The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date Thursday 25th March 2021
Time 08.30 – 11.00
Location Via MS Teams – to be live streamed to the public

OPENING MATTERS AND PROCEDURAL ITEMS

Item No.	Agenda Item	Paper No / Verbal	Lead	Required Action	Time
2021/01	Chair's Welcome, Introductions, Apologies and Declarations	Verbal	Chair	Noting	08.30 (30 min)
2021/02	Purpose and tone of the Committee	Verbal	Chair	Approval/Review	
2021/03	Review of Terms of Reference including membership	Enc 1	Chair	Discussion	
2021/04	Local Actions for Learning Theme 1 – Maternity Care: 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	09.00 (40 min)
2021/05	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	09.40 (40 min)
2021/06	Observations and comments from relevant stakeholders and groups representing service users	Verbal	Chair All	Discussion	10.20 (30 min)
2021/07	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	10.50 (10 min)
2021/08	Meeting closes 11:00 Date of Next Meeting: tbc	Verbal	Chair		11.00

NHS
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
Maternity Voices Partnership Representatives (MVP)
Healthwatch Representative

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

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 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.

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. Feb '21: A sticker system to record hourly risk assessment for labour introduced by ward manager; audit to follow from March.		30/06/21		Hayley Flavell	Mei-See Hon	
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Ongoing antenatal care pathway development under way. Videos and leaflets available plus BabyBuddy app. Access to/utilisation of these needs to be determined. Key info also provided in handheld notes. Method to be introduced to confirm mother's understanding / receipt of info. Feb '21: Updated handheld notes made available. This will be digitalised with Badgernet rollout.		30/06/21		Hayley Flavell	Mei-See Hon	
4.56	The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Named obstetrician and midwife in place as leads for fetal monitoring. Long term resourcing to be secured and confirmation of appropriate training to be evidenced. Feb '21: The post for the substantive midwife is ready to go out to advert.		31/08/21		Anna Milanec	Nicola Wenlock	
4.57	These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Dedicated SBL project midwife in post, progress against Saving Babies' Lives (SBL) v2 monitored within scope of Maternity Transformation Plan (MTP). Feb '21: Peer review to be undertaken with Sherwood Forest Hospitals NHS Foundation Trust (SFH). Plan to lead on the development of a West Midlands dashboard and database of good practice for SBL.		15/07/21		Anna Milanec	Nicola Wenlock	

Colour	Status	Description
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	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

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4.58	Staff must use NICE Guidance (2017) on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.	Y	10/12/20	30/04/21	Not Yet Delivered	On Track	FIGO (International Federation of Gynaecology and Obstetrics) guidelines implemented (as opposed to NICE and supported by NHSI/E improvement advisor in 2020) SATH Fetal Monitoring guideline, approved by the Clinical Network, recommends that there should be further internal review given the action for the report. This is being progressed. Feb '21: FIGO guidelines will be presented to MQOC in March meeting. Audit tasks to evidence this action have been agreed, including confirmation that EFM continues during insertion of epidural and mobilising.		30/06/21		Anna Milanec	Nicola Wenlock	
4.59	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Review of Governance team structure underway.		30/09/21		Anna Milanec	Nicola Wenlock	
4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Review of Governance team structure underway.		30/09/21		Anna Milanec	Nicola Wenlock	
4.61	Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	All women with complex pregnancies are seen by an obstetrician, but an audit is required. Feb '21: Guideline recently updated; evidence of this will be appended to the Ockenden Report Action Plan.		31/05/21		Anna Milanec	Nicola Wenlock	
4.62	There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Consultant ward rounds at 08:30 and 20:30 in place 7 days per week since September 2019, handover sheets in place, weekly MDT in-situ simulation training in place. Liaison with Anaesthesia department required to ensure inclusion on rounds (see section 'Obstetrics Anaesthesia'). Current simulation training package under review.		30/06/21		Hayley Flavell	Mei-See Hon	
4.63	Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Currently achieved. Need to be able to provide on-going evidence, Retrospective audit of notes and ongoing audit to be conducted.		30/06/21		Hayley Flavell	Mei-See Hon	

