangements related to the delivery of the recommendations of the Ockenden Report.

2. The governance arrangements that the Trust has used in the past to assure itself in relation to the implementation of actions from other reports have not served the organisation well, and hence the current position. Governance arrangements and approaches need to be put in place to ensure the successful implementation of all of the Ockenden actions. These need to offer a different approach and, importantly, need to be visible to the public, women & families as a clear demonstration of progress and change. Failure is not an option.

An Ockenden Report Assurance Committee

3. The Board of Directors should establish a time-limited Board Committee (the Ockenden Report Assurance Committee) with a role to provide the assurance and accompanying evidence to the Board of Directors, the public and service users, commissioners, and regulators relating to the delivery, sustainability, and embeddedness of each of the fifty-two actions arising from the first Ockenden Report.

4. So, what will be different from what has gone before? Primarily, a difference in approach that is about ensuring its work involves the public and representative stakeholders and that enables the organisation's progress in implementing the Ockenden actions to be presented through an engaging narrative. There would be no point in the work of the Committee simply being confined to the walls of the organisation. The key task is to implement all the actions in the Ockenden Report and as a result to re-establish confidence in the Trust's Maternity Services, supported by approaches which achieve engagement with the public, women and families in a genuine and meaningful way. Key features in the approach and working of this Committee which support this aim will include:

    - a detailed work programme, agreed with the Board of Directors, with a clear timeline for completion of the work.

    - the appointment of a Chair who is appointed specifically to chair and lead this Committee with the requisite skills and experience – a skill set and experience that is about working with and engaging the public in difficult discussions and circumstances.

- a mechanism for reporting regularly to the Board of Directors and through it to the women, families and the wider public.

- to ensure that the work of the Committee through its membership is thoroughly informed by the involvement of relevant stakeholders and groups representing service users (women and families)

- an approach to describing and presenting its work in a concise, meaningful, and respectful way with women, families and the public always in mind.

- an approach to the work of the Committee which recognises that it needs to work and engage in a way that offers more than the usual approaches to assurance.

- a simple and clear route which enables the organisation to progress the implementation of the Ockenden actions and that is visible to the public and service users.

5. A set of draft terms of reference for this Committee are attached at Appendix 1.

Relationship to the External Expert Advisory Panel – Maternity

6. The External Expert Advisory Panel was established by the Board of Directors in July 2020 to provide external expert advice and scrutiny, together with effective and evidenced assurance of the outputs from the Maternity Improvement Programme and related to the range of actions required and identified from the first Ockenden Report (December 2020).

7. Through the assurance from the Ockenden Report Assurance Committee to the Board of Directors it would remain the intention that the External Expert Advisory Panel provide an advisory role to the Trust, utilising its expertise as a 'critical friend'. The Trust would present its work and progress to the External Expert Advisory Panel four times a year and receive the panel's expert advice and feedback for the benefit of the Board of Directors, women, families and the wider public.

8. The opportunity will be taken to review the terms of reference of the Committee in conjunction with its Chair.

Other Ockenden Report Governance Arrangements

9. In support of the work of the Ockenden Report Assurance Committee it is proposed that an Executive delivery group be established. One option to achieve this would be to split the work programme of the existing Maternity Quality Operational Committee to allow a dedicated Ockenden Report workstream chaired by an appropriate Executive Director. In turn the work of this Committee as it relates to the Ockenden Report would be available to the Assurance Committee and would report to it. The most effective approach to achieving this is being considered and will be resolved shortly.

10. It is apparent from a brief review of the current Maternity Services governance arrangements that there are a number of committees and groups in place. These each need to be reviewed to ensure a focussed approach and where possible stood down. The Board of Directors should not hold a mistaken belief that the existence of a committee or group will ensure delivery of a desirable outcome. More important, is the need for clear direction, leadership, time, and resources to enable the operational team to deliver the desired outcome.

Resources

11. The work of the Ockenden Report Assurance Committee needs to be properly resourced and serviced through an appropriate secretariat.

12. Additional resources may also need to be available to support and enable operational managers to undertake the work that will be required by the Committee and in the delivery of the required actions.

Recommendations

13. The Board of Directors is asked to:

- Agree to the establishment of the Ockenden Report Assurance Committee and its terms of reference;

- Note the proposal to ensure consistency with the terms of reference of the External Expert Advisory Panel;

- Note that further consideration is to be given to the most appropriate mechanism for ensuring effective Executive delivery and oversight of the implementation of the Ockenden Report actions

Director of Governance & Communications
February 2021

Appendix 1

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee

Draft Terms of Reference

1. Introduction and Purpose

The Board of Directors has set up the Ockenden Report Assurance Committee, which will be responsible and directly accountable to it.

The principal purpose of the Committee will be to obtain and provide assurance in relation to the delivery, evidence, sustainability and impact of the implementation of the actions arising from the first Ockenden Report (December 2020). It will, therefore, be a time-limited Committee which will be determined by its programme of work as agreed with the Board of Directors, and which is not expected to extend beyond twelve months.

In establishing this Committee, the Board of Directors is also mindful of the "call to action" signalled in the Ockenden Report that there must be an end to investigations, reviews and reports that do not lead to meaningful change (paragraph 1.13). It is clear, therefore, that in order to rise to this necessary challenge that the approach to the work of this Committee must be different and which is reflected in its membership and duties set out below.

2. Principal Duties

- To thoroughly review and understand the progress and completion of the implementation of all of the actions arising from the first Ockenden Report (December 2020), namely fifty-two actions comprising twenty-seven Local Actions for Learning (LAFL) and seven 'themed' Immediate and Essential Actions (IEAs) which in turn comprise 25 specific sub actions.

- To provide the assurance and accompanying evidence to the Board of Directors, the public, service users (women and families) commissioners and regulators relating to the delivery, sustainability and embeddedness of each of the fifty-two actions arising from the first Ockenden Report.

- To enable delivery of its key principal duties, the Committee will develop, and subsequently agree with the Board of Directors, a detailed work programme which will include a clear timeline for the completion of its work.

- To ensure that the work of the Committee through its membership is thoroughly informed by the involvement of relevant stakeholders and groups representing service users (women and families)

- To work in a way that recognises the organisational impact of this critical work and which is supportive to Executive Directors directly responsible for the implementation of the Ockenden Report actions and, in equal measure, challenging.

- To ensure that any risks to delivery are identified, understood, and are being appropriately managed and mitigated where possible, and to report to the Board of Directors, by exception, any significant risks to delivery.

- To ensure that the work of the Committee is described and presented in a way that is concise, meaningful, and respectful of women and families.

- To commission any further work, as necessary, to ensure delivery of the Committee's work programme.

