The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date Thursday 24th June 2021
Time 09.00 – 11.00
Location Via MS Teams – to be live streamed to the public

AGENDA

Item No.	Agenda Item	Paper / Verbal	Lead	Required Action	Time
2021/28	Welcome and Apologies	Verbal	Chair	Noting	09.00 (15 min)
2021/29	Declarations of Interest relevant to agenda items	Verbal	Chair	Noting	
2021/30	Minutes of meeting of 27th May 2021 Matter Arising – Update on LAFL 4.98 and 4.99	Enc 1.1	Chair Mr Wright	Approval Information	
2021/31	Saving Babies Lives (SBL) (LAFL 4.57) - Presentation	Presentation	Ms Lindsey Reid – Lead Midwife SBL Mr Guy Calcott Consultant Obstetrician and Gynaecologist Lead Consultant for Early Pregnancy and Preterm Birth Prevention Ms Belinda Green Independent Specialist Midwife (Sherwood Forest NHS FT)	Discussion	09.15 (60 mins)
2021/32	Observations and comments from relevant stakeholders and groups representing service users • What have the stakeholders and groups representing service users heard so far in the first four meetings? • What reflections and observations do they have and wish to share at this stage? • Based on where the work of the Committee so far, what would stakeholders wish to see in the future meetings relating to the Ockenden Report action plan?	Verbal	Chair All	Discussion	10.15 (15 min)
2021/33	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	10.30 (15 min)

2021/34	Meeting closes Date of Next Meeting: 22nd July 2021 No Meeting in August	Verbal	Chair		Finish 10.45

Possible Items for Future Meetings (subject to change)

Formal business items

Review of Local Action for Learning 3 – Obstetric Anaesthesia – 22nd July 2021
Further review of Ockenden Action Plan progress – 23rd September 2021

Emerging related themes

Review of all audited Local Actions for Learning
Engagement strategy – listening to women
Management of bereavement
Communication/ Culture

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

Thursday 27th May 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)	
Mr N Lee	Chief Operating Officer (Trust)	
Ms Z Young	Director of Nursing & Quality, Shropshire, Telford & Wrekin CCG and Local Maternity & Neonatal System	
Mr J Jones	Acting Medical Director	
Ms V Barrett	Chair, Healthwatch Shropshire	
Mr B Parnaby	Chair, Healthwatch Telford & Wrekin	
Ms A Wilson	Member, Powys Community Health Council	
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 R Kennedy	Regional Associate Medical Director	
Mr K Haynes	Independent Governance Consultant	
Ms A Kerr-Gold	Executive Assistant	
APOLOGIES		
Ms F Ellis	Maternity Voices Partnership	
Ms L McLeod	Maternity Voices Partnership Development Coordinator Telford & Wrekin	
Ms T Hymas-Taylor	Head of Safeguarding, Representing Chief Nurse, Sherwood Forest Hospitals	
Ms L Cawley	Health Watch	
Ms Nicola Wenlock	Director of Midwifery (Trust)	
Ms J McDonnell	Divisional Director of Operations Women & Children (Trust)	
Ms A Milanec	Director of Governance & Communications (Trust)	
Dr A Rose	Medical Director (Trust)	
Ms E Evans	Maternity Voices Partnership	

No. 2020	ITEM	ACTION
Procedural Items		
019/21	**Welcome, introductions and apologies**. The Co- Chair, Jane Garvey welcomed all present including the public to the live stream of the meeting. Introductions were made and apologies were noted.	
020/21	**Declarations of Conflicts of Interests** There were no declarations of interest noted. The Co-Chair reminded members of the need to highlight any interests which may arise during the meeting.	
021/21	**Minutes of the previous meeting and matters arising** The amended minutes from the meeting of the 25th March, 2021, and the minutes from the 22nd April meeting were agreed as a correct record.	
022/21	**Overview of the Progress to Date in relation to the Ockenden Report recommendations and the Trust's Maternity Transformation Programme** Mr Guy Calcott introduced himself as one of the Consultants in Obstetrics and Gynaecology and also Clinical Quality and Choice Workstream Lead. In his presentation, Mr Calcott explained that the recommendations have been broken down into 52 action points. 20 of the 52 actions are at "Delivered, not yet evidenced status" stage. Just 4 actions have missed their deadline and are currently off-track with the remainder on-track to be delivered by the deadline. An extension to July has been requested for the four actions which remain off-track and which form part of the exception report. Mr Calcott explained that, in terms of the Local Actions for Learning, 25 of the 27 are on track and two are off-track. For the national actions, 20 of the 25 are on track, three have not yet started and two are off track. In his presentation Mr Calcott explained the clear relationship between the work of the Maternity Transformation Programme and the Ockenden actions, namely that the majority of the transformation work streams also cover many of the Ockenden recommendations.	

023/21	**Exception Reports for overdue deliverables** ***1- Ockenden action 4.65: 'where 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.***' Mr Calcott explained that he was leading this particular action and would speak to the associated exception report. Mr Underwood and Dr Hon would speak the remaining three exception reports. He explained that whilst bereavement care is currently given by the staff directly involved in a women's care, this requirement is for the appointment of both a midwife and obstetrician with demonstrable expertise and skill in this area, to further improve the Trust's bereavement services. It was noted that the Lead Midwife was already in post. The current delay, accounting for the exception report, is due to the prepared and locally approved business waiting consideration and approval at the within the Integrated Care System. Mrs Barnett agreed to pursue the matter with the system at pace as it is not directly within the Trust's purview to approve this, and related maternity service requests for additional expenditure. Mrs Barnett agreed to provide an update to the next meeting of the Committee. Mr Calcott also explained that there are plans to set up a Rainbow Clinic or a Rainbow Service and that the lead for bereavement care, along with himself, would be instrumental in developing this service. This service will be offered to women who have experienced bereavement in the past, to support them through a future pregnancy. ***2- Ockenden Action 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."*** Mr Martyn Underwood explained that this action was currently off-track because further guidance was being sought as the Ockenden report recommendation was not directly aligned with current national practice, based on the guidelines of the British Association of Perinatal Medicine (BAPM). He went on to explain that this had been shared with the External Expert Advisory Panel and clarification has been sought from them. In response to a request for clarification from Ms Garvey, Mr Underwood explained that there is a very clear national framework detailing which babies should be discussed with tertiary referral centres, and there are exception reports each month to check for compliance. At present a smaller (e.g. Level 2 as at SaTH) neonatal unit would not speak to a tertiary centre about every baby if it had been able to stabilise the baby immediately and there had been clinical improvement. The Ockenden action requires the local neonatal unit to seek advice from the tertiary referral unit in relation to each baby who requires intensive care. Dr McMahon, the Co-Chair, asked for confirmation that the current level 2 neonatal unit is adequately equipped and staffed to care for babies who are 27 plus weeks, 800 plus grams and are stabilised once the initial resuscitation has been undertaken.	

In response, Mr Underwood confirmed that one of the Ockenden actions (LAFL 4.99) requires SaTH have the capability to stabilise these babies to tertiary level experience which is why a business case has been approved enabling the rotation of the consultants and the ANPs (Advance Nurse Practitioners) through the tertiary centres at Birmingham Women's and Children's and at Stoke, so all of the consultants and ANPs will have one week in each Trust, each year. Mr Underwood explained that this was not something routinely required for a unit like SaTH and that, as a result, SaTH was going a step further. In support of this arrangement, an additional Consultant Neonatologist post had been approved and will be advertised shortly, taking the number of Consultant Neonatologists to seven. The intent is to also increase the number of ANPs.

3- Ockenden Action 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."

Hayley Flavell explained that MTAC had reviewed progress against this action at their meeting on 22nd June, and had decided to keep as 'Not Yet Delivered'. This was due to the outstanding need to develop an approach that enabled a balance between the transparency the Trust is seeking to deliver and the need to ensure an appropriate level of patient confidentiality. Ms Flavell indicated that she was liaising with colleagues at Sherwood Forest to discuss their approach to delivering this action and was intending to produce a report for the consideration of the Board at its meeting in private on 10th June.

Zena Young commented that she was having the same dilemma at the LMNS and that progressing this report is something that they should work on together. Ms Flavell confirmed that she worked closely with Zena Young and that the report that is currently shared at the Board Meeting in Public is the same as that shared at the LMNS meeting, and will continue to need to be in the context of the information reported in order to meet this required action.

Dr McMahon, Co-Chair, asked whether SaTH knows and is confident with where the accountability sits in the event that confidential information about an incident that occurred at SaTH is released into the public domain (either via SaTH or another group) which resulted in potentially identifiable information being publicly available. Ms Flavell confirmed that both the Trust and the LMNS would report using exactly the same data, based on the principles of not breaching patient confidentiality whilst at the same time providing meaningful feedback and learning from serious incidents in line with the recommendation.

