The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date Thursday 22nd April 2021
Time 09.00 – 11.30
Location Via MS Teams – to be live streamed to the public

AGENDA

Item No.	Agenda Item	Paper No / Verbal	Lead	Required Action	Time
2021/09	Welcome and Apologies	Verbal	Chair	Noting	09.00 (15 min)
2021/10	Declarations of Interest relevant to agenda items	Verbal	Chair	Noting	
2021/11	Minutes of meeting of 25th March 2021 and Matters arising: • Maternity Governance / Assurance organogram • List of Acronyms • Public Questions and answers	Enc 1 Enc 1.1 Enc 1.2 Enc 1.3	Chair	Approval For information For information For information	
2021/12	Updated Terms of Reference incorporating comments from 25th March 2021 meeting	Enc 2	Chair	Approval	
2021/13	Immediate and Essential Action 1 – Enhanced Safety: Detailed consideration of the Trust's action plan and progress • Presentation on current action plan progress (15 mins) • Detailed review of Action Plan (Q&A)	Presentation	Service Delivery Team All	Discussion	09.15 (30 min)
2021/14	Local Actions for Learning Theme 4 – Neonatal Service: Detailed consideration of the Trust's action plan and progress • Presentation on current action plan progress (20 mins) Detailed review of Action Plan (Q&A)	Presentation	Service Delivery Team All	Discussion	09.45 (40 min)

2021/15	Local Actions for Learning Theme 2 – Maternal Deaths: Detailed consideration of the Trust's action plan and progress • Presentation on current action plan progress (20 mins) • Detailed review of Action Plan (Q&A)	Presentation	Service Delivery Team All	Discussion	10.25 (40 min)
2021/16	Observations and comments from relevant stakeholders and groups representing service users	Verbal	Chair All	Discussion	11.10 (10 min)
2021/17	Discussion and reflection • Key messages for the Board of Directors • Key messages for service users - women and families • Any other steps we need/wish to take	Verbal	Chair All	Discussion	11.20 (10 min)
2021/18	Meeting closes Date of Next Meeting: 27th May 2021	Verbal	Chair		Finish 11.30

ENC 1

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

Thursday 25 March 2021 via MS Teams

Minutes

NAME	TITLE	ITEM
MEMBERS		
Dr C McMahon	Co-Chair	
Ms J Garvey	Co-Chair	
Professor T Purt	Non-Executive Director (Trust) and Chair of Audit & Risk Assurance Committee	
Mr A Bristlin	Non-Executive Director (Trust) and Non-Executive Director Lead for Maternity Services	
Mrs L Barnett	Chief Executive (Trust)	
Ms H Flavell	Director of Nursing (Trust)	
Dr A Rose	Medical Director (Trust)	
Mr N Lee	Chief Operating Officer (Trust)	
Ms Z Young	Director of Nursing & Quality, Shropshire, Telford & Wrekin CCG and Local Maternity & Neonatal System	
Ms E Evans	Maternity Voices Partnership	
Ms V Barrett	Chair, Healthwatch Shropshire	
Mr B Parnaby	Chair, Healthwatch Telford & Wrekin	
ATTENDEES		
Mr M Underwood	Divisional Medical Director for Women & Children (Trust)	
Dr M-S Hon	Clinical Director – Obstetrics / Maternity (Trust)	
Mr M Wright	Programme Director Maternity Assurance (Trust)	
Mr T Baker	Senior Project Manager Maternity Transformation Programme (Trust)	
Mr D Wild	Chair, Lodestone Communication Ltd	
Ms J Hogg	Chief Nurse, Sherwood Forest Hospitals	
Ms P Neil	Interim Board Secretary (Trust)	Minutes
Mr K Haynes	Independent Governance Consultant	
Ms A Wilson	Member, Powys Community Health Council	
Ms A Milanec	Director of Governance & Communications (Trust)	
Ms F Ellis	Maternity Voices Partnership	
Ms L McLeod	Maternity Voices Partnership Development Coordinator Telford & Wrekin	
APOLOGIES		
Ms Nicola Wenlock	Director of Midwifery (Trust)	
Ms J McDonnell	Divisional Director of Operations Women & Children (Trust)	

No. 2020	ITEM	ACTION
Procedural Items		
001/21	**Welcome, introductions and apologies**. The Co- Chair, Dr McMahon welcomed all present including the public to the live stream of the meeting. Introductions were made and apologies were noted.	
002/21	**Declarations of Conflicts of Interests** There were no declarations of interest declared. The Chair reminded members of the need to highlight any interests which may arise during the meeting.	
003/21	**Minutes of the previous meeting** and matters arising This was the inaugural meeting for the committee. There were therefore no minutes from the previous meeting. There were no matters arising as this was an inaugural meeting.	
004/21	**Action Log** This was the inaugural meeting for the committee. There were therefore no open actions.	
005/21	**Purpose and tone of the Committee** The Co-Chair, Dr McMahon stressed the importance of the work being undertaken by the committee. Dr McMahon, on behalf of the Board of Directors, reiterated the Chief Executive's unreserved apology given on publication of the Ockenden Report in December 2020 to all the women and families affected by the care failings experienced in the Trust and the commitment given that all actions raised in the report would be addressed. Dr McMahon stressed that the Ockenden Report made a specific "call to action", namely that there should be an end to external reviews that did not lead to meaningful change. She explained that one of the critical findings of the Report was that there had been a failure to implement the findings of earlier investigations and to learn; the Trust Board acknowledged that there now needed to be a different approach to ensuring the implementation of the findings. It was recognised that it needed to be more than the usual board assurance committee – an approach that was different and through its reporting is visible to the public, women and families as a clear demonstration of what the Trust is doing and the progress we are making. The Ockenden Report Assurance Committee (ORAC) would include external and internal stakeholders and would be held in public via a live stream. This arrangement would enable engagement with various "voices" and	