3. Membership

Members of the Committee will be:

- Chair
- Other Non-Executive Directors/Associate Non-Executive Directors (at least two)
- Chief Executive
- Executive Director of Nursing
- Medical Director
- Relevant stakeholders and groups representing service users (women and families) and linked to the programme of work under discussion
- Representative of the Commissioners

Attendees of the Committee will comprise:

Representatives of Service Delivery Team which may include:

- Care Group Medical Director – Women and Children's Care Group
- Care Group Director – Women and Children's Care Group
- Director of Midwifery
- Clinical Director – Obstetrics

Representatives of the Project Support Delivery Team which may include

- Programme Director – Maternity Assurance
- Maternity Transformation Workstream Leads
- Maternity Governance Lead
- Maternity Transformation Team Senior Project Manager
- Head of Maternity Improvement

Any other Trust staff as required to support the Committee in its deliberations

External Communications support

4. Secretariat

The Committee will be supported by an appropriately skilled and resourced secretariat.

5. Quoracy

Quoracy of the meetings shall be by simple majority of the Committee's members.

6. Frequency of Meetings

Meetings of the Committee shall be held in accordance with the requirements of the work programme and at least monthly in order to complete its work in a timely manner.

7. Reporting

The Committee shall report monthly to the Board of Directors in the form of a comprehensive report provided by the Committee Chair.

The Board of Directors will also set aside sufficient time at its Board meetings to enable the work of the Committee to be appropriately considered in keeping with the critical importance of this matter. This may take the form of dedicated Board sessions from time to time dealing with the key themes of the Ockenden Report and forming the work programme of the Committee.

In this way the work of the Committee will be made available in the public domain. In addition, it will also be open to the Committee and Board of Directors to develop and ensure regular communication and updates on the progress in implementing the Ockenden Report actions.

8. Relationship to the role of the External Expert Advisory Panel – Maternity

The External Expert Advisory Panel was established by the Board of Directors in July 2020 to provide external expert advice and scrutiny, together with effective and evidenced assurance of the outputs from the Maternity Improvement Programme and related to the range of actions required and identified from the first Ockenden Report (December 2020).

Through the assurance from the Ockenden Report Committee to the Board of Directors it is the intention that the External Expert Advisory Panel provide appropriate additional scrutiny and examination of the work of the Ockenden Report Assurance Committee for the benefit of the Board of Directors.

9. Review

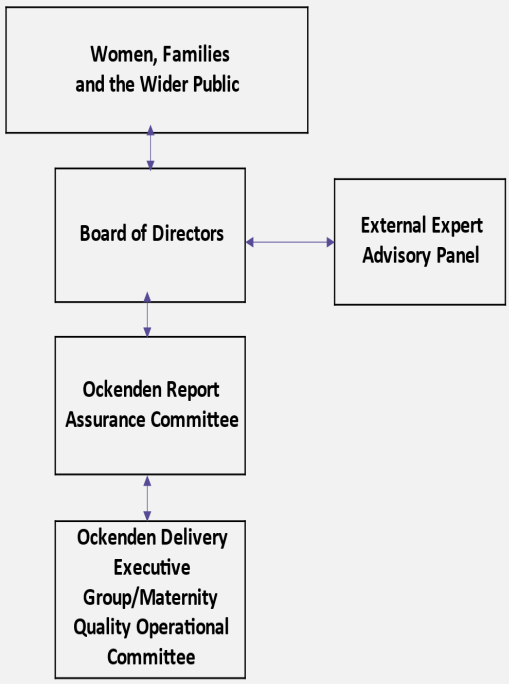
In the event that material amendments need to be made to the terms of reference during the life of the Committee, approval of the Board of Directors will be sought.

February 2021

Appendix 2

Governance Arrangements: Ockenden Report

The Shrewsbury and Telford Hospital NHS Trust



Board of Directors
11 February 2021

Agenda item	AOB			
Report	Ockenden Assurance Assessment Tool			
Executive Lead	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 1204	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	MQOC - 09.02.21 LMNS Board - TBC Board of Directors - 11.02.21			
Dependent upon (if applicable)**:**				
Executive summary:	Following the publication of the first Ockenden Report, all NHS providers of maternity care were required to provide an initial assessment to NHSE/I Regional Office against 12 urgent clinical priorities comprising of key elements contained within the 7 Immediate and Essential Actions (IEA's) by 21st December 2020. This submission also required Trusts to submit position updates in regards to maternity workforce planning, midwifery leadership and NICE guidance related to maternity services. The submission was made using a provided assurance assessment tool. The Trust submitted this by the required deadline. A second submission comprising assessment against all element of the IEA using the assessment and assurance tool was originally due to be submitted to the NHSE/I Regional Office by 15th January 2021. However, due to significant operational pressures within all NHS Trusts as a result of the pandemic, this has now been changed to 15th February 2021. Prior to this, the revised submission must be shared with the LMNS Board and reported at the next public Board of Directors.			

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months
Link to Maternity Safety actions: **Action 1:** Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? **Action 2:** Are you submitting data to the Maternity Services Dataset to the required standard? Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?
Link to urgent clinical priorities: A plan to implement the Perinatal Clinical Quality Surveillance Model All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.						
What do we have in place currently to meet all requirements of IEA 1?	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
Maternity and neonatal dashboard in place and outcomes monitored through MQOC and maternity & neonatal governance meetings Maternity dashboard reported at MQOC and CQRM Gap analysis process for national reports, which identify recommendations for improving / changing clinical practice. Ward to Board reporting mechanisms in place including additional assurance committee - MQOC	Provision of evidence based care. Benchmarking of service & outcomes with other units and against national measures to enable focussed improvements Local dashboard in place to monitor emerging trends and areas for focus	• Reduction in avoidable perinatal harm • Benchmarking against other units • Reduction in repeat causation incidents • Compliance with CNST MIS safety actions 1, 2 and 10	Review at LMNS Board in order to consider what data is required and in what format	31/05/21 NW	Performance analyst Robust clinical outcomes data Rapid implementation of Badgernet EPR	LMNS SRO chairs CQRM and attends MQOC Neonatal dashboard received at Divisional Committee (CGC) Work being scoped with NHSEI to develop national maternity dashboard with SaTH as a key stakeholder
			Report neonatal performance data at MQOC, CQRM & LMNS Board	31/05/21 LA		
			Implement Badgernet EPR	31/05/21 RG		
			Develop SOP for receiving & responding to national reports into service	31/05/21 RM		
			Implement Perinatal Quality Surveillance model	31/06/21 LMNS		
			Implement QI methodology across all dashboard (SPC charts)	30/06/21 LA / NW		
			Review neonatal dashboard to ensure best practice is adopted	30/06/21 LA / NW		

External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.						
All cases which fulfil PMRT criteria currently reviewed with external panel member present All HSIB cases reviewed by external HSIB panel	Externality provides an independent review. Ensures benchmarking with other unit Ensures networking to identify best practice and shared learning	• Reduction in avoidable perinatal harm • Benchmarking against other units • Reduction in repeat causation incidents • Compliance with CNST MIS safety actions 1, 2 and 10 • SaTH not an outlier in any safety measures	• Arrange formal agreements between Trusts in order to achieve fully.	30/06/21 MU	Agreement with another Trust / LMNS Joining with a larger LMNS will support this process	• Another Trust approached on case by case basis. • Peer review process being set up with another Trust
			• Develop partnership with other LMNS and clinical network	30/06/21 LB		
			• Develop agreed framework with peer Trust regarding peer review scope and implementation.	30/04/21 HF		

LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.						
SaTH is a single Trust LMNS. This has been raised with Commissioners and NHSEI. Discussion ongoing to enable collaboration with a second LMNS	NA	Benchmarking against other units SaTH not an outlier in any safety measures Sharing & embedding best practice & learning	Review of membership of LMNS with a view to joining a larger LMNS.	31/05/21 LB	Regional support to merge	Review underway into levels of accountability and responsibility for maternity services held by this LMNS
			Review of current structure and work streams to ensure adequate and effective oversight	30/06/21 LMNS SRO		

The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.						
A new Chair is being approached – currently not CCG Board member	NA	NA	New Chair to be identified and appointed	30/06/21 LMNS SRO	New Chair identified	LMNS SRO is CCG Board member and attends LMNS Board

An LMS cannot function as one maternity service only.						
SaTH is currently a single provider LMNS Discussions ongoing to enable collaboration with a second LMNS	NA	• Benchmarking against other units • SaTH not an outlier in any safety measures • Sharing & embedding best practice & learning	• Review of LMNS with view to joining another LMNS	30/06/21 LB	Regional support to merge	• Partnership with another Trust to provide peer review & benchmarking • Issue raised with NHSI/E regional office
			Review of current LMNS structure and work streams to ensure adequate & effective oversight	30/06/21 LMNS SRO		

All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.						
Maternity SI's discussed at Maternity Clinical Quality review Meeting (**CQRM**) and Maternity Quality Operational Committee (**MQOC**) SI's are reviewed and discussed at Review and Learning from Incident Group (**RALIG)**, which is chaired by the DoN/MD SI's are reported to the Trust Board but the content of this report will now be reviewed in line with this guidance. All SI's and timeliness of same are reviewed monthly at CQRM with commissioners.	All SI's discussed at Maternity Governance monthly Maternity CQRM is held monthly as is MQOC (chaired by an executive DoN/MD) RALIG is held weekly and chaired by executives Challenge is provided at all of these forums in terms of lessons learned and evidence and sustainability of same. A SI rapid review process is in place, however timelines for HSIB reporting means that the ability to extract and apply learning points may be delayed	Reduction in avoidable perinatal harm Benchmarking against other units Reduction in repeat causation incidents Compliance with CNST MIS safety actions 1, 2 and 10	Review and strengthen SI reporting process to Trust Board and LMNS.	30/04/21 Director of Nursing/MD	Support from corporate patient safety team.	DoN/MD oversight Escalation to Quality and Safety Assurance Committee (Board committee).
			Develop process for reporting SIs to Trust Board and LMNS	28/02/21 NW		
			Monthly report to Trust Board & LMNS using peer as example of reporting process to be developed	30/04/21 NW		
			Develop Rapid review criteria to ensure defined incidents are considered at RALIG	30/04/21 RM		

Urgent Clinical Priority (as reported in December 2020): A plan to implement the Perinatal Clinical Quality Surveillance Model						
What do we have in place currently to meet all requirements of IEA 1?	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
Information regarding the model released 18/12/20 Process being reviewed by LMNS SRO Pathway in development	The Trust will use this tool to enhance perinatal safety through consistent delivery, measurement and reporting.	Recommendations implemented Reduction in avoidable perinatal harm/SI's Benchmarking against other units, where available, to inform learning and improvement	Gap analysis against each element and associated action required now the model has been received	30/06/21 LMNS	Performance analyst	Dashboard presented at MQOC and CQRM & action taken where trends are identified ie. PPH audit Peer partnership in place NHSEI partnership in place to develop dashboard
			Maternity Dashboard to be strengthened in line with the model using QI methodology	30/06/21 NW		
			The Trust will seek to secure external review of all serious incidents	30/06/21 MU		
			Pursue a partner LMNS relationship (single LMNS). This would strengthen our ability to benchmark externally and also reduce the burden on a single provider to action and deliver changes required.	30/06/21 LB		

			Develop new structure for reporting using the model	30/04/21 LMNS SRO		

Urgent Clinical Priority (as reported in December 2020): All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB						
Maternity SI's discussed at Maternity Clinical Quality review Meeting (**CQRM**) and Maternity Quality Operational Committee (**MQOC**) SI's are reviewed and discussed at Review and Learning from Incident Group (**RALIG)**, which is chaired by the DoN/MD	All SI's discussed at Maternity Governance monthly Maternity CQRM is held monthly as is MQOC (chaired by an executive DoN/MD) RALIG is held weekly and chaired by executives Challenge is provided at all of these forums in terms of lessons learned and evidence	Reduction in avoidable perinatal harm Benchmarking against other units Reduction in repeat causation incidents Compliance with CNST MIS safety actions 1, 2 and 10	Review and strengthen SI reporting process to Trust Board and LMNS.	Director of Nursing/MD	Support from corporate patient safety team.	DoN/MD oversight Escalation to Quality and Safety Assurance Committee (Board committee).

SI's are reported to the Trust Board but the content of this report will now be reviewed in line with this guidance. All SI's and timeliness of same are reviewed monthly at CQRM with commissioners.	and sustainability of same. A SI rapid review process is in place, however timelines for HSIB reporting means that the ability to extract and apply learning points may be delayed		Rapid implementation of Badgernet maternity EPR to support MSDS submission and data retrieval			

Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard. Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
Link to Maternity Safety actions: **Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** **Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**
Link to urgent clinical priorities: 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. In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive 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.

Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.						
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
This is being implemented by the national team and the Trust await further information	Reports received to Trust Board and LMNS Board Action log reviewed and maintained Embedded within PALS process.	Improved FFT and maternity survey response rates Evidence provided of proactive communication between advocate & service leaders with demonstrated action.	These roles are being developed, defined and recruited to nationally. It is understood that this process in underway	TBA by national team	National team to action urgently	Safety champions & FTSU Guardians in place MVP feedback
The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.						
See above. This will be included within the national job description for the advocates.	Meetings held with advocate in attendance where requested by families**.**	Feedback from families and advocate to Trust Board as detailed above	Once in post, methodology for this is to be developed	TBA by national team	National team to action urgently	PALS member in attendance if requested by family.

Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.						
Non-Executive Safety Champion in post with oversight of Maternity & Neonatal Services They meet monthly and include visits to services. Executive Safety Champion in post – Trust Executive Medical Director	• Reporting to MQOC - reporting needs to be in line with CNST reporting requirements • Reporting to Trust Board	• Improved staff survey results and reduced staff turnover • Increased staff survey response rates in all staff groups • Improved FFT and maternity survey response rates (as above) • Achieve compliance with associated CNST MIS safety actions • Staff able to identify Safety champions and articulate role plus one action completed by them in responses to feedback	Work to be undertaken to ensure that women's voices are represented at Board level	Exec and NED safety Champions and local maternity safety champions – ongoing action	Increase presence/ connection to Freedom to Speak Up (FTSU) guardian to ensure staff voices are heard independently of managerial team	• FTSU guardians in place in Trust and visiting maternity areas. • Staff and service users on MTP work stream Local maternity safety champions and PMAs in post Creating safe space (previously referred to as Listening sessions) secured and to be run throughout February 2021 to feed into cultural assessment and action planning. Ensure this work is part of the wider Trust culture programme
			Staff and patient feedback to form part of local Maternity Transformation Plan's (MTP) culture and OD work stream including feedback from Safe Spaces (formally known as Listening Session) Dates to be agreed & publicised throughout Care Group	J Mc 31/05/21		
			Seek support from Head of Leadership and Lifelong Learning – Midlands & NHSEI for support and interventions to ensure staff voices are heard.	J Mc 28/02/21		

			Report to be taken to Board of Directors (frequency to be agreed)	31/03/21 Exec and NED safety Champions and local maternity safety champions		
			Review HEE Quality Intervention report to further develop cultural workstream ensuring voices of students within maternity services are heard. Action plan to be developed in partnership with Corporate Nursing and OD	DM 31/05/21		

CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.						
Compliant with CNST MIS safety action 7 Evidence of co-production with MVP eg. PCSP, Birth Choices leaflet, support person passport, recruitment, MTP work streams Use of CQC core assessment framework to underpin Maternity Improvement Plan SaTH has ongoing engagement with MVP for all MTP workstreams. Maternity survey based on CQC maternity survey questions, conducted monthly. "Patient stories" shared at Care Group Committee NHS Choices website reviewed and feedback	Achievement of CNST MIS SA 7 Compliance with CQC assessment element Monthly Patient Experience report to Maternity Governance, MQOC, CQRM, PACE MVP minutes LMNS work stream update to LMNS board	Improved FFT and maternity survey response rates Increased engagement from families in service developments Increased responsiveness to complaints Co-produced documents endorsed by MVP	Action to be discussed with CQC at relationship meeting	30/06/21 HF	Funding for MVP chair / members to enable this work to be completed Dedicated PALS officer with 'in reach' service into maternity unit	Use of the CNST MIS to evidence co-production and involvement An engagement plan is being developed to ensure women and families are listened to and their voices are heard. This will ensure an integrated approach
			Evidence that active and meaningful involvement is in place is required.	31/05/21 MVP		
			Undertake gap analysis against the Caring domain in the CQC core assessment framework for maternity services	30/04/21 Matrons / MVP Chair / members		

from women provided to staff involved. Trust Website feedback reviewed and provided to staff involved. Social media pages – both Trust and MVP Patient and Carer Experience Panel meeting in place (PACE)			Further work to link with other Trusts identified as exemplar in relation to patient engagement to understand their measure of success in regards	Director of Midwifery 31/07/21		
			Develop, in partnership with service users “always” events and commitment statement for the service	Deputy Head of Midwifery 31/07/21		
			Develop a “you said, we have” process in maternity services	Deputy Head of Midwifery 31/07/21		
			Ensure that An engagement plan is being developed to ensure women and families are listened to and their voices	Triumvirate 31/07/21		

			are heard. This will ensure an integrated approach			
			Ensure this work is part of the wider Trust culture programme to enable cross learning of patient involvement across all areas of the Trust	Acting Director of Workforce – 31/07/21		

Urgent Clinical Priority (as reported in December 2020): 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 co-produce local maternity services						
• Friends and Family Test in operation • Maternity Voices Partnership (MVP) attended periodically by midwifery representatives. • Maternity Voices Partnership involved in: coproduction of information leaflets, interview panels, • Maternity Transformation Programme has MVP representatives' reps on work-streams. • 2 'Who's Shoes' events have been held in 2020 • Maternity survey based on CQC maternity survey questions, conducted monthly. • "Patient stories" shared at Care Group Committee • NHS Choices website reviewed and feedback from women provided to staff involved. • Trust Website feedback reviewed and provided to staff involved. • Social media pages – both Trust and MVP • Patient and Carer Experience Panel meeting in place (PACE)	– Monthly Patient Experience report to Maternity Governance, MQOC, CQRM, PACE – MVP minutes – LMNS work stream update to LMNS board – Increased responsiveness to complaints – CNST Maternity Incentive Scheme (MIS) safety action 7 compliance achieved	• FFT response rate of 20% or more • FFT score of 97% or more of extremely likely/likely • Increased evidence of service used involvement of service development and improvement – maternity Survey • Feedback from MVP members	• Invite MVP representative to attended Maternity Governance meeting.	Director of Midwifery 31/03/21	- MVP Involvement Dedicated PALS officer with 'in reach' service into maternity unit	
			• Undertake Further work to link with other Trusts identified as exemplar in relation to patient engagement to understand their measure of success in regards to pt. involvement	Director of Midwifery 31/07/21		
			• Develop, in partnership with service users "always" events and	Deputy Head of Midwifery 31/07/21		

			commitment statement for the service			
			• Develop a “you said, we have” process in maternity services	Deputy Head of Midwifery 31/07/21		
			• Ensure that An engagement plan is being developed to ensure women and families are listened to and their voices are heard. This will ensure an integrated approach	Triumvirate 31/07/21		
			• Ensure this work is part of the wider Trust culture programme to enable cross learning of patient involvement across all areas of the Trust	Acting Director of Workforce – 31/07/21		

Urgent Clinical Priority (as reported in December 2020): In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive 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.						
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Non-executive director (NED) in place as maternity & neonatal safety champion and NED link with maternity services. They meet monthly and include visits to services. This will be reviewed in line with new requirements. Executive Safety Champion in post – Trust Medical Director Listening sessions (LS) secured and to be run throughout January 2021 to feed into cultural assessment and action planning	Reporting to MQOC - reporting needs to be in line with CNST reporting requirements	Improved staff survey results and reduced staff turnover Increased staff survey response rates in all staff groups Improved FFT and maternity survey response rates (as above) Achieve compliance with associated CNST MIS safety actions All staff able to identify Safety champions and articulate role plus one action completed by them in responses to feedback	Staff and patient feedback to form part of local Maternity Transformation Plan's (MTP) culture and OD work stream		Increase presence/ connection to Freedom to Speak Up (FTSU) guardian to ensure staff voices are heard independently of management	FTSU guardians in place in Trust and visiting maternity areas. Staff and service users on MTP work stream Local maternity safety champions and PMAs in post
			To be taken to Trust board bi-monthly	Exec and NED safety Champions and local maternity safety champions – ongoing action		
			Listening Session Dates to be agreed & publicised throughout Care Group	JMc		
			Action plan to be developed in partnership with Corporate Nursing and OD			
			Review HEE Quality Intervention report to further develop cultural workstream			

			ensuring voices of students within maternity services are heard.			
			Seek support from Head of Leadership and Lifelong Learning – Midlands & NHSEI for support and interventions to ensure staff voices are heard.			

Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.
Link to Maternity Safety actions: **Can you demonstrate an effective system of clinical workforce planning to the required standard?** **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**
Link to urgent clinical priorities: Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. 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

Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.						
What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
New Multi-Disciplinary leadership Team in post in the last 12 months, leading the Care Group (Doctor, Midwife and Manager) MDT Practical Obstetric Multi-Professional Training (PROMPT) training in place and occurring monthly (doctors and midwives) Weekly MDT simulation exercises take place on delivery suite with ad hoc sessions on Midwifery Led Unit Twice weekly Cardiotocograph (CTG) learning and feedback sessions on Delivery Suite – MDT delivered by CTG midwife and/or consultant	Oversight of training maintained by Practice development midwife Monthly report to Maternity Governance detailing training stats MDT faculty meetings to agree curriculum	Audit results to be received by: Maternity Governance Care Group Board By exception to MQOC	Ensure work underway within Maternity Transformation Plan (MTP) to develop further best practice in this area to fully embed MDT training within maternity with validation by the LMNS Board	30/06/21 WPS	Backfill for all to attend especially anaesthetic staff (and theatre staff in the future) Appropriate uplift within midwifery workforce to support attendance to all mandated training.	PROMPT Training is currently online due to COVID, with the exception of some elements such as airway management in newborn resuscitation MDT SIMs continue Programme responsive to incident themes e.g. in relation to Twin births
			Attendance reporting to commence using the CNST reporting template for all aspects; MDT skills drills to take place out of hours, to include an escalation scenarios, anaesthetic attendance at training sessions.	PD Midwife & CG MD March 2021		

Weekly risk management meetings in place, which are MDT, with Lead Obstetrician, Clinical Director, midwifery managers and maternity risk manager in attendance Identified Obstetric anaesthetic lead with Human Factor specialist interest attends MDT training						

Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.						
• There is a twice-daily ward round on the delivery suite with the delivery suite midwifery coordinator, duty anaesthetist and obstetric consultant in attendance. These occur at 08:30 and 20:30 • If there is a change of consultant, there is an additional ward round at 17:00. • 7 day working of consultant in place within maternity services • 7 day rota in place to ensure obstetric consultant cover meeting • MDT training is in place	• Compliance with MDT training is monitored at Maternity Governance committee	• Maternity Governance • Divisional Committee • Consultants meeting • By exception to MQOC	• Consultant to sign a daily sheet that records the ward round	All consultants – with immediate effect	• None	Clear escalation process in place for on call consultants to attend overnight if needed.
			• Monthly audit of attendance at Ward Rounds to be introduced.	Audits commence Feb 2021	Audit Midwife in post	Prioritisation of audits
			• Recruit 6 x additional consultant obstetricians to offer 24/7 cover by Summer 2021	Care Group Medical Director – Sept 2021	Funding approved. Recruitment support and RCOG approval	Use of locum cover
			Achieve compliance with CNST Maternity Improvement Scheme (MIS) safety action 4. Multidisciplinary Simulation (SIM) training and PROMPT courses already take place.	15/07/21 MSH	Anaesthetic attendance. Time for all staff to complete including backfill where required Adequate uplift to cover all	Prioritisation of attendance based on job role

					elements of training in all staff groups	
			A process for measuring compliance against all measures needs to be developed	Audit lead (RL) 31/03/21		

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.						
This is not in place currently for all funding.	Formal reporting not in place	Reported and monitored at MQOC	Identify which funding streams need to be ring-fenced including money from Health Education England (HEE) for students	DoF 31/03/21		Funding received from NHSR for actions from year 2 CNST already being used to support maternity improvement such as fetal monitoring lead midwife, SBL lead midwife, Birthrate plus assessment
			Mechanism for this yet to be established with the Executive Director of Finance	DoF 31/03/21		
			Develop formal reporting process	TK 31/03/21		

Urgent Clinical Priority (as reported in December 2020): Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.						
There is a twice daily ward round on delivery suite with a consultant in attendance. These occur at 08:30 and 20:30. If there is a change of consultant there is an additional ward round at 17:00. 7 day working of consultant in place within maternity services 7 day rota in place to ensure obstetric consultant cover meeting	Compliance with/performance against these is not reported, currently. This will form part of a routine audit A process for measuring compliance these needs to be developed	Maternity Governance Care Group Board Consultants meeting By exception to MQOC	Consultant to sign a daily sheet that records the ward round Monthly audit of attendance at Ward Rounds. Recruit 6 x additional consultant obstetricians to offer 24/7 cover by Summer 2021 Achieve compliance with CNST MIS safety action 4	All consultants – with immediate effect Audits commence Feb 2021 Care Group Medical Director – Sept 2021	None Dedicated Audit Resource required. Audit Midwife post has been agreed and will proceed to recruitment. Funding approved. Recruitment support and RCOG approval	NA Clear escalation process in place for on call consultants to attend overnight if needed.

Urgent Clinical Priority (as reported in December 2020): 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						
• MDT PROMPT training in place and occurring monthly. • Weekly MDT simulation exercises take place on delivery suite with ad hoc sessions on Midwifery Led Unit • Twice weekly CTG learning and feedback sessions on Delivery Suite – MDT delivered by CTG midwife and/or consultant • Weekly risk management meetings in place, which are MDT – with lead obstetrician and Clinical Director with MW managers and MW risk manager in attendance • Identified Obstetric anaesthetic lead with Human Factor specialist interest attends MDT training	• Oversight of training maintained by Practice development midwife • Monthly report to Maternity Governance detailing training stats • MDT faculty meetings to agree curriculum	Audit results to be received by: Maternity Governance Care Group Board By exception to MQOC	• Attendance reporting to commence using CNST reporting template for all aspects • MDT skill drill to take place OOH to include an escalation scenario • Anaesthetic attendance at training sessions	• PD Midwife & CG MD – January 2021 • To start March 2021	• Backfill for all to attend especially anaesthetic staff (and theatre staff in the future) • Appropriate uplift within midwifery workforce to support attendance to all mandated training.	• PROMPT Training is currently online due to COVID, with the exception of some elements such as airway management in newborn resuscitation • MDT SIMs continue • Programme responsive to incident themes e.g. in relation to Twin births
Urgent Clinical Priority (as reported in December 2020): Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety						

Not in place currently	To be determined	To be determined	Identify which funding streams needs to be ring-fenced including money from HEE for students Mechanism for this yet to be established with DoF	Director of Finance 30/06/21	NA	Funding received from NHSR for actions from year 2 CNST already being used to support maternity improvement such as fetal monitoring lead midwife, SBL lead midwife, Birthrate plus assessment

Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. Women with complex pregnancies must have a named consultant lead Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team
Link to Maternity Safety Actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**
Link to urgent clinical priorities: All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Women with Complex Pregnancies must have a named consultant lead.						
• All women with complex pregnancies have a named consultant lead • Appropriate risk assessment documented at each contact • Women with risk factors are assigned to a consultant led ANC	Audit as part of weekly MDT risk meeting	To be determined	Implement a formal auditing process and report to respective local governance meetings	30/06/21 Audit Midwife	Audit midwife in post	Completed as part of MDT risk meeting until Audit Midwife in post
			Include as part of forward audit plan and ensure reporting to Maternity Audit Committee	30/06/21 RL		
			Review of Midwifery led cases for appropriate referral onwards, to be undertaken.	30/06/21 LMu		