4- Ockenden Action IEA 7.2: "Women must be enabled to participate equally in all decision making processes and to make informed choices about their care."

Before speaking to this item, Dr Mei-See Hon provided further information in relation to the earlier discussion regarding neonatal staffing and training. In particular she referred to published data from the national neonatal audit programme (2020) that looked at how the Neonatal Unit at SaTH performed versus other Trusts. With the exception of performance of two metrics which were slightly below the national rate Dr Hon cited a number of key metrics which confirmed that all other performance metrics exceeded the national average, Dr Hon stated that this reflected the hard work that neonatal colleagues had put into the service and, in particular, into engaging with families on ward rounds.

	In relation to IEA 7.2, Dr Hon explained that, at the recent meeting of the Maternity Transformation Committee, it had been decided that this action should remain 'Not Yet Delivered', as the committee recognised that the Trust had not done enough, yet, to hear from women as to whether they feel they have all the information they require. It was agreed to liaise more closely with the MVP, who in turn are recruiting a wider section of volunteers and conducting a postnatal survey. In addition Dr Hon confirmed that the Clinical Director of Maternity Services has been appointed to lead work stream 5, further reinforcing this work Topics for discussion have been identified, and this area will be prioritised for the next phase of the project. An exception report has been filed for the missed deadline, but no revised delivery date has been confirmed. Dr Hon explained that an interim Head of Communications had been recruited to support this work. Mr Tony Bristlin requested an update on the Ockenden Audit Tool, highlighting it as a key element in the progress of all of the actions. Dr Hon explained that, in collaboration with the Trust Audit Department, all the Ockenden Actions have been reviewed to identify those that require audit and those that would require audit of clinical records. An audit tool has been designed that will allow the Trust to conduct one large audit, meeting the majority of the need, rather than working with multiple small audits. This can also be used in other units. Once the new maternity notes system is up and running, it will be possible to automate audit reports on a regular basis. The first audit of a set of pilot notes is scheduled for June, with the aim of running a larger scale report in September/October. An Audit Midwife has been appointed as it will be a very manual process for the first 9-12 months whilst enough data is gathered on Badgernet to be able automate the reports.	

024/21	**Immediate and Essential Actions 2-7:** **Detailed consideration of each of the IEAs 2-7 and current progress/status** **IEA 2: Listening to Women and Families** • ***Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.*** • ***The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.*** • ***Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.*** • ***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.*** Dr Hon explained that an independent senior advocate for maternity services is required in each Trust providing maternity services and also at LMNS Boards. This is a national initiative and the Trust is awaiting guidance from the centre and has not been able to meet the original end of June deadline. In discussion about the role of the Maternity Safety Champions, Mr Tony Bristlin highlighted that as he sits on the Maternity Transformation Assurance Committee and the CNST challenge group and as one of the Maternity Safety Champions, he is able to triangulate the information between all three. He also meets with the other Safety champion monthly and together they host a meeting involving obstetricians, senior midwives and neonatal specialists. The Champions visit the wards to identify, with the staff, important safety actions, which they follow through to delivery. Completed safety actions are communicated to the maternity team via a noticeboard and the team are working on processes to improve that communication in the team. He added that he reports to the Board on safety concerns and associated actions, In addition, is role does have a responsibility to assure that the voices of women and families using our services are heard in and by SaTH. Dr Hon presented examples of the work being done by workstream 5 to ensure that there is evidence of engagement and meaningful involvement of the Maternity Voices Partnership in the delivery of the MTP, including assessment and input into information leaflets, videos, the Trust website and key processes. In response to a question from Ms Garvey, Dr Hon explained that it is a challenge to include the voice of all women, especially those from rarely heard groups. The MVP is currently expanding their membership to be more representative of our communities, She went on to explain that, in reality, this action should remain open because there would always be room for hearing more and engaging more. **IEA 3: Staff Training and Working Together** • ***Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.***	

- ***Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.***
- ***Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.***

Dr Hon provided an update that these actions are due to be in place by the end of June 2021. She highlighted that:

- ✓ MDT Practical Obstetric Multi-Professional Training (PROMPT) training is in place and occurring monthly (doctors and midwives).
- ✓ Weekly MDT simulation exercises take place regularly on delivery suite with ad hoc sessions on the Midwifery Led Unit.
- ✓ Work is underway within the Maternity Transformation Plan (MTP) to develop further best practice in this area.
- ✓ Twice weekly Cardiotocograph (CTG) learning and feedback sessions are held on the Delivery Suite for the MDT, delivered by the CTG midwife and/or consultant.
- ✓ Weekly risk management meetings are in place, which are MDT meetings, with a Lead Obstetrician, midwifery managers and maternity risk manager in attendance.
- ✓ An identified Obstetric anaesthetic lead with Human Factor specialist interest attends MDT training.
- ✓ Attendance reporting to commence using the CNST reporting template;
- ✓ MDT skills drills to take place out of hours, which will include escalation scenarios. There is anaesthetic attendance at these training sessions.

Martyn Underwood added that a business case and request for £440K has been submitted to enable midwives and doctors to be released from their duties to able to attend specific training on CTG and human factors. Approval of this funding is expected in the next few weeks.

IEA 4: Managing Complex Pregnancies

- ***Women with Complex Pregnancies must have a named consultant lead.***
- ***Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.***
- ***The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.***
- ***This must also include regional integration of maternal mental health services.***

Dr Hon explained that these actions are due to delivered by the end of June 2021 and evidenced by the end of September 2021.

Dr Hon stated that all women with complex pregnancies already have a named consultant and appropriate risk assessments are carried out and documented at each contact as part of the guidelines. She further explained that although the requirement for a risk assessment has been in the guidelines for a long time, in order to move from delivered to embedded this too will need to be subject to audit.

Specialist antenatal clinics for diabetes and endocrine, haematology, cardiac disease, rheumatology, respiratory, gastro, neurology and mental health are delivered at SaTH. Women with additional or emerging needs are reviewed at a monthly MDT meetings, to discuss their specific medical needs and to discuss individualised birth plans.

A business case has been submitted for additional consultant hours to staff an "Urgent" Antenatal clinic to see women who have developed complex obstetric conditions. In addition, Dr Hon explained that maternal medicine centres are being developed nationally, and that she was in discussion with the West Midlands lead regarding the pathways under development.

Dr Hon stated that there is an established perinatal mental health team who hold weekly MDT meetings, supported by established referral and communication pathways. There is an Obstetric Clinical lead engaged with this topic.

Vanessa Barrett asked for an update on a question she raised in a previous meeting regarding whether women are supported in understanding the concept of having a named consultant.

Dr Hon confirmed that this concern has been included in work stream 5 so it will be addressed.

IEA 5: Risk Assessment Throughout Pregnancy

- ***Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.***

Dr Hon explained that following the meeting of the Maternity Transformation Assurance Committee, members were satisfied to approve this action to the 'Delivered, Not Yet Evidenced' stage, based on the evidence provided for LAFL 4.54. To progress to evidenced, MTAC require evidence of risk assessment being made a mandatory field in Badgernet, and audit evidence to show that Place of Birth choice is reviewed at each appointment.

IEA 6: Monitoring Foetal Wellbeing

- ***The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:***
  - ***Improving the practice of monitoring foetal wellbeing***
  - ***Consolidating existing knowledge of monitoring foetal wellbeing***
  - ***Keeping abreast of developments in the field***
  - ***Raising the profile of foetal wellbeing monitoring***
  - ***Ensuring that colleagues engaged in foetal wellbeing monitoring are adequately supported***
  - ***Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.***
- ***The Leads must plan and run regular departmental foetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.***
- ***The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.***

Dr Hon explained that these actions are due to be delivered by 30/06/2021 and evidenced by 30/09/2021.

Dr Hon reminded the Committee that in March she explained that the lead midwife for foetal monitoring had left the Trust and the organisation was in the process of recruiting. She confirmed that two midwives had now been appointed to the role who would job share and are now continuing the work. In addition, there is a lead obstetrician with dedicated time in their job plan to deliver this work. Dr Hon went on to explain that they are currently developing a competency package, together with a foetal monitoring training day, that will be delivered shortly.

Dr Hon explained that MDT training meetings are run twice a week where traces are reviewed. The lead midwife for CTGs attends those risk meetings in order to look at CTG abnormalities or CTG trends during incidents. The only risk to this action is that these midwives are secondees and approval is required to make these posts substantive.

Dr Hon went on to confirm that there is a dedicated SBL (Saving Babies Lives) project midwife actively driving SBL delivery forward with support, guidance and assurance from SFH partners. This will be discussed in further detail at a next meeting where SBL will be the main topic of discussion.