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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. Feb '21: 4-hourly reviews implemented. SOP for documentation of obstetric reviews to be developed. Immediate audit of 10 cases to be conducted in March 2021.		30/06/21		Anna Milanec	Nicola Wenlock	
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Two bereavement midwives in place. Business case submitted for additional 90 hrs of consultant time for delivery of bereavement care. Need to appointment obstetrician to co-lead on bereavement care. Feb '21: Business case submitted for additional 90 hrs of consultant time plus SPA time for delivery of bereavement care		30/06/21		Hayley Flavell	Mei-See Hon	
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Bereavement pathway adopted partially and commitment in place to embed it fully. Implemented the maternity bereavement experience measure. SANDS (Stillbirth and Neonatal Death Society) online training modules mandated for clinical staff, which will need to be evidenced over time. SANDS review scheduled for Feb 2021 (now postponed due to Covid lockdown).		31/08/21		Anna Milanec	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	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 multidisciplinary clinics. Where there is not a relevant MDT clinic they are seen by an Obstetrician with an interest in maternal 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. Feb '21: Informal pathways to tertiary centres are in place. The West Midlands Clinical Network are leading on the development of specialist maternal medicine centres (SaTH does not meet clinical criteria to be a specialist centre).		30/06/21		Hayley Flavell	Mei-See Hon	
4.74	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Named consultant is already identified for all high risk pregnant women antenatally. If risk status changes during labour, the on-call consultant assumes responsibility and becomes their named consultant. The on-call consultant attends the antenatal ward daily and reviews all inpatients. They also go to the postnatal ward daily between 1100-1200 for a handover of complex postnatal patients. This will be evidenced by an “attendance” audit and by using the handover sheets whereby complex postnatal and antenatal cases have an “indirect” handover. Further clarity to be sought of specifics of this requirement i.e.: what constitutes demonstrated expertise?		30/06/21		Hayley Flavell	Mei-See Hon	

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Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20		Not Yet Delivered	On Track	Anaesthetists participating in some MDT ward rounds MDT emergency obstetrics course run in the SIM centre approx. 3 x per year Lead obstetric anaesthetist key facilitator in weekly in situ simulation training Obstetric anaesthetists to complete online Prompt course by 31/3/21 Include obstetric education section in each Anaesthetic governance meeting Regular obstetric anaesthesia meetings with a learning section Involvement of anaesthetists in PROMPT – both as facilitators and participants.				Anna Milanec	Nicola Wenlock	
4.86	Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.	Y	10/12/20	30/09/21	Not Yet Delivered	On Track	Good engagement with anaesthetics department. Consultant Anaesthetic Lead working closely with Clinical Director for obstetrics to ensure that anaesthetics staff are fully-embedded in the delivery of safe and effective care.				Rhia Boyode	Janine McDonnell	
4.87	Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA. Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.	Y	10/12/20	30/09/21	Not Yet Delivered	On Track	Annual audit cycle in regards to Royal College of Anaesthetists (RCoA) Guideline audit currently in place (covers theatre and epidural practice). Trust Guidelines last reviewed in 2016; new review underway. Regular guidelines review to be implemented as standing agenda item of bi-monthly obstetrics anaesthetic meeting. Audit method for compliance with the guidelines to be devised.		30/09/21		Anna Milanec	Nicola Wenlock	
4.88	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.	Y	10/12/20		Not Yet Delivered	On Track	Middle grade rota is staffed by experienced obstetric anaesthetists only. Continuous Professional Development (CPD) for consultants that cover obstetrics at night but who do not have regular sessions in obstetrics is in place. SOP/Guideline: "W*hen to Call a Consultant*" being developed. Compliance of completed CPD sessions to be collated. 'Cappuccini' audit underway and will be repeated: will demonstrate contactability of anaesthetic consultants.				Anna Milanec	Nicola Wenlock	
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Review of effectiveness of application of the ACSA (RCoA) – 189 standards is underway. In place as standing agenda item at the Obstetric Anaesthesia meeting.				Anna Milanec	Nicola Wenlock	

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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.				Anna Milanec	Nicola Wenlock	
4.91	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Currently working towards compliance with Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, safety action 8. Simulation course held 3 x per year In situ simulation training conducted weekly All obstetric anaesthetists to submit evidence of completion of the online PROMPT course by 31/3/21				Arne Rose	Will Parry-Smith	