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.						
Process already in place including specialist antenatal clinics for diabetes and endocrine, haematology, cardiac disease, rheumatology, respiratory, gastro, neurology and mental health. Review of women with additional needs at monthly multidisciplinary meetings. This may include specific medical conditions but, also, for individualised birth plans. Business case submitted for additional consultant hours to staff an "Urgent" Antenatal clinic to see women developing complex obstetric conditions.	Review at weekly risk meeting	Not formally reported	Ensure that Antenatal risk assessments to continually reassess care pathway are incorporated and being further developed, including mapping and integration with Badgernet. Connections to be developed in order to achieve holistic solution.	31/05/21 LY		Individual pathways incorporating pre-existing morbidities created
			Validate and document that these requirements are being fulfilled through formal audit process (to be developed)	31/10/21 RL		

The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.						
This is a national action Pathways in place for transfer to specialist centres if required i.e. cardiac	NA	NA	Formal Onward referral process to be developed	30/06/21 MSH	Regional agreement with tertiary centres	Obstetric Clinical Director engaged in discussions with network. This is an on-going discussion regionally and nationally in terms of how SaTH dovetails with these and connects to them. Exploration of specialist centres underway
			Formalise connection with Specialist Maternal medicine centres	TBC	National team to implement	
			Gain an updated understanding of this across the region – regional leads are taking this forward. SaTH has determined that we do not wish to be a maternal medicine centre but we are currently awaiting further guidance.	TBC	National team to implement	

This must also include regional integration of maternal mental health services.						
Local Perinatal mental health service in advanced stage of development. Bid submitted and approved, working in partnership with MPFT and neighbouring Trust to offer service services including: Psychologist Specialist Midwife Using psychological based interventions, trauma informed approach and individual & group interventions, including but not limited families involved in the IMR Monthly steering group in place with MDT representation from key stakeholders.	Monthly monitoring via steering group	Steering group	Further work required by the regional team	TBC	National / regional action required	Local PMH service
Urgent Clinical Priority (as reported in December 2020): All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.						
All complex pregnancy women have a named consultant lead	Reviewed at weekly risk meeting but not formally audited	Not formally reported at present.	Implement a formal auditing process and report to respective local governance meetings Review of Midwifery led cases for	22/12/20 – commence as part of weekly risk meeting	Personnel to undertake audit	Appropriate risk assessment documented at each contact – ongoing audit as in action number 5

			appropriate referral onwards			
Urgent Clinical Priority (as reported in December 2020): Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.						
Obstetric Clinical Director engaged in discussions with network. This is an on-going discussion regionally and nationally in terms of how SaTH dovetails with these and connects to them	Not yet in place	Not yet in place	Gain an updated understanding of this across the region – regional leads are taking this forward. SaTH has determined that we do not wish to be a maternal medicine centre but we are currently awaiting further guidance.	Clinical Director for Obstetrics to lead on this – end Feb 2021	National team to develop specialist maternal medicine centres – advised 18 currently under development	Pathways in place for transfer to specialist centres if required i.e. cardiac

Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**
Link to urgent clinical priorities: 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 must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.						
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact Maternity notes includes assessment of risk status at each antenatal appointment Also in place For Intrapartum care high risk women will have risk re-assessed hourly throughout labour with "fresh eyes" review. .	Monitored via weekly risk meeting	Not formally reported	Formalised audit to be implemented; Audit required to confirm ongoing assessment and reassessment, including during labour, is being observed	Audit midwife TBC	Audit midwife	Assessed during weekly MDT risk meeting Manual audit underway as stop-gap; weekly feedback
			Complete baseline audit to determine current compliance	Audit midwife TBC		
			Rapid Implementation of Badgernet EPR system to allow data extraction and analysis A separate risk assessment tool is being developed for women receiving low risk care in all birth settings to clearly document a regular review of risk status	IT team 31/05/21	Dedicated team to ensure rapid implementation.	

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.						
Place of birth revalidated at each contact as part of ongoing risk assessment Birth choice leaflet developed in co-production with MVP to ensure Mother's choices based on a shared and informed decision-making process respected	Weekly risk meeting	Not formally reported	This is to be checked within the scope of the audit mentioned at LEA 5.1	Audit midwife TBC	Audit midwife	Weekly review at risk meeting
Urgent Clinical Priority (as reported in December 2020): 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.						
Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact.	Not currently formally audited but this is reviewed at the Maternity MDT weekly risk meeting, chaired by risk midwife and risk obstetrician. This is to ensure that care is safe and appropriate.	Maternity Governance Committee (monthly)	Formalised audit to be implemented Rapid Implementation of Badgernet EPR system to allow data extraction and analysis.	22/12/20 – commence as part of weekly risk meeting	Additional audit resource within the Care Group required. IT team to support rapid implementation	Manual audit to commence 22/12/20 with weekly feedback

Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing – Consolidating existing knowledge of monitoring fetal wellbeing – Keeping abreast of developments in the field – Raising the profile of fetal wellbeing monitoring – Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**
Link to urgent clinical priorities: 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.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: * Improving the practice of monitoring fetal wellbeing * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Raising the profile of fetal wellbeing monitoring * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.						
What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Lead MW for fetal monitoring 0.4 WTE in place on secondment. Lead obstetrician in place with allocated time and job description – 1 SPA per week incorporating PROMPT, Fetal monitoring (0.5) & education and training. Practice education midwife working with peer in another Trust regarding training and development.	Monthly report to Maternity Governance detailing activity of leads, training provided, emerging concerns and actions arising	Reduced number of incidents reported with fetal monitoring identified as a causative factor or incidental finding Reduction in avoidable harm relating to fetal monitoring Compliance with safety actions 6 and 8	Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases.	30/06/21 AGP	Funding for 1.0 WTE midwife to be included in business case	Band 7 DS co-ordinator in post on secondment. Named consultant lead in post Audit in place
			Job descriptions and personal specifications to be scoped to ensure they fulfil all of the required criteria	31/03/21 AGP		
			Develop CTG / IA competency programme	31/03/21 KH		
The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.						