IEA 7: Informed Consent

- ***All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care.***
- ***Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.***
- ***Women's choices following a shared and informed decision making process must be respected.***

Dr Hon confirmed that these actions were due to be delivered by 31/03/2021 and evidenced by 30/06/2021.

She added that MTAC approved this action to 'Delivered, Not Yet Evidenced' based on the evidence referenced for LAFL 4.55, including online and handheld information. She outlined the introduction of new 'business cards' which are handed to mothers; the cards contain a QR link to the BabyBuddy app and other verified information sources. She went on to explain that this will be one of those actions that remains a continuous improvement project.

Dr Hon explained that the final part of the immediate essential action is about women being able to participate equally in decision-making processes and being able to make informed choices about their care. She explained that this is part of the work that is on going, using user stories. The other part of the work was about supporting choices and Dr Hon reminded the Committee about the birth options clinics ran through SaTH, and about the Trust's planning meetings where women who may chose a birth option outside guidelines are discussed, in order to plan how their needs can best be met without compromising their safety. This action will be subject to audit to confirm that it is embedded.

In response to a question from Ms Garvey, Dr Hon confirmed she was happy with the pace of the progress so far.

	Dr McMahon seconded that whilst the plan is written in such a way that it doesn't look like a lot of work, one shouldn't underestimate the efforts and the workload involved to achieve these targets and deadlines. In support, Dr Richard Kennedy added that he felt that the performance metrics were tracking in the right direction based, he felt, on an excellent plan and team in place.	

025/21	**Q&A** 1. **"Will women be able to see 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."** Dr Hon confirmed that feedback and confirmation of understanding is part of the process. Notes will be available in electronic and paper form and can be translated into different languages. It is not yet known how many patients will opt not to use the digital format of notes, but BadgerNet has a function to print each of the documents to create a file for the lady. Mike Wright asked for an update on discussions with Ms Julie Hogg, Chief Nurse from Sherwood Forest regarding surveys of patient understanding (action from ORAC 1 discussion). In Julie's absence, Tina will take this action and request an update from Julie. 2. **Health Watch Shropshire asked about information sharing across county borders. "At Health Watch 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 or planned?"** Martyn Underwood confirmed that Joy Payne, interm Head of Midwifery, has been in communication with Powys Health Board about this recently. BadgerNet will help to share information with adjacent hospitals on a read only basis. Currently, all information is in handheld records. With the rollout of BadgerNet, the Trust will be able to share information electronically with other hospitals that also access BadgerNet. Dr Hon added that the other aspect of this to consider is the referral pathways. Martyn Underwood explained that going forward with BadgerNet, the aim is that the patient will have access to all of their information on their electronic records which they can share with their GP in a read only mode. In addition, GPs will have access to BadgerNet, as in other units in the country that already have BadgerNet. If woman do not have access to, or prefer not to use, a handheld device, they will have a paper version of their notes. 3. **"If this goes above the NICE guidance will the trust be able to demonstrate adherence to what is included in the NICE guidance as well as FIGO?"** Dr Hon explained that there is no straightforward answer to this. The only point where FIGO is being used instead of NICE is the section that looks at foetal monitoring. It is about the tool that is used to interpret the CTG and about whether to use straightforward pattern recognition or whether to move more into trying to explain what's going on physiologically with baby. SaTH is using what they consider to be a more inclusive way of interpreting CTGs by implementing FIGO.	Action

4. **Health Watch Shropshire asked: "Health Watch Shropshire runs the independent health complaints advocacy service and Shropshire residents, 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 women and families concerned. "**

Hayley Flavell stated that the same approach is used for all incidents across the organisation. As a Trust, she is confident that women and families are provided the opportunity to ask questions and to share their perspective on the incident. All concerns are incorporated into the investigations and reports. All women are invited to a meeting to go through their report. Not all women wish to ask questions, contribute to the report or receive feedback.

5. **Health Watch Shropshire asked: "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.'**

Dr Hon clarified that there are 2 things that need to be considered. One is the mother's confidential medical information, as discussing her care must with her consent. The second is the father's/family's experience and their feelings.

Dr Hon shared that a new Lighthouse service is being implemented which offers psychological support to partners and families. The service has been set up with the Midlands Partnership Foundation Trust to provide counselling services to families who have suffered bereavement or a traumatic birth experience.

In response to a question from the Co-Chair Ms Garvey, Dr Hon stated that the service had been running for about a month and the team meets every Wednesday. A dedicated psychologist is leading the service and the terms of reference are being finalised.

The Co-Chair, Ms Garvey asked if a father could attend this service on his own.

Mei-See Hon confirmed that he could as it would be support for him in his own right.

6. **Health Watch Shropshire and Health Watch Telford and 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.**

Louise Barnett summarised the response from the Trust and confirmed that there is a range of support offered to women and families (partners included), provided by the local mental health trust. These services are all confidential and range from telephone consultations to face to face appointments.

026/21	**Discussion and Reflection** The Co-Chair, Jane Garvey emphasised that the point of the committee is to be transparent and accessible, and accordingly she encouraged members of the public, women and service users to email the Trust with questions that they might have which will be shared and considered by the Committee at its next meeting. She went on to initiate a discussion around the amount of progress that has been made, the way the meetings are being run and the way the information is being given out. Vanessa Barrett stated she feels excited and positive about the progress demonstrated and fully recognises the effort and amount of work that goes on behind the scenes to progress each action. Anthea Wilson echoed Vanessa Barrett's comment and raised concerns about the conflict between the national priorities and the Ockenden recommendations. She also reflected on the fact that the most difficult area to address seems to be involving the patients and families in the SaTH processes but is also one of the most important things to address. Catriona McMahon asked if there was anything that people were left feeling unsure about or anything they feel should be done differently. She encouraged any question that comes to mind. In response to Anthea Wilson's comment, Richard Kennedy stated that the Ockenden report is a national priority so it is going to be a game changer for the maternity services. He feels there is no conflict and that the national guidance and the Ockenden recommendations are complementary and that there will inevitably be some local nuances. In response to a question from Ms Garvey about the standards that were expected of the Trust, Louise Barnett stated that SaTH is determined to deliver the best possible care to the community and welcomes the report that was received. Some areas that were raised require input and SaTH welcomes the challenge to ensure that local patients feel confident about using their services. Zena Young wanted to commend the Trust on its approach and focus on the programme despite the current strains on health services across the nation. When asked about the format of the meeting by The Co-Chair, Zena Young confirmed that it is exactly what the public need to see in terms having assurance and confidence in the service. The Co-Chair, Ms Garvey asked if there is anything that should be discussed that hasn't yet been featured in any of the meetings and that should be prioritised for June. Mike Wright raised the Saving Babies Lives standard as he feels they are hidden within the Ockenden recommendations but are really significant objectives to achieve. Jane Garvey and Mei-See Hon confirmed that this could be prioritised for June provided the SBL project midwife isn't on leave in June.	

	Hayley Flavell raised the benefit of getting feedback from friends and family tests and people who have been or are going through the service currently. Mei-See Hon stated that the MVP are in the midst of conducting a survey and have started to receive some responses so she and Tom will work on this with Emily and Louise in their workstream 5 engagement meeting and may have some data to present from there. It was suggested that MVP is invited to present some of the work presented to LMNS about their engagement with the harder to reach groups to determine how they are trying to engage to be more inclusive. The Co-Chair, Jane Garvey felt that it would be beneficial but feels they may need encouragement to do so. Mei-See Hon suggested that the lead of workstream four, Will Price-Smith be invited to present the results of his recent research and interviews of staff and service users to get more qualitative data. The Co-Chair, Jane Garvey agreed and added that Mike Wright had suggested sharing parent stories which she felt would be beneficial. Anthea Wilson suggested putting a call out on social networks for any families currently going through the service and would like to give feedback. The Co-Chair, Jane Garvey agreed. Mike Wright raised that there were a few items at the bottom of the agenda that hadn't been discussed and that need to be carried over for a further meeting.	
027/21	**Closing remarks from the Co-Chairs** The Co-Chair, Jane Garvey and Catriona McMahon encouraged everyone to email in questions and topics of conversations to be addressed in future meetings. Ms Garvey thanked all the speakers and participants.	
028/21	**Date of next Board of Directors' meeting in private:** At 0900 on Thursday 24 June 2021 – vis MS Teams	
MEETING CLOSED		

Board of Directors' Meeting
10 June 2021

Agenda item	132/21			
Report	The Ockenden Report – Progress Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 2, BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR 16 CRR 18 CRR 19 CRR 23 CRR 27 CRR 31	
	For noting			
	For information			
	For consent			
Presented to:				
Dependent upon (if applicable)**:**				
Executive summary:	This report presents an update to the Trust's Ockenden Report Action Plan and other related matters. The Board of Directors is requested to receive and review: • This report, and the Ockenden Report Action Plan at **Appendix One** • Decide if any further information, action and/or assurance is required			
Appendices	**Appendix One:** Ockenden Report Action Plan at 30th May 2021			

1. PURPOSE OF THIS REPORT

1.1 This report presents an update on all 52 actions in the Trust's Ockenden Report[1] Action Plan since the last meeting of the Board of Directors in Public on 6th May 2021. In addition, updates are provided in relation to other related matters.