	feedback on the improvement plan and actions taken. The Co- Chair explained that feedback from the public would be very much welcomed and explained how the Trust proposed to manage feedback from the public for meetings that were live streamed. The public were invited to submit questions to the Trust via the published email; all questions would be responded to; and all questions and answers would be published with the next set of agenda papers. The role of ORAC (a time-limited committee) as an assurance committee was to scrutinise whether the Trust was doing enough to ensure there was no repeat of the failure to deliver care. The committee, a delegated committee, reporting to the Trust Board of Directors was required to perform two actions; firstly, manage oversight, scrutiny and assurance; and secondly, to ensure public engagement with the process of the committee. Committee membership included the CCG, Local Maternity & Neonatal System (LMNS), Maternity Voices Partnership, Healthwatch and over time subject matter experts would be invited to attend. The Co-Chair explained that although the Committee's work would be time-limited (based on the need and intention to progress within a reasonable timescale all of the required actions), the intention is that it works its way thematically through each of the 52 Ockenden Report actions. A number of meetings are planned, therefore, and the intention is that these are scheduled so that the outcomes can be reported to meetings of the Board of Directors. The meeting today was going to look at Maternity Care (Local Actions for Learning 1) and Enhanced Safety (Immediate and Essential Actions 1). The Co- Chair encouraged the public to engage with and to challenge the committee on the meeting content and issues discussed and thanked the public for attending the inaugural meeting.	
006/21	**Review of the Terms of Reference including membership** The Co-Chair, Dr McMahon introduced the draft terms of reference of the Committee and sought comments from members on their contents and whether they appropriately reflected it overall purpose. Ms Young asked that the LMNS, through her representation, be listed in the membership. Ms Young also suggested 'routinely seek additional scrutiny' as an amendment to the wording of the External Expert Advisory Panel's principal purpose. Subject to the suggested amendments, the draft terms of reference were agreed. The Co- Chair confirmed that the terms of reference would be updated as appropriate.	

007/21	**Local Actions for Learning (LAFL) Theme 1 – Maternity Care (13 Actions)** The meeting reviewed LAFL Theme 1 – Maternity Services for which the Trust's Clinical Director – Obstetrics, Dr Hon and the Trust's Divisional Medical Director for Women and Children, Mr Underwood had prepared a detailed presentation for each of the actions and progress to date. The contents of presentation should be considered together with these minutes. Mrs Flavell outlined the governance review undertaken by the Trust to ensure ORAC received accurate information. The Maternity Transformation Assurance Committee (MTAC), formerly the Maternity & Quality Operational Committee (MQOC), co-chaired by the Director of Nursing and the Medical Director, would report to the Ockenden Report Assurance Committee (ORAC) which in turn would report directly to the Trust's Board of Directors. Professor Purt requested that an organogram be provided, showing the new governance arrangements in place and their relationship to other committees and the Board. Dr Hon reported activity against each of the 13 Local Actions for Learning (LAFLs) highlighting the key issues and current progress: **1. 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. (LAFL 4.54)** Dr Hon confirmed that the clinical referral team had a clear SOP (Standard Operating Procedure), requiring that medical conditions and previous pregnancy complications are detailed in antenatal notes, thus enabling the community midwife to appropriately risk assess women. The plan was that all patient records would be converted to BadgerNet in 2021. In response to a question from Ms Barrett (Healthwatch Shropshire), Dr Hon explained that BadgerNet (a new maternity patient information system that is being introduced in 2021) was a popular system used by neighbouring Trusts in the region (Wolverhampton and Birmingham), minimising any local border issues which might emerge from conflicting systems, but that not all Trusts across England use BadgerNet. In response to a question from Ms Garvey, Dr Hon suggested that a decision to use one system country wide would have to be a decision taken at a national level. Dr Hon confirmed that patients were encouraged to engage with midwifery staff about the assessment of their risk by ensuring the language used on BadgerNet was accessible to the public. Dr Hon confirmed, in response to a question from Mr Bristlin, that a new	

role with responsibility for auditing evidence of actions being embedded was being resourced with a plan for this LAFL action to be audited and results shared with the Maternity Transformation Assurance Committee.

Ms Young asked for assurance that the risk assessment process had been implemented and that women were being treated in accordance with their assessed risk. Dr Hon confirmed risk review meetings were held weekly. Mr Underwood confirmed that Ms Sascha Wells-Munro, NHSE/I Maternity Improvement Adviser, had reviewed the process at a recent visit to the Trust and had considered it to be appropriate.

Dr Hon confirmed, in response to a question from the Co-Chair, Dr McMahon, that 'delivered not yet evidenced' means, the process had been put in place but that it had yet to be evidenced by a formal audit of behaviour being sustainably embedded across the organisation. Dr Hon confirmed that the introduction of BadgerNet, whilst complex, had been prioritised and resourced by the Trust and that it would be fully operational by June 2021.