Twice weekly training and review MDT meetings in place reviewing practice and identifying learning. Lead Midwife attends weekly risk meetings to ascertain if CTG is a key or incidental finding in any incident. K2 training for midwives and obstetricians in place Incidents reviewed for contributory / causative factors to inform required actions.	Monthly report received at MGC	Reduced number of incidents reported with fetal monitoring identified as a factor	Implement cascade training	30/06/21 Leads	Additional PA time for lead consultant Funding for midwifery posts	Secondments in place Weekly risk meeting attended by MDT
			Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases	30/06/21 AGP		
			Audit compliance with new guideline	30/06/21 Leads		
			Review process for review of cases of adverse outcome to ensure leads are in attendance and lead at case reviews.	30/04/21 RM		

The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.						
Named project midwife responsible for Saving Babies Lives in place - 1.0 WTE secondment Ongoing implementation and reporting of progress of SBL Care Bundle in place Quarterly survey submitted to network Regular review as part of CNST MIS safety action 6 Network support to achieve care bundle	Monthly report to Maternity governance meetings Dedicated time to undertake work – rostered and PA time Staff able to articulate the roles and impact Improved outcomes for women and babies	No incidents that have fetal monitoring issues identified as a contributory (or incidental) factor. Appropriate monitoring methods used for each woman Improved CTG interpretation as detailed in monthly report Compliance with Guideline Full implementation of SBL element 4	Ongoing implementation and reporting of progress of SBL Care Bundle in place	30/06/21	Funding realised Recruit to vacant posts.	Secondments in place Incidents reviewed for contributory / causative factors to inform required actions
			Confirm Audit of guidelines underway	31/03/21 KT		

			SBL – post in place end September	DoM Oct 2021		
			Fetal monitoring lead post in place – end June	DoM July 2021		

Urgent Clinical Priority (as reported in December 2020): 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.						
• Named project MW responsible for Saving Babies Lives in place 1.0 WTE secondment • Lead MW for fetal monitoring 0.4 WTE in place on secondment • Lead obstetrician in place with SPA time and SPA job description – 1 SPA per week incorporating PROMPT, Fetal monitoring (0.5) & Education and training • Twice weekly training and review MDT meetings in place reviewing cases and identifying learning. • Lead Midwife attends weekly risk meetings to ascertain if CTG is a key or incidental finding in any incident. • K2 training for midwives and obstetricians in place	• Monthly report to Maternity governance meetings • Dedicated time to undertake work – rostered and PA time • Staff able to articulate the roles and impact • Improved outcomes for women and babies	• No incidents that have fetal monitoring issues identified as a contributory (or incidental) factor. • Appropriate monitoring methods used for each woman • Improved CTG interpretation as detailed in monthly report • Compliance with Guideline • Full implementation of SBL element 4	• Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases	• SBL – post in place end September • Fetal monitoring lead post in place – end June • DoM July 2021 responsible for above • Audit of guidelines by FM / SBL lead March 2021	• Funding realised • Recruit to vacant posts.	• Secondments in place • Incidents reviewed for contributory / causative factors to inform required actions

			Audit compliance with new guideline			

Immediate and essential action 7: Informed Consent All Trusts must 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. All maternity services must 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 Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**
Link to urgent clinical priorities: 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. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
All maternity services must 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						
Patient feedback notice boards in place on inpatient areas. Translation services available for consultations. Patient information leaflets available on the Internet (SATH Homepage), including recently developed leaflet of choice for place of birth co-produced with the MVP. Also includes link to national PIL on Caesarean section (Tommy's) and Birth after previous caesarean section (RCOG). Work currently on-going as part Antenatal Care Pathway sub-project; videos, leaflet and Baby Buddy app available. Developing links for women to watch videos on relevant pregnancy topics such as IOL to assist in digesting information. Women who are requesting to have a caesarean section are referred to a consultant-led	Monthly Patient experience report to MGC, MQOC Trust wide PaCE meetings	• No incident reported relating to incorrect place of birth unless maternal request Women birth in appropriate setting - informed choice Maternal request CS are performed. • Women report satisfaction with level of involvement in decision making relating to their care. • No complaints received	• Confirm through audit that the mother and partner / family have been provided with the relevant information and offered opportunity to seek further clarity / information. • Implement Digitalisation of patient record through the Badgernet system • Review of other websites required to identify best practice. • Link with local LMNS and units that also provide care to women from Shropshire to ensure consistent approach to information.	31/03/21 AGP 31/05/21 IT team 30/04/21 RC/ EH 30/04/21 RC / EH	NA	Substantial actions already in place

birth options clinic, where this is explored and management is individualised according to their choice. The Communication and Engagement workstream includes MVP and patient representation.						
Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.						
• Work currently on-going as part of Antenatal Care Pathway sub-project • Personalised Care and Support Plan booklets in place and given to all women. • Co-production with MVP	MVP meeting quarterly Patient experience report to MGC & MQOC monthly	• Women report satisfaction with level of involvement in decision making relating to their care. • No complaints received	Confirm through audit that the mother and partner / family have been provided with the relevant information and offered opportunity to seek further clarity / information.	31/03/21		
			A process for auditing this will need to be established; Include as part of monthly survey	AGP 31/03/21		
Women's choices following a shared and informed decision making process must be respected						
Personalised Care and Support Plan booklets in place and given to all women - co-produced with MVP. Birth choice clinic in place	Patient experience report to MGC & MQOC monthly	No cases reported whereby women feel that their choice was not followed or respected.	• A mechanism for measuring and auditing this needs to be developed.	31/03/21 AGP		

		No complaints received	Dedicated PALS officer to be appointed to Maternity Services to offer in-reach and provide real time feedback.	30/04/21 JP		

Urgent Clinical Priority (as reported in December 2020): 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. An example of good practice is available on the Chelsea and Westminster website.						
• Maternity services information on SaTH website – see link: https://www.sath.nhs.uk/wards-services/az-services/maternity/patient-info/ https://www.sath.nhs.uk/wards-services/az-services/maternity/covid19/ • There are links to NHS guidance pages, videos, leaflets, general info about SaTH maternity services • Baby buddy app in place for the Trust, which is auditable • Friends and Family Test in place, with positive results • Patient feedback notice boards in place on inpatient areas • Translation services available • Communications lead in maternity	• Patient experience report received monthly at Maternity Governance Meeting then on to MQOC	• Co-produce pages for the website and any leaflets we publish with the local Maternity Voices Partnership – this enables the voice of women in the community to be heard and provide feedback • A website page is also available which is dedicated to care during Covid including a Q&A list with the questions being asked by women.	• Review of other websites for best practice. • Link with local LMNS and units who also provide care to women from Shropshire to ensure consistent approach to information. • Rapid Implement Badgernet, which will enable women to access their maternity records – requires intervention from DoN to hasten programme • Need to establish a mechanism for collecting and collating compliments • A formal report that triangulates sources of patient feedback, concerns and complaints via Trust and/or commissioner mechanisms needs be developed. To be agreed with commissioners. • Dedicated PALS officer to be appointed to Maternity Services to offer in-reach and provide real time feedback	• Deputy HOM – March 2021 • DoN • Deputy HOM – March 2021 • Deputy HOM – March 2021 Head of Complaints services	• Badgernet implementation required at pace	• Website pages in place

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
• Unit working to 2017 Birthrate Plus levels • Further Birth Rate + review commissioned (2020) and draft report received. Awaiting final report whereupon a workforce gap analysis will be presented to the next available Public Trust Board meeting, with timeframes for implementation. • Workforce review and plan in progress • Increase in obstetric cover agreed to move	• Report received monthly to committees and Trust Board. This includes data on staffing acuity and red flags • Commissioned Birthrate plus assessment – draft report received & will be used to determine staffing requirements of the current configuration of services. Any additional resource required yet to be agreed through	• Acuity tool for inpatient areas – wards and delivery suite • Number of red flags with harm, levels of negative acuity – red or amber • Dynamic approach to escalation supported by twice daily huddles Mon - Fri – out of hours supported by manager on call • Monthly report to Trust Board • Submission of monthly UNIFY data	• Finalise report • Maternity specific on call rota staffed by senior midwifery team	• 31/01/2021 DoM & CGMD • CGD Feb 2021	• Additional funding to support to be agreed through Trust normal processes	• Use of acuity tool and twice daily staffing review – also includes weekly look ahead to identify any midwifery staffing issues to facilitate early resolution

to 24/7 consultant cover by Summer 2021	Trust standard processes.					