2. THE OCKENDEN REPORT (INDEPENDENT MATERNITY REVIEW - IMR)

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

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

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

2.3. All of the Ockenden actions (LAFL and IAE's) have been cross-referenced to the Trust's Maternity Transformation Plan, which now includes The Maternity Improvement Plan, as workstream 6.

2.4. The latest version of the first Ockenden Report Action Plan is presented at **Appendix One** for the Board's consideration (Note: Glossary and Index are at the back of the plan).

3. STATUS OF REQUIRED ACTIONS

3.1. During May 2021, none of the actions have been due to meet their delivery dates. As such, there are no changes this month to the numbers of action at delivered, not yet evidenced status. The **'Delivery Status'** position of each of the 52 actions as at 30 May 2021 is summarised in the following table:

	Total Number of Actions	**Not Yet Delivered**		**Delivered, Not Yet Evidenced**		**Evidenced and Assured**
		March	April/May	March	April/May	
LAFL	27	24	15	3	12	0
IEA	25	23	17	2	8	0
Total	**52**	**47**	**32**	**5**	**20**	**0**

3.2. The **'Progress Status'** position of each action as at 30 May 2021 is summarised in the following table, which shows that 45 actions remain 'on-track'. In May 2021, the Board of Directors was advised that four actions were off track for a variety of reasons. These are:

[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.

3.2.1. **LAFL 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.*

There is the need for additional posts to be in place before this action can be met fully. These form part of the overall maternity business case that is under consideration. Interim arrangements are in place in the meantime.

3.2.2. **LAFL 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.*

There is an apparent contradiction between the requirement as expressed in the Ockenden Report, and current national and network guidance (from BAPM - the British Association of Perinatal Medicine). Attempts are being made to seek clarification on this.

3.2.3. **IEA 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 the LMS for scrutiny, oversight and transparency. This must be done every 3 months.*

There is plan to start to provide a summary of all maternity serious incidents and key related issues to the Board of Directors' meeting in public from August 2021.

3.2.4. **IEA 7.2** – *women must be enabled to participate equally in all decision making processes and to make informed choices about their care.*

This actions requires greater consultation with service users, the Maternity Voices Partnership, and Workstream 5 of the Maternity Transformation Plan – Communications and Engagement. Dr Mei-See Hon, Clinical Director is taking over as the leader for this workstream, which should ensure that greater traction is made going forward.

3.2.5. The three actions that have not yet started (insert IEA's 1.1, 1.3 and 1.4), all relate to the Trust not being a single Local Maternity and Neonatal System (LNMS) and, also, the assurance of the same. Discussions about this are progressing steadily and the status of these three actions will be considered at the Maternity Transformation Assurance Committee on Tuesday 8th June 2021.

During May 2021, discussions have been taking place with the Shropshire, Telford and Wrekin LMNS to commission some work as part of the system-wide dashboard development in order to support the Trust to strengthen the timeliness and accuracy of maternity-related data that is reported on currently. The idea is to integrate the Trust and LMNS data sources to produce one suite of information that can then be used in a variety of ways and for a number of meetings and accountability forums. This work is being progressed and will be tested before being taken forward more formally.

In the meantime, the following table summarises the position in relation to the 'Progress Status' of all of the actions

	Total Number of Actions	Not Started	Off Track (see exception report)		At Risk (see exception report)		On Track		Completed
			March	April/ May	March	April/ May	March	April/ May	
LAFL	27	0	0	2	0	0	27	25	0
IEA	25	3	0	2	0	0	22	20	0
Total	**52**	**3****	**0**	**4 (det.* by 4)**	**0**	**0**	**49**	**45 (det.* by 4)**	**0**

*deteriorated but due to have proposed revised timeframes for completion considered at the MTAC meeting on 8th June 2021** delivery and progress status due to be considered at the MTAC meeting on 8th June 2021

3.3. In summary, good progress is being made with the action plan overall, and the governance and assurance around this is becoming more robust and clearer. The Maternity Transformation and Assurance Committee (MTAC) will continue to oversee the delivery of and assurance around this action plan.

4. OTHER MATTERS RELATING TO THE OCKENDEN REPORT ACTIONS

4.1. <u>IEA Return to NHS Midlands on delivery of the Immediate and Essential Actions</u>

4.1.1. The Trust made the required submission to NHSE/I on 12th February 2021 prior to the required deadline of 15th February. This provided the Trust's status against all of the Immediate and Essential Actions.

4.1.2. All NHS providers of maternity care are required to upload their evidence against the seven Immediate and Essential Actions to a central portal by Monday 14th June 2021. A minimum evidence template has been provided to Trusts to support this work. The Trust is in the process of compiling and uploading its evidence. On Tuesday 15th June, representatives of the Trust will attend a 'confirm and challenge' meeting with NHS Midlands region, the CCG and LMNS to determine the Trust's progress against the IEA actions. The outcome of this will be reported to the Board of Directors in due course.

4.2. <u>Patient/Family Engagement</u>

4.2.1. The Terms of Engagement with the Healthcare Safety Investigation Branch (HSIB) have now been finalised. The Trust is now developing a Family Liaison role and the job description and person specification for this are now being developed and progressed.

4.3. <u>External Expert Advisory Panel (EEAP)</u>

4.3.1. A meeting between the members of the EEAP and the Trust's Chair, Director of Nursing, Independent Governance Adviser and the Programme Director for Maternity Assurance took place on 18th May. This was to re-engage with the panel and to discuss options for them to work with the Trust. This was a really positive meeting and the panel would like to continue to work with the Trust. With regards to the way forward, the panel has suggested having meetings with the Trust, for them to establish direct contact between panel members and their clinical counterparts and, possibly, a panel visit to the Trust. These are all now being progressed with the panel.

4.4. Workforce Plan, Including Birthrate Plus Assessment

4.4.1. The Trust has received the final Birthrate Plus report from the audit that was undertaken in 2020. It was hoped to bring the results from this to this meeting. The draft report was considered as part of the Clinical Negligence Scheme for Trusts' (CNST) review work that is underway currently. However, further work is required on it in order to make it compliant with the standards. Therefore, this will need to be deferred to the July 2021 meeting of the Board of Directors.

5. OCKENDEN REPORT ASSURANCE COMMITTEE (ORAC)

The third Ockenden Report Assurance Committee took place on Thursday 27th May 2021. The Chair will discuss this committee in her report at today's meeting.

6. SUMMARY

Progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace.

7. ACTION REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to receive and review:

- This report, and the Ockenden Report Action Plan at **Appendix One**
- Decide if any further information, action and/or assurance is required

Hayley Flavell
Executive Director of Nursing
June 2021

Appendix One: Ockenden Report Action Plan at 23rd April 2021

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. MTAC agreed on 22/04/2021 that the evidence provided, including booking guideline, risk assessment proforma and Clinical Referral Team process, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	31/01/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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. MTAC agreed on 22/04/2021 that the evidence provided, including information videos, virtual ward tours, online antenatal classes, the new Personalised Care and Support Plan (co-produced with the MVP) and Place of Birth Choice leaflet, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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	

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

APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 30 May 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
4.58	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. MTAC agreed on 22/04/2021 that the evidence provided, including an approval record from the Clinical Network of SaTH's fetal monitoring guideline and re-approval by the Quality Operational Committee and QSAC, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	SaTH NHS SharePoint
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	
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	Delivered, Not Yet Evidenced	On Track	All women with complex pregnancies are seen by an obstetrician, but an audit is required. MTAC agreed on 22/04/2021 that the evidence provided, including the revised risk assessment proforma (used at booking), and the CRT Referral Process, was sufficient to move this to 'Delivered, Not Yet Evidenced', with a formal audit to follow.	22/04/21	31/05/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	SaTH NHS SharePoint

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.62	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. MTAC agreed on 22/04/2021 that the evidence provided, including examples of obstetric handover sheers, an small audit of the handover run-rate, an example of the safety huddle attendance record, evidence of anaesthetist representatives attending ward rounds, planned purchase of PROMPT sim equipment to be held on wards for in-situ training, and evidence (design and feedback sheets, with attendance records to follow) of regular multi-disciplinary team simulation training was sufficient to move this to 'Delivered, Not Yet Evidenced', with a follow-up check including attendance records to follow.	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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. MTAC agreed on 22/04/2021 that the evidence provided (completed obstetric handover sheets) was sufficient to move this to 'Delivered, Not Yet Evidenced', but noted that they would need to see the new handover sheet that is being introduced to add greater control and oversight, and the results of a formal audit, before it can be accepted as 'evidenced and assured'.	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint

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

APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 30 May 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
4.64	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	Delivered, Not Yet Evidenced	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. MTAC agreed on 22/04/2021 that the evidence provided (demonstration of use of stickers to show continuous monitoring is carried out, and the preliminary findings of a snap audit of 12 case notes to show continuous monitoring, including during insertion of epidural was being carried out) was sufficient to move this to 'Delivered, Not Yet Evidenced', but outlined a requirement for a full, formal audit (number of cases tbc) as the next step for evidencing	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	SaTH NHS SharePoint
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	Off Track (see exception report)	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. At their meeting on 22/04/2021, MTAC found this action has not yet been delivered, because the business case has not yet been approved (though they have seen the document itself). They noted that an appropriate guideline (Fetal Loss and Early Neonatal Death) is in place and appropriately experienced midwives are in place, and that the consultants are providing bereavement care. However, for this service to be consistent and fully optimised, the committee need to see the protected consultant time / appointment - this must also show service user representation in the selection of candidates. An exception report has been provided: new agreed delivery date tbc.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Escalation policy already in place. Updated November 2020 to describe situations where Consultants must be in attendance. Process in place to assess competencies of all middle grade doctors, not just O&G trainees. Compliance with escalation process to be audited. At their meeting on 22/04/2021, MTAC approved status to be 'delivered, not yet evidenced' based on the escalation process poster that is displayed on the wards. The next wish to see the completed guidelines / SOP document, and an audit of adherence.	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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 multi-disciplinary 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		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.74	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	Delivered, Not Yet Evidenced	On Track	Complex antenatal and postnatal inpatients are identified at the morning and evening Delivery Suite handovers 7 days a week. This information is recorded on the handover sheets. The on call consultant attends the antenatal ward round daily to conduct a ward round along with the Tier 2 doctor. They also attend the postnatal ward to review any women identified as complex. This will be evidenced by an attendance audit and through auditing the information on the handover sheets. Further clarity to be sought of specifics of this requirement i.e.: what constitutes demonstrated expertise? MTAC approved this as 'Delivered, Not Yet Evidenced' at their meeting of 22/04/2021, noting the revised risk assessment form and CRT referral process (as with LAFL 4.54 and 4.61).	22/04/21	30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint

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

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

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4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Review of effectiveness of application of the ACSA (RCoA) – 189 standards is underway. In place as standing agenda item at the Obstetric Anaesthesia meeting.				Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	
4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20		Not Yet Delivered	On Track	Obstetric Anaesthetist expertise is incorporated to regular Datix reviews. Regular input to 'Human Factors' investigations, also. Anaesthetics consultants to dedicate SPA time to Obstetrics in addition to current service lead in order to progress this. Will require audit evidence.				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	Delivered, Not Yet Evidenced	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 MTAC approved this as 'Delivered, Not Yet Evidenced' based on evidence of 89% completion rate of the online PROMPT training by anaesthetists, and feedback notes and course design of MDT training organised by the anaesthetic consultants. Attendance records, plus demonstrated fulfilment of CNST MIS Safety Action 8 will move this to 'Evidenced and Assured Status'. Face-to-face MDT training will resume from 28 April (having been online early during the worst of the pandemic).		30/10/21		Hayley Flavell/ Arne Rose (tbc)	Will Parry-Smith	SaTH NHS SharePoint

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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	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. MTAC approved this as 'Delivered, Not Yet Evidenced' having seen proof of the combined notes format having been adopted (by the deadline set out above). They also saw examples of the SaTH Exutero Exception monthly log for the previous quarter. Next items to check will include plans for the BadgerNet rollout referenced above.		30/04/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	SaTH NHS SharePoint
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	Off Track (see exception report)	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 Both MTAC and the nominated Neonatal Consultant supporting this project declared this action 'Not Yet Delivered' in their review on 22/04/2021. As reported at ORAC on the same day, there are some discrepancies with this requirement and current national guidance. SaTH will seek the advice of the External Expert Advisory Panel on how best to proceed. Given the initial due date has passed, a project exception report has been filed, with revised delivery date tbc.		30/04/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	

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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	Delivered, Not Yet Evidenced	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. MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen of firm planes for such placements to take place at Royal Stoke Hospital, New Cross Hospital and Birmingham Women's Hospital, as soon as pandemic conditions allow. Once the placements have been ongoing for sufficient time, it will be reviewed and tested to see whether it has been embedded.		30/10/21		Hayley Flavell/ Arne Rose (tbc)	Janine McDonnell	SaTH NHS SharePoint

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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	31/01/2021			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	Off Track (see exception report)	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 MTAC reviewed progress against this at their meeting on 22/04/2021, and decided there is not enough evidence of transparency (in terms of publishing), so this remains 'Not Yet Delivered'. An exception report has been filed, but the revised due date is tbc. Next steps are for the Trust to consult with SFHNHST to learn from how they report safety matters in the public domain, with a view to adopting best practice.		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	Delivered, Not Yet Evidenced	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) MTAC approved this to 'Delivered, Not Yet Evidenced' based on evidence (meeting minutes, walk-about notes, 'you said, we did' board, AAA reports) of regular and meaningful engagement by the NED with the Maternity Safety Champions Group. MTAC noted the Trust must engage more with MVP partners, to ensure service user voices are truly heard; this will be facilitated via Workstream 5 of the MTP amongst other initiatives. ORAC (2 meetings held to date) is attended by MVP and LMNS representatives.		30/04/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	SaTH NHS SharePoint - Maternity Safety Champions workspace
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 work stream. 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	Delivered, Not Yet Evidenced	On Track	There is a twice-daily ward round on the delivery suite with the delivery suite midwifery coordinator, duty anaesthetist and obstetric consultant in attendance. These occur at 08:30 and 20:30.If there is a change of consultant, there is an additional ward round at 17:00. 7-day working of consultant in place within maternity services; 7-day rota in place to ensure obstetric consultant cover meeting 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. MTAC approved this action to 'Delivered, Not Yet Evidenced' on 22/04/2021, based on the same evidence as discussed for 4.62, as well as information provided on ongoing recruitment of locum consultant obstetricians, with some substantive roles also planned. It was noted that CNST MIS Safety Action 4 has been reduced in scope for Year 3 (as of March 2021), so this benchmark is less applicable now.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint

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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)	Guy Calcott	
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)	Guy Calcott	

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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)	Guy Calcott	
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)	Guy Calcott	

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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	10/12/20	31/03/21	Delivered, Not Yet Evidenced	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. MTAC were satisfied to approve this to 'Delivered, Not Yet Evidenced' on 22/04/2021 based on the evidence provided for LAFL 4.54. They require to see evidence of risk assessment being made a mandatory field in Badgernet, and audit evidence to show that Place of Birth choice is reviewed at each appointment, in order to progress this to the next delivery stage.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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	Delivered, Not Yet Evidenced	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 MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen for elements of LAFL 4.54 and 4.55 (specifically, the monthly review clinic, from which minutes were provided, and the birthplace choices leaflet and online information)		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint

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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	

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 7: Informed Consent													
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.													
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Patient information leaflets available on the Internet (SaTH Homepage), including recently developed leaflet of choice for place of birth co-produced with the MVP. Also includes link to national PIL on Caesarean section (Tommy's) and Birth after previous caesarean section (RCOG). Work 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 requesting 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 service available). 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. MTAC approved this to 'Delivered, Not Yet Evidenced' status based on the evidence referenced for LAFL 4.55, including online and handheld information. They noted the introduction of new 'business cards' handed to mothers; the cards contain a QR link to BabyBuddy app and other verified information sources. MTAC also noted that, following a study of other Trusts' online information, including on social media platforms, and in partnership with the MVP, the Trust is moving forward with a quote to revamp their online presence to maximise accessibility, the funds coming from the MTP budget.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	SaTH NHS SharePoint
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	Off Track (see exception report)	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. MTAC decided in their meeting on 22/04/2021 that this remains 'Not Yet Delivered', as they are not satisfied we have yet done enough to hear from women whether they feel they have all the information they require. MTAC instructed the MTP to liaise more closely with the MVP, who in turn are recruiting a wider section of volunteers and conducting a postnatal survey. Further, WS5 has been further reinforced with the appointment of the Clinical Director of Maternity Services as lead. Topics to explore have already been identified, and this area will be prioritised for the next phase of the project. An exception report has been filed for the missed deadline, but no revised due date has yet been confirmed.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	

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

APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 30 May 2021)

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
7.3	Women's choices following a shared and informed decision making process must be respected	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	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. MTAC approved this to 'Delivered, Not Yet Evidenced', having been provided with copious meeting minutes (anonymised) from the Birth Options Clinic, showing multiple instances of individualised care being put in place in order to enable the mother's chosen care pathway and place of birth. Further audits, including a review of the findings of the above-mentioned MVP-led survey will be examined once available.		30/06/21		Hayley Flavell/ Arne Rose (tbc)	Guy Calcott	

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.