In summary, it was confirmed that for this action (LAFL 4.54) that a thorough risk assessment was taking place at the booking appointment and at every antenatal appointment supported by a detailed SOP (Standard Operating Procedure) and including weekly risk reviews. Pending the appointment of midwifery audit resource this would be formally audited. The risk assessment process would be further improved with the introduction of the Badgernet digital system.

2. 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. (LAFL 4.55)

Dr Hon suggested that contemporaneous evidence-based information was dynamic; always being updated and that information, to support decisions made by women and families about how they birth their babies, was regularly published in material produced by the Trust across a number of topics. Dr Hon confirmed that the MVP had been involved in co-production of material published. Dr Hon also suggested there is a drive to digital information that would aid in reaching women with access challenges (first language, braille, remote locations, teenage pregnancies, etc.) – whilst also recognising that not all women would engage with digital formats, and therefore the need for a mix of approaches.

In response to a question from the Co-Chair, Ms Garvey, on the Baby Buddy app, Dr Hon advised that the app was used by women to maintain a record of their pregnancy and access progress relevant information.

	Dr Hon suggested that all women had the right to make choices on birthing their babies and that risks associated with pregnancy and birth were explained clearly and understood. For those women who wish to manage their pregnancy and birth outside the national guidance it was the midwives' responsibility to mitigate any risks with support. Discussion focussed on how it was possible to seek confirmation regarding each individual patient's understanding of the information that was being presented and the choices available. In response Ms J Hogg explained her Trust's use of the Patient Activation Measure (PAM) which assesses patient knowledge, skill and confidence for self-management and enabled a support package to be tailored to meet their needs. PAM could also be used to determine a women's understanding of any risks associated with their decision. Ms Hogg confirmed that she would be happy to work with the Trust regarding its application. In response to a question from the Co-Chair, Ms Garvey, regarding how the Trust makes sure that the information provided is good enough, Dr Hon explained that Maternity Voices Partnership has been involved in the co-production and testing of the information. Dr Hon confirmed, in response to a question from Mr Bristlin that decisions regarding the management of cases presenting with potential risks were considered in the monthly multidisciplinary team meetings of professionals involved in providing support and planning for at risk births. **3. 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 foetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties. (LAFL 4.56)** Dr Hon advised that recruitment was underway for a new Foetal Monitoring Lead Midwife to work alongside a Lead Obstetrician to deliver foetal monitoring and educational support. The current post holder left in February 2021. Ms Garvey asked, following the departure of the recent post holder and until the new post holder was in place, (Foetal Monitoring Lead Midwife) who had been undertaking the work since February 2021. Dr Hon confirmed that the Obstetrician currently in post was continuing the work in the absence of the midwife. Mrs Barnett confirmed that the Trust was mitigating any risk associated with the post being vacant and expediting the recruitment of a suitably competent replacement. Mr Underwood confirmed that foetal monitoring training and support continued and reported that a number of interventions were in place including a K2 training package for all midwives and doctors in maternity and midwives' training days, CTG meetings every Monday and Thursday to discuss complex cases (doctors, midwives, all staff), Fresh Eyes – an	

	independent person reviewed the CTGs, regular consultant ward rounds, central digital reporting system (large TV screen in the hand over room where all CTGs are displayed) were all designed to reduce the risk of errors in interpretation. **4. 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 ongoing oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group. (LAFL 4.57)** Dr Hon reported that Saving Babies Lives was a care bundle designed to reduce stillbirths. A business case has been prepared for the purchase of equipment to predict pre-term births. In response to a question from the Co-Chair, Dr McMahon, Dr Hon suggested that the areas with the greatest need for improvement are foetal monitoring and smoking. Mr Bristlin asked Ms Young if the continued oversight required to be provided by the LMNS and the CCG of the work being undertaken on this LAFL could be provided. Ms Young confirmed progress had been made; that a self-assessment was completed in February 2021; and that the work undertaken by the Clinical Network had highlighted the need to review policies, guidelines and assurance that audits were being carried out. It was agreed that there should be a separate session on the Savings Babies Lives care bundle. In addition, Ms Hogg suggested the need for a 'deep dive' at some point in the future which could form part of the Trust's arrangements with Sherwood Forest. **5. Staff must use NICE Guidance (2017) on foetal 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. (LAFL 4.58)** Dr Hon explained that in January 2020 the Trust recognised that the department's guidelines were inadequate. There are currently two national guidelines that detail requirements for foetal monitoring– NICE and FIGO. New FIGO (Fédération Internationale de Gynécologie et d'Obstétrique) guidelines were introduced at the Trust in July 2020; a decision to implement the FIGO guidelines had been reported to the MQOC in March 2021; and would be reported to the QSAC in April 2021, with a view to re-affirmation of support for the FIGO guidelines. Dr Hon and Mr Underwood explained that it was generally felt that the	

FIGO guidelines are more thorough and rounded, leading to a more holistic assessment.

Dr Hon, in response to a question from Mrs Barnett, mentioned the K2 assessment package (FIGO version) being implemented after Easter 2021. Links with other organisations were currently being developed.

Ms Garvey asked, if it would be obvious to a woman in labour which set of guidelines she and her baby were being monitored under (NICE or FIGO). Dr Hon suggested there would be no obvious difference to a woman in labour.