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

Every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation
Director of Midwifery (DoM) in post who reports to the Executive Director of Nursing. The DoM is currently supported by a Deputy Head of Midwifery and two Matrons. Additional posts have been approved – Head of Midwifery and 2 matrons.
A Lead Midwife at senior level in all parts of the NHS, both nationally and regionally - N/A - Applicable to region / national team
More consultant midwives – consideration will be given to this as part of the aforementioned workforce review. SaTH currently does not have a Consultant Midwife. A new band 8a Matron for Better Births is being implemented
Specialist Midwives in every Trust
SaTH currently has a range of Specialist midwives – New roles are being developed including Audit midwife and others will be reviewed in the workforce plan
N/A - Strengthening and supporting sustainable midwifery leadership in education and research – applicable to HEIs
A commitment to fund ongoing midwifery leadership development – there is a commitment to fund on-going midwifery leadership development. SaTH offers some leadership development but more work is required to ensure midwives are supported with bespoke leadership programmes. This is under review currently as part of the Maternity Transformation Programme
Professional input into the appointment of midwife leaders
The recruitment panel for the current DoM included the NHSEI Maternity Advisor (MSSP) (now Deputy Chief Midwifery Officer for England)

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Guidelines Midwife reviews all new / updated guidance, including NICE, and completes a gap analysis A Named Midwife is in place for Maternity Guidelines. This midwife monitors clinical guidelines, SOP's and Policies to ensure compliance with NICE guidelines. Named Consultant Obstetrician for Maternity Guidelines in place Benchmarking is undertaken when National Guidelines are published. This is	Maternity Guidelines Group meets 9 times a year. Clinical Guidelines and SOPs are approved through Maternity Guideline Group and ratified by Maternity Governance Maternity Guideline Group meeting held at least 9 times per year (with the exception of Covid-19 this year) Full report to Maternity Governance 3 times per year. Quarterly to CQRM	Guideline Midwife responds to updates on National Guidelines. Where required benchmarking is undertaken to ensure clinical guidelines are appropriate for the service. Maternity Audit Group commenced and active audit plans in place. Link with Clinical Education Midwife to ensure that the clinical guidelines align with training, based on national guidelines	Continue to maintain a named Midwife for Guidelines. Submit reports to Maternity Governance	Named Midwife for Guidelines	- Audit Midwife - PMO team to support with data analysis Administration Support	

then reported to Maternity Governance. Compliance with NICE Quality Standards and Clinical Guidelines are monitored and RAG assessed. These are reviewed at the Trust's Clinical Audit The Maternity Network reviews any policies and guidelines at variance with NICE		Weekly Risk Meetings identify any guideline issues Quality Improvement action plans Maternity Improvement Plan We are registered Stakeholders with NICE and submit during consultation process where applicable. Development of clinical guidelines with Specialist Midwives for Fetal Monitoring, Saving Babies Lives, Bereavement, Infant Feeding, Antenatal Screening, Perinatal Mental Health, Public Health, Safeguarding, Professional Midwifery Advocates Part of the West Midlands Network have consulted Network Guidelines				

	This report provides this full assessment. Good progress is being made against each of the IEAs. The initial assessment demonstrates that the Trust currently has 77 measures in place to support the delivery of the IEAs and a further 75 actions have been identified in order to be fully compliant and evidence delivery The Board of Directors is requested to: • Receive and review the completed Maternity Services Assessment and Assurance Tool at **Appendix One** • Decide if any further information, action and/or assurance is required before its submission on 15th February 2021.
Appendices	**Appendix One –** Maternity Services Assessment and Assurance Tool

1. PURPOSE OF THIS REPORT

1.1 This report presents the completed Maternity Services Assessment and Assurance Tool which is required to be shared with the LMNS Board and the Board of Directors, prior to being submitted to NHSE/I Regional Office by 15th February 2021.

2. THE OCKENDEN REPORT (IMR)

2.1. The Trust received the first 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, on 10th December 2020.

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. Following the publication of the first Ockenden Report, all NHS providers of maternity care were required to provide an initial assessment to NHSE/I Regional Office against 12 urgent clinical priorities comprising of key elements contained within the 7 Immediate and Essential Actions (IEA's) by 21st December 2020. The submission was made using a provided assessment and assurance tool. The Trust submitted this by the required deadline.

2.4. A second submission comprising assessment against all element of the IEA using the assessment and assurance tool was originally due to be submitted to the NHSE/I Regional Office by 15th January 2021. In order to achieve this, the Chief Executive was given permission, with other officers, to approve this submission on behalf of the Board. However, due to significant operational pressures within all NHS Trusts as a result of the pandemic, this has now been changed to 15th February 2021, which now allows time for it to be shared with LMNS and Board of Directors before being submitted.

3. STATUS OF REQUIRED ACTIONS

3.1. The assessment and assurance tool requires the Trust to detail what is currently in place to meet all requirements of each of the IEAs and what additional actions are needed in order to be fully compliant.

3.2. The initial assessment demonstrates that the Trust currently has 77 measures in place to support the delivery of the IEAs.

3.3. The initial assessment demonstrates that the Trust has identified a further 75 actions required in order to be fully compliant and evidence delivery of each of the IEAs.

3.4. The actions will be assigned to each of the Maternity Transformation Programme (MTP) workstreams and progressed monitored through MQOC and the LMNS Board.

3.5. The Trust recognises that this assessment is a dynamic and iterative process and further actions and measures in place to address the IEAs may be identified and detailed in subsequent version of the assessment and assurance tool.

3.6. All actions within the assessment and assurance tool have a provisional named person responsible for delivery and a provisional estimated delivery date. These are subject to confirmation following wider discussion.

3.7. The completed assessment and assurance tool is detailed in appendix one.

4. SUMMARY

4.1. Good progress is being made against the required actions with a significant number of actions commenced and on track.

4.2. Progress against each outstanding action for each IEA will be recorded and collated within the Project Management Office and a progress report produced monthly for MQOC. This will offer a dashboard view on the progress of each outstanding action. The processes for agreeing what constitutes good evidence and assurance have yet to be determined and agreed.

5. ACTION REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to:

- Receive and review the completed Maternity Services Assessment and Assurance Tool at Appendix One, and;
- Decide if any further information, action and/or assurance is required before submission on 15th February 2021.