The Shrewsbury and Telford Hospital NHS Trust

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	Overall MTP Executive Sponsor					
Arne Rose	Executive Medical Director	Executive Sponsor					
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					
Mei-See Hon	Clinical Director, Obstetrics	Communications and engagement Workstream					

Ockenden Report Assurance Committee

Ockenden Report Action Plan:

A review of the action plan and current progress/status

Date: 27th April 2021

Presenter:

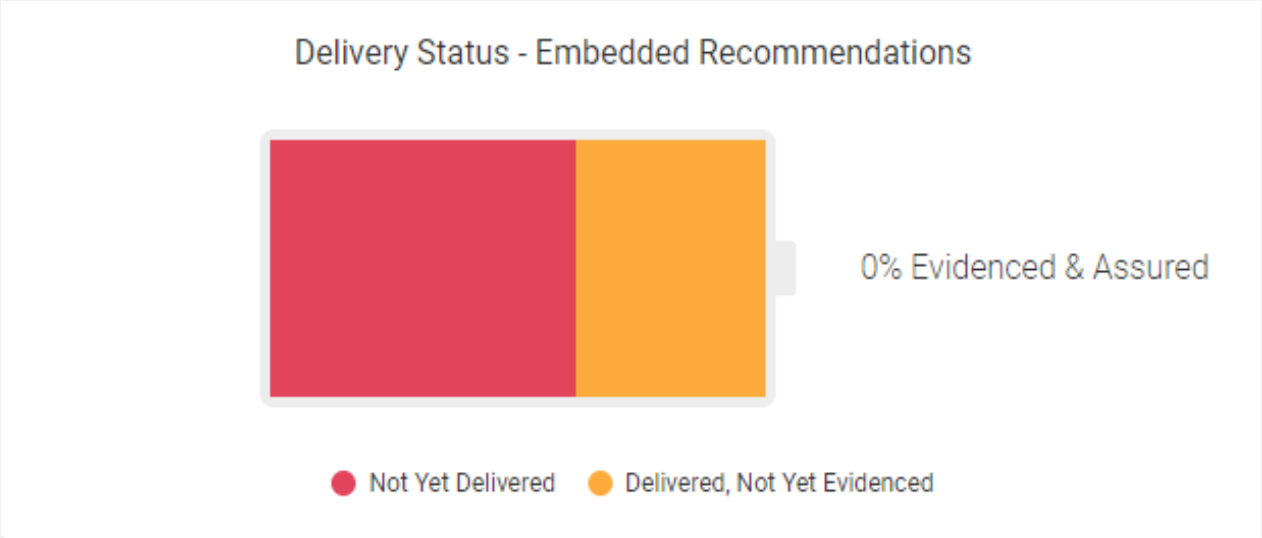
Mr Guy Calcott

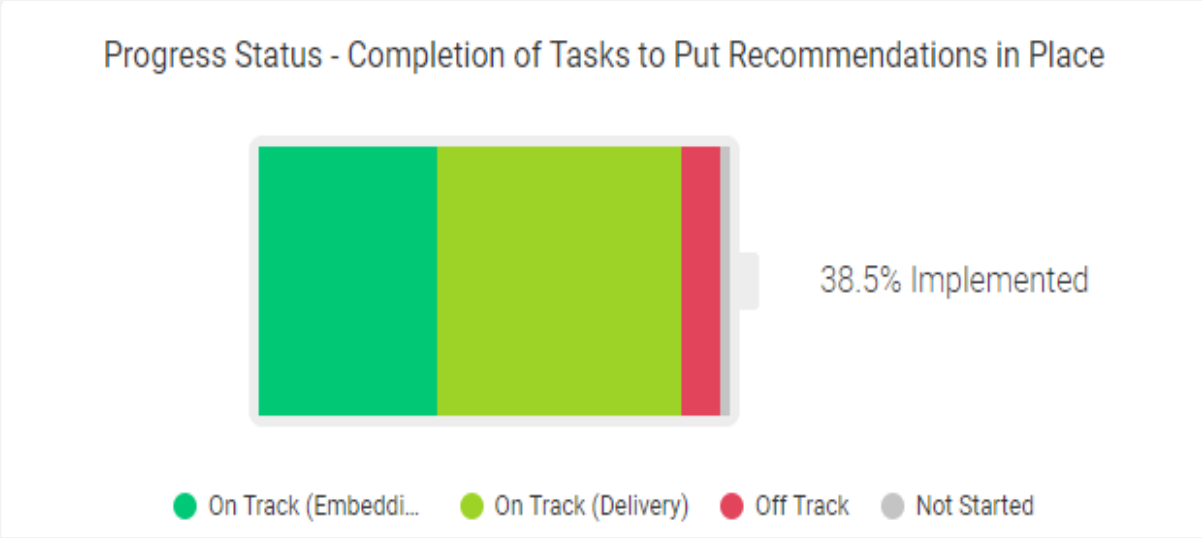
Consultant – Obstetrics & Gynaecology

Clinical Quality & Choice Workstream Lead

Overall Status – Delivery and Progress

The Shrewsbury and Telford Hospital NHS Trust





Executive Summary.

- Delivery phases 1 and 2 complete, 20 of the 52 actions now at 'Delivered, Not Yet Evidenced Status'
- 4 actions have missed their deadline and are now Off Track; exception reports have been submitted to Trust Board and are enclosed here, in order to have the revised delivery dates agreed.
- Maternity Transformation Assurance Committee (MTAC) and, in turn Ockenden Report Assurance Committee (ORAC) now established to review, sign-off or reject evidence provided

Not yet delivered – Action not yet in place
Delivered, Not Yet Evidenced – Action in place, evidence being collated
Evidenced and Assured – Action in place and embedded