6. **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. (LAFL 4.59)**

Dr Hon explained that it was acknowledged that the governance structure for maternity services at the Trust needed further improvement. In 2019, a weekly risk meeting was set up where all cases were reviewed. In January 2021, a number of staff undertook a course at Cranfield University in relation to incident management/investigations. An oversight incidents group had been formed for the review of all incidents. Dr Rose suggested that the learning from near misses / incidents with women and children would be relevant to care across the organisation.

Ms Barrett asked how the women, affected by the incidents, were informed about the findings from the review of incidents. Dr Hon confirmed that women, whose cases were formally reviewed, are invited to discuss the review's report and action plans with the Trust. Ms Flavell confirmed the levels of governance in place included divisional review and executive review at the Review, Action, Learning Group (RALIG), which is chaired by Dr Rose and where oversight of the rapid review process is managed.

In response to a question from Ms Garvey, Mrs Flavell confirmed that the timescale for reviewing an incident was generally 60 days from RALIG to CCG and Trust Board. Mrs Barnett mentioned that measures had been introduced to ensure the Trust was transparent about the reporting of serious incidents at the Board of Directors' meeting held in public each month.

7. **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. (LAFL 4.60)**

It was explained that the commentary for LAFL 4.59 above also applied to this required action.

8. **Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour. (LAFL 4.61)**

Dr Hon mentioned the importance of this action, requiring oversight of all complex pregnancy and labour cases linking closely with LAFL 4.54 – risk assessment at each appointment. She confirmed that the guideline (Clinical Risk Assessment Guidelines) had recently been updated and that this also relates to LAFL 4.62 below. In addition, Dr Hon confirmed that there would be an audit to confirm that consultant obstetricians are involved in 100% of complex pregnancies.

9. **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. (LAFL 4.62)**

Dr Hon confirmed that, in September 2019, the Trust had implemented seven day working in Maternity with a consultant resident in the delivery suite between 08:30 – 21:00 every day, as a minimum. From April 2021 an anaesthetist would attend the daily Safety Huddle convened at the beginning of each shift.

In response to a question from Ms Garvey, Dr Hon suggested that the extended resident consultant cover on the ward (12.5 hours per day / 7 days per week) and twice daily ward rounds in Maternity was not a common procedure in the majority of maternity units across England. The Trust was currently undertaking a recruitment programme for implementing 7 days per week resident consultant cover between 21:00 and 08:30 each day.

Ms Hogg asked if the Trust had a plan for reinstating the simulation training package, paused over the past 12 months due to social distancing requirement. Ms Hon confirmed that Practical Obstetric Multi-Professional Training (PROMPT), the national simulation training, paused nationally at the beginning of the pandemic had been replaced by an online package for the mandated annual training.

10. **Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.(LAFL 4.63)**

Dr Hon mentioned that the multi-disciplinary handover meetings now in place in Maternity Services included the anaesthetist, incoming and outgoing obstetrics team, the delivery suite co-ordinator and, allowing for relevant Covid-19 restrictions, the theatre team and midwives from the

post-natal and antenatal ward. The latter currently submit their updates by telephone in advance of the ward round / handover meeting, to facilitate requirements for social distancing. The ward rounds were then carried out by the incoming obstetrics team, the delivery suit co-ordinator and the anaesthetist. To ensure women are not overwhelmed whilst in labour, agreement is reached, prior to the ward round, as to who needs to be seen by the anaesthetist and/or the obstetrician. If a women is undergoing midwifery lead low risk care they may not necessarily be seen on the ward round unless their situation changes.

Dr Hon mentioned the feedback received from the women and their families had been positive overall. They felt reassured by the team approach and CTG monitoring at the desk. Dr Hon suggested that reassuring engagement with women should be tailored to individual needs.

Dr Rose highlighted that 24/7 resident consultant care would be introduced at the Trust in the very near future, and that this was as a result of a considerable investment made by the Trust, and indicated that did pose a significant recruitment challenge.

In response to a question from Ms Barrett regarding whether SaTH follows the same early onset guidelines in neonatal sepsis as the rest of West Midlands, Dr Hon deferred a response to a later date when a neonatal expert, not present at this meeting, could answer the question. Mr Underwood confirmed that the regional guidelines were followed by the Trust.

11. 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. (LAFL 4.64)

Dr Hon confirmed that the Trust was following national guidelines and that all women on oxytocin would as a minimum have a face to face review and assessment by an obstetrician every 4 hours. The guidelines for this face to face assessment had recently been reviewed and implementation would be assessed by audit.

Ms Garvey asked how much a woman, given oxytocin during labour, would be able to understand, at that point, why she was being given oxytocin. Dr Hon explained that a discussion would take place with the woman in advance of being induced as to why they would be given oxytocin. And that the use of oxytocin for the purpose of augmentation during labour formed part of an antenatal discussion with the woman. She also highlighted that NICE are carrying out a national review of women's understanding of the use of oxytocin during labour.