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

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IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 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 Feb 21: Decision made to implement the Perinatal Quality Surveillance Model (PQSM), implement QI methodology across all dashboards, and develop an SOP for receiving and responding to national reports into service				Hayley Flavell	Nicola Wenlock	
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Not Yet Delivered	On Track	This is achieved in some cases currently. Arrange formal agreements between Trusts in order to achieve fully. Joining with a larger LMNS will support this process All cases which fulfil PMRT criteria currently reviewed with external panel member present. Feb '21: Formal partnership announced with SFHFT		31/07/21		Hayley Flavell	Nicola Wenlock	
1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	Review underway into levels of accountability and responsibility for maternity services held by this LMNS Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate and effective oversight				Hayley Flavell	Hayley Flavell	
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	SATH currently a single trust LNMS. Issue raised with NHSI/E regional office Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate effective oversight				Hayley Flavell	Hayley Flavell	
1.5	The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	This is in place but is not yet evidenced				Hayley Flavell	Hayley Flavell	
1.6	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.	Y	10/12/20	30/04/21	Not Yet Delivered	On Track	Review and strengthen SI reporting process to Trust Board and LMNS. Discussions commenced on how best to do this. Quarterly / monthly report to Trust Board using peer as example of reporting process to be developed (Feb '21 update - consider leveraging SFHFT template). Feb '21: Decision made to develop rapid review criteria to ensure defined incidents are considered at RALIG		30/06/21		Anna Milanec	Nicola Wenlock	

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	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

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

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Immediate and Essential Action 3: Staff Training and Working Together Staff who work together must train together													
3.1	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	New Multi 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.				Arne Rose	Will Parry-Smith	
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	There is a twice-daily ward round on the delivery suite with the delivery suite midwifery coordinator, duty anaesthetist and 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 Feb '21 All 6 recruited - as locum posts; resident consultant at weekends agreed. Recruitment to substantive posts pending. Achieve compliance with CNST Maternity Improvement Scheme (MIS) safety action 4. Multidisciplinary Simulation (SIM) training and PROMPT courses already take place.		30/06/21		Hayley Flavell	Mei-See Hon	
3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	This is not in place currently. MTP Workstream 4 has in scope proposals regarding how much time is required by clinical staff in order to complete their training and an uplift may be required. Identify which funding streams need to be ring-fenced including money from Health Education England (HEE) for students Mechanism for this yet to be established with the Executive Director of Finance				Hayley Flavell	Hayley Flavell	

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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	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. Feb '21:Measure have been put in place to ensure that Antenatal risk assessments to continually reassess care pathway are incorporated. Further developments, including those relating to Badgernet, to follow				Hayley Flavell	Mei-See Hon	
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	Mei-See Hon	

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4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Obstetric Clinical Director engaged with network on this topic. Feb '21 - Dr Hon is progressing this liaison with the regional team				Hayley Flavell	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. Feb '21: A sticker system to record hourly risk assessment for labour introduced by ward manager; audit to follow from March.		30/06/21		Hayley Flavell	Mei-See Hon	
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Place of birth revalidated at each contact as part of ongoing risk assessment Mother's choices based on a shared and informed decision-making process respected This is to be checked within the scope of the audit mentioned at LEA 5.1		30/06/21		Hayley Flavell	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. Feb '21: The position advertisements are live and will be filed as evidence in the project plan		31/08/21		Anna Milanec	Nicola Wenlock	
6.2	The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Twice weekly training and review MDT meetings in place reviewing practice and identifying learning. Lead Midwife attends weekly risk meetings to ascertain if CTG is a key or incidental finding in any incident. K2 training for midwives and obstetricians in place Incidents reviewed for contributory / causative factors to inform required actions. Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases Audit compliance with new guideline.				Arne Rose	Will Parry-Smith	
6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Named project midwife responsible for Saving Babies Lives in place - 1.0 WTE secondment Ongoing implementation and reporting of progress of SBL Care Bundle in place CNST safety action 6 compliance reporting and SBL compliance reporting in place. Feb '21: The MIP project plan has been migrated into the MTP project management tool to aid cross-referencing of actions		15/07/21		Anna Milanec	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. Feb '21: MTP will fund overhaul of the Trust's maternity web page. Engagement on a vendor to supply this is underway.		30/06/21		Hayley Flavell	Mei-See Hon	
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	Work currently on-going as part of Antenatal Care Pathway sub-project Confirm that the mother and partner / family have received and consumed the information as intended Feb '21: A process for auditing this has established.		30/06/21		Hayley Flavell	Mei-See Hon	
7.3	Women's choices following a shared and informed decision making process must be respected	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	A mechanism for measuring and auditing this needs to be developed. Feb '21 - MDT monthly meetings where place of birth is discussed will be examined and the minutes documented within the Ockenden Report action plan, to check that mother's choice is being supported. Dedicated PALS officer to be appointed to Maternity Services to offer in-reach and provide real time feedback.		30/06/21		Hayley Flavell	Mei-See Hon	

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Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadine or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	On track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that this action is being delivered and sustained.

Accountable Executive and Owner Index

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

Delivery Status

	Total number of recommendations	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	24	3	0
IEA	25	23	2	0
Total	52	47	5	0

Progress Status

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