Delivery and Progress Status in detail

The Shrewsbury and Telford Hospital NHS Trust

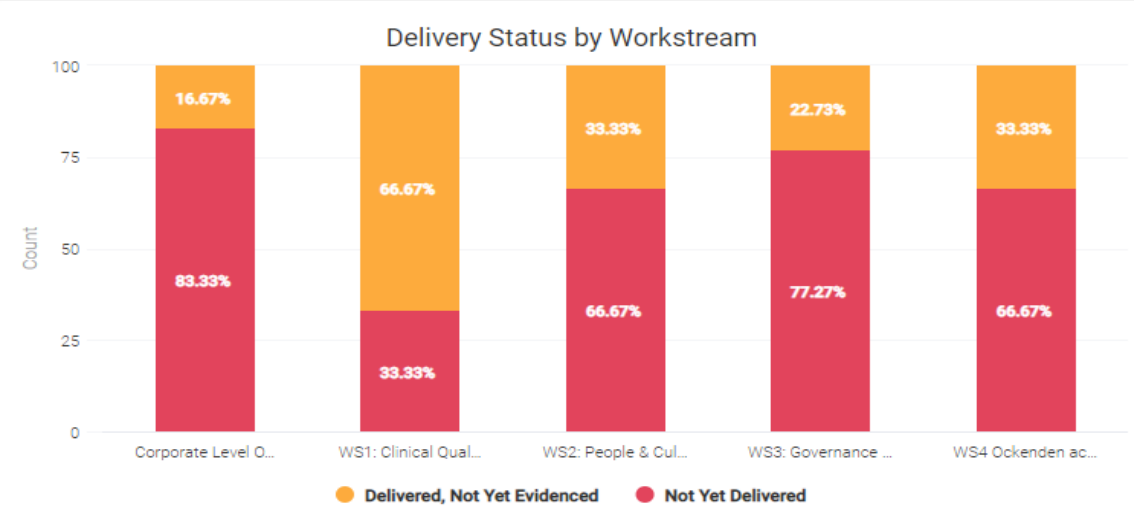
Delivery Status

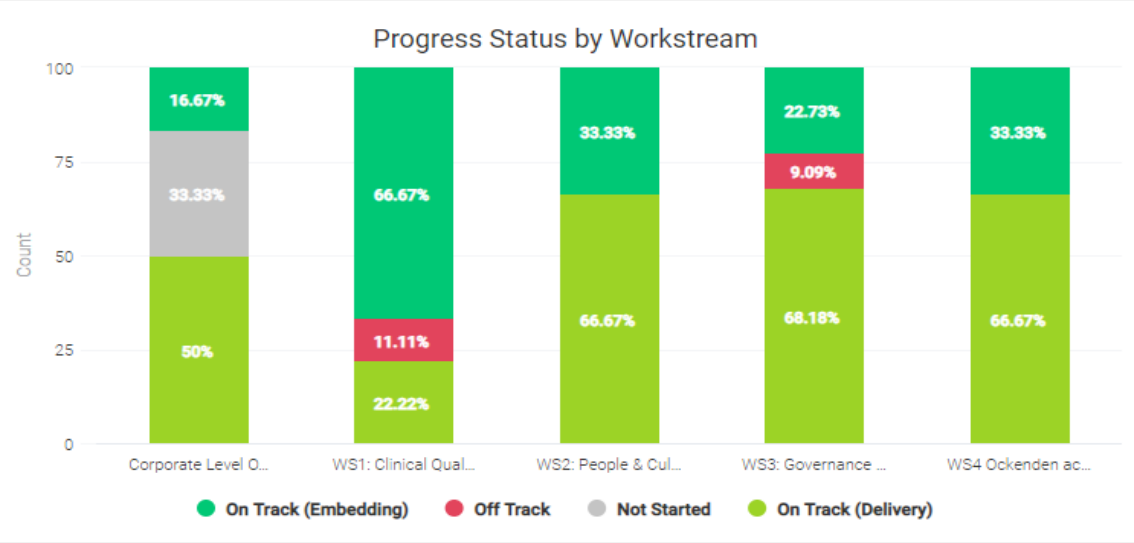
	Total number of recommendations	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	15	12	0
IEA	25	17	8	0
Total	52	32	20	0

Progress Status

	Total number of recommendations	Not Started	On Track	At Risk	Off Track	Completed
LAFL	27	0	25	0	2	0
IEA	25	3	20	0	2	0
Total	52	3	45	0	4	0

Status per Workstream – Delivery & Progress





Corporate level

- 6 IEAs assigned, all due to be in place by Jun and evidenced by Sep. IEA 1.5 is Delivered. All are on track.

Workstream 1 (Clinical Quality & Choice)

- 8 LAFLs and 10 IEAs assigned. 6 LAFLs and 6 IEAs are Delivered. 1 LAFL and 1 IEA Off Track.

Workstream 2 (People and Culture)

- 3 LAFLs assigned. 1 is Delivered; all are On Track

Workstream 3 (Governance and Risk)

- 15 LAFLs and 7 IEAs assigned. 4 LAFLs and 1 IEA Delivered. 1 LAFL and 1 IEA are Off Track

Workstream 4 (Partnerships, Learning and Research)

- 1 LAFL and 2 IEAs assigned. 1 LAFL delivered. All are On Track

Note: Workstream 5 does not have any Ockenden actions directly assigned, but underpins all the others. New lead (Dr Hon) may bring across some actions from WS1 that relate to 'choice'.

NHS
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NHS Trust

Exception Reports for overdue deliverables

Ockenden Requirements Implementation: Exception Report

Date of Report:	**20/04/2021**	**Ockenden ID:**	4.65	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	**Hayley Flavell / Arne Rose (tbc)**	**Requirement:**	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.				
Action Lead:	**Mei-See Hon**						

Reason for exception and consequences	**Mitigation**
The funding for the posts in question has not yet been approved, hence we are not yet able to hire or provide the consultant time. We therefore cannot state that this action has been delivered. It should be stressed that the bereavement service is nonetheless being delivered, with specialist midwives in place and consultants making time to provide this form of care. However, in order to standardise it and co-ordinate it to maximum effectiveness, we need the investment.	1) The business case will be submitted to the Innovation and Investment Committee. There is a semi-protected 800k amount set aside which could potentially be used to fund these priority posts. 2) Current obstetricians are making the best effort to delver this care in the interim – we aim to standardise and co-ordinate this care, hence the need for these posts (service enhancement) – i.e. service already exists.

Recommendation	**What lessons have been learnt from this exception?**
1) The optimal solution would be to push for the business case to be approved, as only with this investment can we fully meet this requirement.	A refined process for seeking urgent approval for priority investments need to be devised by the DoF. Over time, as we have gained a deeper understanding of the actions, it has become apparent that some of our initial deadlines could not be met if the action is to be carried out in full, especially where things are outside of our control (of the division) (dates need revising)

Recommendation approval (name / date)	**Original due date:**	**31/03/2021 (to be evidenced by 30/06/2021)**
	Proposed revised delivery date:	**31/07/2021 (evidenced by 30/09/2021)**

Ockenden Requirements Implementation: Exception Report

Date of Report:	**22/04/2021**	**Ockenden ID:**	4.98	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	**Hayley Flavell / Arne Rose (tbc)**	**Requirement:**	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.				
Action Lead:	**Nicola Wenlock**						

Reason for exception and consequences	**Mitigation**
We have not been able to implement this yet, due to an apparent contradiction between the requirement as expressed in the Ockenden report, and current national guidance (from the British Association of Perinatal Medicine - BAPM). If discussions about every baby receiving intensive care (even if they do not meet the threshold as laid down in the service specification and national recommendations) need to take place with NICUs, then this falls outside the Network's agreed pathways and national recommendations.	1) Prepare a short paper precisely detailing the contradiction 2) Share this with a consultant neonatologist member of the External Expert Advisory Panel, to seek their guidance 3) Share this with the Ockenden Team in an appropriate format, and if needed, request clarification on the action from them.

Recommendation	**What lessons have been learnt from this exception?**
1) The mitigation set out above is recommended, as it will be useful to other Trusts and Maternity Services as well as us.	We have learned that there are a number of actions in the Ockenden Report which require further contextualising or clarification, and that a process for managing this is needed.

Recommendation approval (name / date)	**Original due date:**	**31/03/2021 (to be evidenced by 30/06/2021)**
	Proposed revised delivery date:	**31/07/2021 (evidenced by 30/09/2021)**

Ockenden Requirements Implementation: Exception Report							
Date of Report:	**20/04/2021**	**Ockenden ID:**	IEA 1.6	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	**Hayley Flavell / Arne Rose (tbc)**	**Requirement:**	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.				
Action Lead:	**Nicola Wenlock**						

Reason for exception and consequences	**Mitigation**
MTAC reviewed progress against this at their meeting on 22/04/2021, and decided there is not enough evidence of transparency (in terms of publishing), so this remains 'Not Yet Delivered'. An exception report has been filed, but the revised due date is tbc. Next steps are for the Trust to consult with SFHNHST to learn from how they report safety matters in the public domain, with a view to adopting best practice.	1) We will append extracts from the Trust Board Terms of Reference and invite review of whether this currently calls for sufficient transparency in the publishing of information relating to safety matters 2) We propose that Governance leads from SaTH liaise with their counterparts at Sherwood Forest Hospitals NHS Trust to understand how they report safety matters in the public domain, with a view to potentially adopting the same model if it has proven successful.
Recommendation	**What lessons have been learnt from this exception?**
We recommend the above solution as it offers maximal transparency and an opportunity to learn from good practice from our partner Trust.	This has made us aware of a potential lack of transparency that may be relevant for other Divisions in the Trust, so there may be a need for action across the board.

Recommendation approval (name / date)	**Original due date:**	**31/03/2021 (to be evidenced by 30/06/2021)**
	Proposed revised delivery date:	**31/07/2021 (evidenced by 30/09/2021)**

Ockenden Requirements Implementation: Exception Report

Date of Report:	**20/04/2021**	**Ockenden ID:**	IEA 7.2	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	**Hayley Flavell / Arne Rose (tbc)**	**Requirement:**	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.				
Action Lead:	**Mei-See Hon**						

Reason for exception and consequences	**Mitigation**
MTAC decided in their meeting on 22/04/2021 that this remains 'Not Yet Delivered', as they are not satisfied we have yet done enough to hear from women whether they feel they have all the information they require. MTAC instructed the MTP to liaise more closely with the MVP, who in turn are recruiting a wider section of volunteers and conducting a postnatal survey. Further, WS5 has been further reinforced with the appointment of the Clinical Director of Maternity Services as lead. Topics to explore have already been identified, and this area will be prioritised. for the next phase of the project. An exception report has been filed for the missed deadline, but no revised due date has yet been confirmed.	1) Use existing SaTH survey evidence, or devise new ones, to audit this 2) Supply more evidence in terms of Birth Options Clinic Meeting minutes or PALS feedback 3) Redouble our efforts to engage with Service Users via our MVP partners across all MTP workstreams, nut particularly Workstream 5, appoint a new lead with the requisite seniority and skills and focus on finding maternity cover for the current Comms. Specialist. Use user-centric project methodology (Agile User Stories) to ensure the Service User is kept at the heart of all change initiatives.