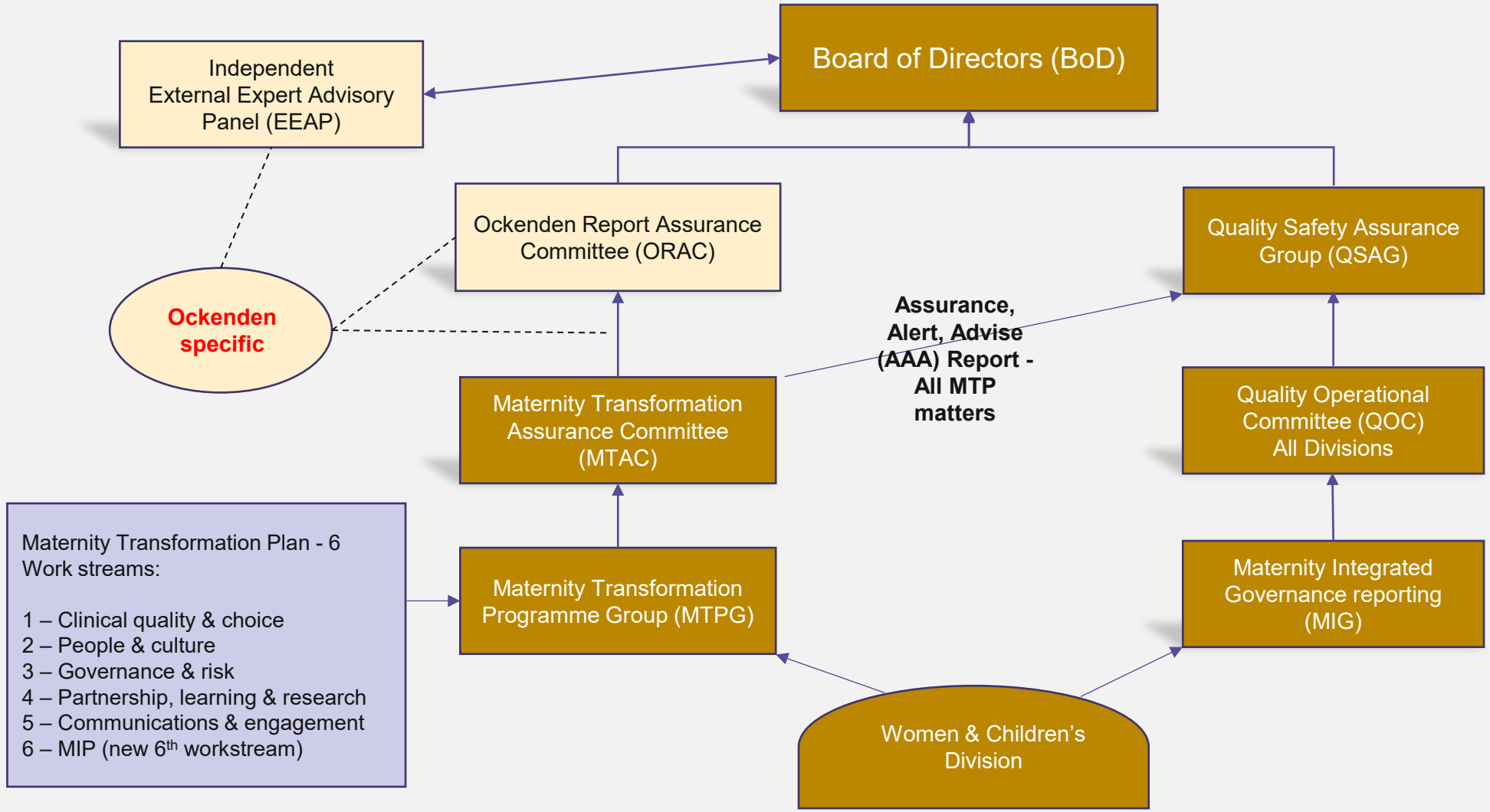
Ms Garvey also asked if a woman who requested an epidural would be

	given one. Dr Hon reported that the unit had a dedicated anaesthetist on call with a second dedicated anaesthetist available where necessary. Oxytocin was an obstetric intervention used only in the delivery suite and not used in home births or the midwife lead unit at the Trust. **12. 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. (LAFL 4.65)** Dr Hon suggested that sadly there will always be a need for bereavement care and that a full time specialist bereavement midwife was recruited to the post in January 2021. They will be responsible for direct patient care, for implementing national bereavement pathways, the Perinatal Mortality Review Tool (PMRT), a national requirement for all stillbirths and neonatal deaths and for working with Stillbirth And Neonatal Deaths Society (SANDS). **13. The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway. (LAFL 4.66)** Dr Hon confirmed that mandatory online training models were in place for all maternity staff. In response to a question from the Co- Chair, Dr Hon confirmed that, allowing for sensitivities around the parents' desire for confidentiality, bereavement support for the extended family was covered by a later LAFL dealing with mental health / bereavement services. The extended family were not excluded from bereavement support. Dr Hon mentioned the Rainbow Clinics and the need for ensuring the women who attend feel safe and supported. Dr Hon reported that staff morale, in response to a question from Ms Wilson, formed one of the workstreams (People and Culture) of the Maternity Transformation Programme. The Trust is working hard to maintain staff resilience, and support health and wellbeing.	
008/21	**Closing remarks from the Co-Chairs** The Co-Chair, Ms Garvey, highlighted the importance of the language used when communicating messages and information to the public either at the meetings (a list of acronyms) or to women and families to ensure everyone understands what was being said. Ms Evans affirmed the importance of engaging with and involving all community stakeholders as representative voices. Ms Evans suggested that communication should be a priority – being heard; being listened to; clear communication between all parties; and meaningful conversations with each individual woman and family about personalised care.	

	Dr McMahon suggested that the following key messages would be brought to the Board of Directors' attention: the voice of inclusion, consent to the delivery of care, implementation of a robust audit capability, no delay to the implementation of BadgerNet. The Co-Chair, Dr McMahon, confirmed that outcomes from the Ockenden Report Assurance Committee would be reported to the Board of Directors, with the Board holding the Committee to account for delivery of the actions from the Ockenden Report. Dr McMahon confirmed that dates for the next six meetings would be circulated shortly. Ms Garvey commented that she would find it beneficial if the meeting could be held in public, when the easing of Covid-19 restrictions permits. As to a "take home" message for any women and families listening she felt it important to emphasise a wish to actively listen to women and families; a strong desire to be clear, open and transparent about the Committee's and Trust's processes and aims; a need to make the meeting more accessible to women and families by being clearer in what is said by avoiding NHS jargon; by staying focussed in order to deliver a shared goal to deliver the best possible service and outcomes. Mrs Barnett suggested it was critical that the Trust maintains a clear focus on what had to be achieved; listen to women and their families; and engage families, partners, other experts and organisations in open and transparent discussions about delivery of the service and associated challenges. The Co-Chair, Dr McMahon, reiterated that the Trust welcomed questions from the public, and would receive a response from the Trust and be made available generally. Dr McMahon thanked the public for attending as observers.	
009/21	**Date of next Board of Directors' meeting in private:** At 0900 on Thursday 22 April 2021 - via MS Teams	
MEETING CLOSED		**1023**

Maternity Governance & Assurance Structure at 8th April 2021

The Shrewsbury and Telford Hospital NHS Trust



Ockenden Recommendations Assurance Committee

List of Acronyms
ENC 1.2

SaTH, regional and national committees and organisations

Acronym	Meaning	Description
n/a	Badgernet	Digital Patient Records and Notes system Electronic Patient Records.
CCG	Clinical Commissioning Group	Commission most of the hospital and community NHS services in the local area
CQRM	Care Quality review Meeting	
Datix	n/a	Record system for incidents within the Trust.
DoM	Director of Midwifery	
HW	Healthwatch	Independent National champion for people who use Health and Social Care services.
HoM	Head of Midwifery	
IIC	Investment and Innovation Committee	
LMNS	Local Maternity and Neonatal System	
n/a	Medway	Electronic Patient Records System (EPR) as above
MIP	Maternity Improvement Programme	
MLU	Midwife Led Unit	
MPFT	Midlands Partnership Foundation Trust	
MQOC	Maternity Quality Oversight Committee	
MTAC	Maternity Transformation Assurance Committee	An integrated organisation that provides physical and mental health, learning disabilities and adult social care services.
MTP	Maternity Transformation Programme	A programme of 5 workstreams designed to deliver the actions outlined in the Ockenden report plus additional improvement initiatives
MVP	Maternity Voices Partnership	A group of women/families representing NHS maternity service-users, who work together with the NHS, with the aim to improve maternity care.
ORAC	Ockenden Report Assurance Committee	

QSAC	Quality and Safety Assurance Committee	
RALIG	Review, Action and Learning from Incidents Group	
RAST	Risk Analysis Screening Tool	-To be replaced with Clinical Review Team (CRT)
SaTH	The Shrewsbury and Telford Hospitals [NHS Trust]	n/a
SFHNHST	Sherwood Forest Hospitals NHS Trust	Strategic transformation partner with SaTH

Clinical and training terms

Acronym	Meaning	Description
CTG	Cardiotocograph	Records the fetal heart rate patterns and contractions
FIGO	International Federation of Gynaecology and Obstetrics	In the context of the Ockenden report, this relates to their Intrapartum Fetal Monitoring Guidelines
NICE	National Institute for Health and Care Excellence	In the context of the Ockenden report, NICE relates to their 2017 guidance on fetal monitoring.
PAM	Patient Activation Measure	A tool or system for ascertaining the level to which a patient has understood the information relating to their care
O&G	Obstetrics and Gynaecology	Obstetrics and gynaecology is concerned with the care of pregnant woman, her unborn child and the management of diseases specific to women. The specialty combines medicine and surgery.
SII	Serious Incidents Investigation	https://www.england.nhs.uk/patient-safety/serious-incident-framework/
PROMPT	PRactical Obstetric Multi-Professional Training course	An evidence based training package that teaches healthcare professionals how to respond to obstetric emergencies. The course has been found to be associated with improved clinical outcomes and reduced patient safety incidents.
MDT	Multi-Disciplinary Team	A team comprising all clinical specialisms needed to care for the patient, for example obstetricians, midwives and anaesthetists
K2MS PTP™	K2 [brand name] Perinatal Training Programme	On line teaching and assessment package re CTGs and intrapartum emergencies

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee – 25th March 2021
Questions from the Public and the responses to them

1. **Will women be asked for their feedback on their notes and how they are presented? Will there be checks that women understand them and find them useful? I encourage the Trust to consider those members of the population who have low literacy levels, including the inability to read, disability or impairment and people for whom English is not their first language. It also goes without saying that digital exclusion is an issue at the moment and there should not be an over reliance on electronic forms of communication.**

Response
The service will be asking for feedback and understanding as part of the wider work on sharing of information, which will include considering the best ways to do this. Paper versions of Patient Information Leaflets are still available for those who require them. These can be translated into different languages as required. In addition, the Trust uses interpreting services to support women and families whose first language is not English. However, the paper medical records are in English, and this is in line with other units both regionally and nationally,

At the meeting, discussion focussed on how it was possible to seek confirmation regarding each individual woman's understanding of the information that was being presented and the choices available to them. Ms J Hogg described her Trust's use of the Patient Activation Measure (PAM), which assesses patient knowledge, skill and confidence for self-management and enables a support package to be tailored to meet their specific needs. PAM could also be used to determine a women's understanding of any risks associated with their decision. Ms Hogg confirmed that she would be happy to work with the Trust regarding its application. Mrs Flavell, Director of Nursing, will take this forward with Ms Hogg.