Recommendation	**What lessons have been learnt from this exception?**
3) Option 3 (with elements of the other 2) is recommended – Workstream 5 has already started using this methodology so provide rapid improvements tailored to specific MVP / Service User feedback. We have a fantastic opportunity to truly hear our service users and respond to their specific needs in this way.	It is neither possible nor appropriate for the Trust and its Maternity Services to judge whether women are, or feel themselves to be adequately informed and empowered to participate equally in such decisions. We therefore have to redouble our efforts to connect with Service Users directly and via the MVP, and devise suitable methods of auditing this – or leverage existing ones such as the MVP postnatal survey.

Recommendation approval (name / date)		
	Original due date:	**31/03/2021 (to be evidenced by 30/06/2021)**
	Proposed revised delivery date:	**31/07/2021 (evidenced by 30/09/2021)**

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Assurance Committee

Immediate and Essential Actions 2-7:

Detailed consideration of each of the IEAs 2-7 and current progress/status

Date: 27th April 2021

Presenter:

Dr Mei-See Hon

Clinical Director, Obstetrics

IEA 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.

- Not Yet Delivered; On Track.
- The Trust had hoped this would be in place by 30/06/2021, but this is dependent on the national initiative.

Summary:

✓ These roles are being developed, defined and recruited to nationally. It is understood that this process in underway.

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.

- Not Yet Delivered; On Track.
- The Trust had hoped this would be in place by 30/06/2021, but this is dependent on the national initiative.

Summary:

✓ These roles are being developed, defined and recruited to nationally. It is understood that this process in underway.

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.

- Delivered, Not Yet Evidenced.
- In place by 31/03/2021, was due to be evidenced by 30/04/2021; we feel that it is embedded.
- *Requires agreement from ORAC before it can be marked as 'Evidenced and Assured'.*

Summary:

✓ MTAC approved this to 'Delivered, Not Yet Evidenced' based on evidence (meeting minutes, walk-about notes, 'you said, we did' board, AAA reports) of regular and meaningful engagement by the NED with the Maternity Safety Champions Group.

✓ MTAC noted the Trust must engage more with MVP partners, to ensure service user voices are truly heard; this is being actively delivered via Workstream 5 of the MTP (amongst other initiatives).

✓ ORAC is attended by MVP and LMNS representatives.

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.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021.

Summary:

✓ SaTH has ongoing engagement with the MVP for MTP workstream 5, and in co-ordination with them are refreshing service user representation in the other workstreams.

❑ Evidence that active and meaningful involvement is in place is required. Action to be discussed with CQC at relationship meeting.

IEA 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.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021.

Summary:

✓ 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, 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.

3.2 (note link to LAFL 4.62*)

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.

- Delivered, Not Yet Evidenced; On Track for embedding.
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021.

Summary:

✓ MTAC approved this action to 'Delivered, Not Yet Evidenced' on 22/04/2021, based on the same evidence as discussed for 4.62, as well as information provided on ongoing recruitment of locum consultant obstetricians, with some substantive roles also planned.

❑ Audit results to be scrutinised to check attendance records for full evidence and assurance.

**LAFL Theme 1: 'Maternity Care', subject of initial ORAC meeting.*

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021.

Summary:

✓ MDT bid submitted (£440k) - funding will be spent on staff uplift and protected/ / backfill time for mandatory and enhanced training.

❑ MTP budget, once approved by NHSEI, to be made available for scrutiny and spends reports shared with LMNS for review.

❑ Confirmation from Director of Finance will be provided.

IEA 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.

Women with Complex Pregnancies must have a named consultant lead.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021.

Summary:

✓ All women with complex pregnancies have a named consultant lead.

✓ Appropriate risk assessment documented at each contact.

✓ Case notes audit tool devised in partnership with Clinical Audit Team.

❑ Case notes audit to be carried out.

4.2

The Shrewsbury and Telford Hospital NHS Trust

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021.

Summary:

✓ 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.

✓ Individual pathways incorporating pre-existing morbidities created.

❑ 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.

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.

- Not Yet Delivered; On Track.
- Trust had hoped this would be in place by June 2021, but national developments are ongoing.

Summary:

✓ 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.

This must also include regional integration of maternal mental health services..

- Delivered, Not Yet Evidenced; On Track for embedding.
- Due to be in place by 30/06/2021.

Summary:

✓ Obstetric Clinical Director engaged with network on this topic.

✓ we have an established perinatal mental health team with weekly MDT meetings and established referral and communication pathways.

❑ Propose that provision of the relevant guidelines will show this action to be evidenced and assured.

IEA 5: Risk Assessment Throughout Pregnancy

- Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

5.1 (note links to LAFL 4.54*)

The Shrewsbury and Telford Hospital NHS Trust

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

- Delivered, Not Yet Evidenced; On Track for Embedding.
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021.

Summary:

✓ MTAC were satisfied to approve this to 'Delivered, Not Yet Evidenced' on 22/04/2021 based on the evidence provided for LAFL 4.54.

❑ They require to see evidence of risk assessment being made a mandatory field in Badgernet, and audit evidence to show that Place of Birth choice is reviewed at each appointment, in order to progress this to the next delivery stage.

**LAFL Theme 1: 'Maternity Care', subject of initial ORAC meeting.*

5.2 (Note link to LAFL 4.54 and 4.55*)

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

- Delivered, Not Yet Evidenced; On Track for Embedding.
- Due to be in place by 31/06/2021 and evidenced by 30/06/2021.

Summary:

✓ MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen for elements of LAFL 4.54 and 4.55 (specifically, the monthly review clinic, from which minutes were provided, and the birthplace choices leaflet and online information).

**LAFL Theme 1: 'Maternity Care', subject of initial ORAC meeting.*

IEA 6: Monitoring Fetal Wellbeing

- **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:

*** Improving the practice of monitoring fetal wellbeing**
*** Consolidating existing knowledge of monitoring fetal wellbeing**
*** Keeping abreast of developments in the field**
*** Raising the profile of fetal wellbeing monitoring**
*** Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported**
*** Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.**

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021.

Summary:

✓ Job descriptions and personal specifications to be scoped to ensure they fulfil all of the required criteria.

❑ Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases.

❑ Develop CTG / IA competency programme.

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.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021 and evidenced by 30/09/2021.

Summary:

✓ 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.

✓ Both midwifery posts made substantive and this has been included in the workforce review and associated business cases.

✓ K2 training for midwives and obstetricians in place.

❑ Incidents reviewed for contributory / causative factors to inform required actions.

❑ Audit compliance with new guideline.

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.

- Not Yet Delivered; On Track.
- Due to be in place by 30/06/2021 and evidenced by 15/07/2021 (CNST deadline).

Summary:

✓ Dedicated SBL project midwife actively driving SBL delivery forward.

✓ Support, guidance and assurance from SFH partners.

✓ 12 of the 14 evidence requirements for SBL set out in CNST Safety Action 6 have been compiled; detailed assurance pending.

IEA 7: Informed Consent

- 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.

7.1 (note link to LAFL 4.55*)

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.

- Delivered, Not Yet Evidenced; On Track for Embedding.
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021.

Summary:

- ✓ MTAC approved this to 'Delivered, Not Yet Evidenced' status based on the evidence referenced for LAFL 4.55, including online and handheld information.
- ✓ They noted the introduction of new 'business cards' handed to mothers; the cards contain a QR link to BabyBuddy app and other verified information sources.
- ✓ MTAC also noted that, following a study of other Trusts' online information, including on social media platforms, and in partnership with the MVP, the Trust is moving forward with a quote to revamp their online presence to maximise accessibility, the funds coming from the MTP budget.

**LAFL Theme 1: 'Maternity Care', subject of initial ORAC meeting.*

Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.

- Not Yet Delivered; Off Track.
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021; requested amendment to 31/07/2021 and 30/09/2021 respectively.

Summary:

✓ MTAC decided in their meeting on 22/04/2021 that this remains 'Not Yet Delivered', as they are not satisfied we have yet done enough to hear from women whether they feel they have all the information they require.

✓ MTAC instructed the MTP to liaise more closely with the MVP, who in turn are recruiting a wider section of volunteers and conducting a postnatal survey.

✓ Further, WS5 has been further reinforced with the appointment of the Clinical Director of Maternity Services as lead. Topics to explore have already been identified, and this area will be prioritised for the next phase of the project.

7.3

Women's choices following a shared and informed decision making process must be respected.

- Delivered, Not Yet Evidenced; On Track for Embedding.
- Due to be in place by 31/03/2021 and evidenced by 30/06/2021.

Summary:

✓ MTAC approved this to 'Delivered, Not Yet Evidenced', having been provided with copious meeting minutes (anonymised) from the Birth Options Clinic, showing multiple instances of individualised care being put in place in order to enable the mother's chosen care pathway and place of birth.

✓ Further audits, including a review of the findings of the above-mentioned MVP-led survey will be examined once available.