2. **Cross-border information sharing – Vanessa our Chair (Healthwatch Shropshire) asked about information sharing across county borders in the meeting. At Healthwatch Shropshire we are particularly aware of this issue and how it affects women in the south of the county, e.g. Ludlow who go on to have their baby in Hereford. Can you tell us the arrangements that are currently in place/planned?**

Response
Work has been ongoing with Powys to ensure robust pathways for women that have shared care; this work is almost completed. The same process with Wrexham is about to start, including the production of patient information, which is being co-produced with the Maternity Voices Partnership, so that women are informed about the differences in antenatal pathways in Wales and England, and in order to assist them in making informed choices about their care.

The introduction of Badgernet (new electronic Patient Information System) is going to improve the information sharing with some of our neighbouring trusts including

Hereford and Wolverhampton, who also use the system. One of the Trust's Senior Midwives is going to be looking at any changes in information sharing processes that may be needed with our other neighbouring trusts that women have shared care with. The first meeting is planned to take place in April 2021.

3. **Regarding the use of FIGO (International Federation of Gynaecology and Obstetrics) guidelines as opposed to NICE, if this goes and above the NICE guidance, will the Trust be able to demonstrate adherence to what is included in the NICE guidance as well as against FIGO?**

Response
FIGO and NICE are separate entities and one does not build upon or go above the other. Both are recognised tools to interpret Cardiotocographs (CTG's). CTG interpretation is only one small part of the NICE guidance on intrapartum care and the rest of the guidance is in place (as per Saving Babies Lives). CTG interpretation is the only part of the NICE intrapartum guideline that we are not using, and we are using FIGO instead. Sherwood Forest Hospitals NHSFT has done the same and sent the Trust their guideline yesterday to compare. The tool is been updated and will go via the Trust Governance processes for approval.

4. **Adverse experience / Serious Incidents (SI's) – This links to questions I have been asking across the Trust. Healthwatch Shropshire runs the Independent Health Complaints Advocacy Service for Shropshire residents and those using NHS services in Shropshire, can you assure us that women and families involved in this process are given the opportunity and encouraged to ask their own questions that are then incorporated into any investigations and included in the feedback to the women and families concerned.**

Response
The Trust is confident that women and families have the opportunity to ask questions and give their perspective and that these concerns are incorporated into investigations and reports. All women are invited to a feedback meeting to go through the report. However, not all women wish to ask questions or contribute to the report or meet for feedback.

5. **Involvement of fathers and families – It sounded like their involvement is based on the consent of the mother? Could it not be argued that as part of good public engagement they should have the opportunity to ask questions and have feedback in their own right? We have spoken to some fathers who have been shaken by their experience of childbirth and had questions.**

Response
This is a very difficult area to consider. What Dr Hon was referring to is that she cannot, as the mother's Obstetrician, discuss details of her care with anyone else including her birth partner without the woman's express consent. This is for reasons of patient confidentiality. If the father or partner wants to have a separate conversation about their own thoughts and feelings then that is a different matter and not something that the maternity service is currently commissioned to do, although every reasonable effort will be made to be as helpful as possible. The Trust does

have a programme starting for mental health support for women who have had difficult experiences but it is not clear if this has been commissioned for fathers. We will check this with the Trust's commissioners.

6. **Support for patients and staff - You may or may not be aware that last year Healthwatch Shropshire and Healthwatch Telford & Wrekin jointly wrote formally to the Trust to ask questions about the availability of support for those families involved in the Ockenden Enquiry, those using services now and previous/current staff working within maternity. We received a response from the Trust.**

Response

The Trust is working with the Healthcare Safety Investigation Branch (HSIB) to develop its patient and family engagement strategy and plan. HSIB is an organisation that conducts independent investigations of patient safety concerns in NHS-funded care across England. HSIB is funded by, and reports, to the Department of Health. HSIB has specific expertise in the area of patient and family engagement, which the Trust will be able to draw upon. The partnership agreement between the Trust and HSIB is being finalised. The first part of this work will consider engagement with those women and families affected by the Independent Maternity Review.

The Shrewsbury and Telford Hospital NHS Trust

OCKENDEN REPORT ASSURANCE COMMITTEE TERMS OF REFERENCE

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" signaled 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)[1]. It is clear, therefore, that in order to rise to this necessary challenge, the approach to the work of this Committee must be different and which is reflected in its membership and duties set out below.

Membership

Members of the Committee will be:

Role
Chair of SaTH
Co-Chair - External
Non-Executive Director - SaTH
Non-Executive Director - SaTH
Chief Executive - SaTH
Director of Nursing - SaTH
Medical Director - SaTH
Chief Operating Officer - SaTH
CCG Representative and Local Maternity and Neonatal system
Maternity Voices Partnership Representatives (MVP)
Healthwatch Representatives

Attendees of the Committee will comprise:

Role
Divisional Medical Director- Women and Children's Care Group – SaTH
Divisional Director of Operations – Women and Children's Care Group – SaTH
Director of Midwifery – Women and Children's Care Group – SaTH
Clinical Director – Obstetrics – SaTH
Programme Director – Maternity Assurance
Senior Project Manager, Maternity Transformation Programme

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

Independent Governance Consultant
Chairman, Lodestone – External Communications support
Sherwood Forrest Representative
Maternity Transformation Workstream Leads
Any other member of Trust staff as required to support the Committee in its deliberations

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.

Quoracy

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

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.

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.

Relationship to the role of the Independent 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 Assurance 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.~~

An **External Expert Advisory Panel – Maternity** has been convened by the Board of Directors to provide expert oversight relating to the Trust's implementation of the recommended actions from the first Ockenden Report (December 2020).

The principal purpose of the External Expert Advisory Panel is to provide independent expert oversight and advice, and in doing so act as a "critical friend" for the benefit of the Trust Board, in relation to the Trust's implementation of the recommended actions contained in the first Ockenden Report.

The External Expert Advisory Panel will act in a way that is complementary to (and supportive of) the Trust's internal assurance and accountability mechanisms which have been established to ensure the implementation of the recommended actions contained in the first Ockenden Report. In this regard, the Trust Board remains ultimately accountable for the implementation of the recommended actions contained in the first Ockenden Report and for ensuring that they are embedded in the organisation.

By providing independent expert oversight and advice in relation to the Trust's implementation of the recommended actions contained in the first Ockenden Report, the Panel will support the Trust Board in enabling it to discharge its responsibility for the provision of Maternity Services that are safe, effective, caring, responsive and well-led on behalf of the women and families of Shropshire, Powys, Telford and Wrekin. The Panel will, therefore, provide a level of additional oversight for the benefit of the Board of Directors.
Secretariat
The Committee will be supported by an appropriately skilled and resourced secretariat.
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.

Approved:	February 2021
To be reviewed:	February 2022

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/ Arne Rose (tbc)	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	Delivered, Not Yet Evidenced	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/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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	Delivered, Not Yet Evidenced	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		Hayley Flavell/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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.

Yellow shading on a row means that this action's delivery and progress status are under review and likely to change - due for review on 7th April 2021

APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 26 March 2021)

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Review of Governance team structure underway.		30/09/21		Hayley Flavell/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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	Delivered, Not Yet Evidenced	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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	

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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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	Mei-See Hon	

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20		Not Yet Delivered	On Track	Anaesthetists participating in some MDT ward rounds MDT emergency obstetrics course run in the SIM centre approx. 3 x per year Lead obstetric anaesthetist key facilitator in weekly in situ simulation training Obstetric anaesthetists to complete online Prompt course by 31/3/21 Include obstetric education section in each Anaesthetic governance meeting Regular obstetric anaesthesia meetings with a learning section Involvement of anaesthetists in PROMPT – both as facilitators and participants.				Hayley Flavell/ Arne Rose (tbc)	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 Clinical Director for obstetrics to ensure that anaesthetics staff are fully-embedded in the delivery of safe and effective care.				Hayley Flavell/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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.				Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	
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.				Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	

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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.				Hayley Flavell/ Arne Rose (tbc)	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				Hayley Flavell/ Arne Rose (tbc)	Will Parry-Smith	

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	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		Hayley Flavell/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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.				Hayley Flavell/ Arne Rose (tbc)	Janine McDonnell	

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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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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		Hayley Flavell/ Arne Rose (tbc)	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/ Arne Rose (tbc)	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 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 Work underway within Maternity Transformation 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.				Hayley Flavell/ Arne Rose (tbc)	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 obstetric 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/ Arne Rose (tbc)	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/ Arne Rose (tbc)	Hayley Flavell	

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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.													
4.1	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/ Arne Rose (tbc)	Mei-See Hon	
4.2	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/ Arne Rose (tbc)	Mei-See Hon	

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4.3	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/ Arne Rose (tbc)	Mei-See Hon	
4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	Obstetric Clinical Director engaged with network on this topic.				Hayley Flavell/ Arne Rose (tbc)	Mei-See Hon	

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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 will have risk re-assessed hourly throughout labour with "fresh eyes" review. 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. 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/ Arne Rose (tbc)	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 5.1		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Mei-See Hon	

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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		Hayley Flavell/ Arne Rose (tbc)	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.				Hayley Flavell/ Arne Rose (tbc)	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 safety action 6 compliance reporting and SBL compliance reporting in place.		15/07/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	

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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/ Arne Rose (tbc)	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 of Antenatal Care Pathway sub-project Confirm that the mother and partner / family have received and consumed the information as intended A process for auditing this will need to be established.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	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/ Arne Rose (tbc)	Mei-See Hon	

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Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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	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	Overall MTP Executive Sponsor	
Arne Rose	Executive Medical Director	Executive Sponsor	
Mei-See Hon	Clinical Director, Obstetrics	Co-Lead, Quality and Choice Workstream	
Guy Calcott	Obstetric Consultant	Co-Lead, Quality and Choice Workstream	
Janine McDonnell	W&C Divisional Director	Lead, People and Culture Workstream	
Nicola Wenlock	Director of Midwifery	Lead, Risk and Governance Workstream	
William Parry-Smith	Obstetric Consultant	Lead, Learning, Partnerships and Research	
tbc	tbc	Communications and engagement Workstream	