The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date **Thursday 27th May 2021**
Time **09.00 – 11.30**
Location **Via MS Teams – to be live streamed to the public**

AGENDA

Item No.	Agenda Item	Paper / Verbal	Lead	Required Action	Time
2021/19	Welcome and Apologies	Verbal	Chair	Noting	09.00 (10 min)
2021/20	Declarations of Interest relevant to agenda items	Verbal	Chair	Noting	
2021/21	Minutes of meeting of 25th March 2021 (as amended) Minutes of meeting of 22nd April 2021 and matters arising	Enc 1.1 Enc 1.2	Chair Chair	Approval Approval	
2021/22	Ockenden Report Action Plan – A review of the action plan and current progress/status • Consideration of the overall action plan and current progress (25 mins) • Q&A session (15 mins)	Enc 2 Presentation	Mr Martyn Underwood (Medical Director, Women & Children's Division) All	Discussion	9.10 (40 mins)
2021/23	Immediate and Essential Actions 2-7 – Detailed consideration of each of the IEAs 2-7 and current progress/status • Presentation on each of the IEAs 2-7 and review of current progress (25 mins) • Detailed review of Action Plan (Q&A) (15 mins) (Note IEA 1 was reviewed at the meeting on 22nd April 2021)	Presentation	Dr Mei-See Hon (Clinical Director, Maternity Services) All	Discussion	09.50 (40 min)
2021/24	Review of questions asked by members of the public and the responses provided	Enc 3	Chair All	Discussion	10.30 (15 min)

2021/25	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 three 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	10.45 (30 min)
2021/26	Discussion and reflection • Key messages for the Board of Directors • Key messages for service users - women and families • Any other steps we need/wish to take	Verbal	Chair All	Discussion	11.15 (15 min)
2021/27	Meeting closes Date of Next Meeting: 24th June 2021	Verbal	Chair		Finish 11.30

Possible Items for Future Meetings (subject to change)

Formal business items –

Review of all audited Local Actions for Learning
Review of Local Action for Learning 3 – Obstetric Anaesthesia

Emerging related themes –

Saving Babies Lives
Engagement strategy – listening to women
Management of bereavement
Communication/ Culture

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

Thursday 25 March 2021 via MS Teams

Minutes

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

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

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

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

	role with responsibility for auditing evidence of actions being embedded was being resourced with a plan for this LAFL action to be audited and results shared with the Maternity Transformation Assurance Committee. Ms Young asked for assurance that the risk assessment process had been implemented and that women were being treated in accordance with their assessed risk. Dr Hon confirmed that there is a weekly incident review meeting where cases are reviewed for the whole pregnancy cycle and one area of care assessed relates to whether the risk assessment has taken place. risk review meetings were held weekly. Mr Underwood confirmed that Ms Sascha Wells-Munro, NHSE/I Maternity Improvement Adviser, had reviewed the process at a recent visit to the Trust and had considered it to be appropriate. Dr Hon confirmed, in response to a question from the Co-Chair, Dr McMahon, that 'delivered not yet evidenced' means, the process had been put in place but that it had yet to be evidenced by a formal audit of behaviour being sustainably embedded across the organisation. Dr Hon confirmed that the introduction of BadgerNet, whilst complex, had been prioritised and resourced by the Trust and that its launch is planned for the end of May/ beginning of June 2021. Furthermore, it was explained that it will take time for the first cohort of women to have their whole pregnancy cycle recorded on Badgernet and consequently there would be a delay in its implementation being immediately useful for audit purposes. In summary, it was confirmed that for this action (LAFL 4.54) that a thorough risk assessment was taking place at the booking appointment and at every antenatal appointment supported by a detailed SOP (Standard Operating Procedure) and including weekly risk reviews. Pending the appointment of midwifery audit resource this would be formally audited. The risk assessment process would be further improved with the introduction of the Badgernet digital system. 2. All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's Choices following a shared decision-making process must be respected. (LAFL 4.55) Dr Hon suggested that contemporaneous evidence-based information was dynamic; always being updated and that information, to support decisions made by women and families about how they birth their babies, was regularly published in material produced by the Trust across a number of topics. Dr Hon confirmed that the MVP had been involved in co-production of material published. Dr Hon also suggested there is a drive to digital information that would aid in reaching women with access challenges (first language, remote locations, teenage pregnancies, etc.) – whilst also recognising that not all women would engage with digital formats, and therefore the need for a mix of approaches.	

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

Dr Hon suggested that all women have the right to choose how they birth their baby, and it is the midwifery and obstetric teams responsibility to ensure that all risks are clearly explained and that understanding is checked. For women who wish to manage their pregnancy and birth outside of national guidance there is a monthly planning meeting to explore all options, ensuring that all relevant information has been shared and plans made to mitigate risk as much as is possible.

Discussion focussed on how it was possible to seek confirmation regarding each individual patient's understanding of the information that was being presented and the choices available. In response Ms J Hogg explained her Trust's use of the Patient Activation Measure (PAM) which assesses patient knowledge, skill and confidence for self-management and enabled a support package to be tailored to meet their needs. PAM could also be used to determine a women's understanding of any risks associated with their decision. Ms Hogg confirmed that she would be happy to work with the Trust regarding its application.

In response to a question from the Co-Chair, Ms Garvey, regarding how the Trust makes sure that the information provided is good enough, Dr Hon explained that Maternity Voices Partnership has been involved in the co-production and testing of the information.

Dr Hon confirmed, in response to a question from Mr Bristlin that decisions regarding the management of cases presenting with potential risks were considered in the monthly multidisciplinary team meetings of professionals involved in providing support and planning for at risk births.

3. The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of foetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties. (LAFL 4.56)

Dr Hon advised that recruitment was underway for a new Foetal Monitoring Lead Midwife to work alongside a Lead Obstetrician to deliver foetal monitoring and educational support. The current post holder left in February 2021.

Ms Garvey asked, following the departure of the recent post holder and until the new post holder was in place, (Foetal Monitoring Lead Midwife) who had been undertaking the work since February 2021. Dr Hon confirmed that the Obstetrician currently in post was continuing the work in the absence of the midwife. Mrs Barnett confirmed that the Trust was

	mitigating any risk associated with the post being vacant and expediting the recruitment of a suitably competent replacement. Mr Underwood confirmed that foetal monitoring training and support continued and reported that a number of interventions were in place including a K2 training package for all midwives and doctors in maternity and midwives' training days, CTG meetings every Monday and Thursday to discuss complex cases (doctors, midwives, all staff), Fresh Eyes – an independent person reviewed the CTGs, regular consultant ward rounds, central digital reporting system (large TV screen in the hand over room where all CTGs are displayed) were all designed to reduce the risk of errors in interpretation. 4. These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group. (LAFL 4.57) Dr Hon reported that Saving Babies Lives was a care bundle designed to reduce stillbirths. A business case has been prepared for the purchase of equipment to predict pre-term births. In response to a question from the Co-Chair, Dr McMahon, Dr Hon suggested that the areas with the greatest need for improvement are foetal monitoring and smoking. Mr Bristlin asked Ms Young if the continued oversight required to be provided by the LMNS and the CCG of the work being undertaken on this LAFL could be provided. Ms Young confirmed progress had been made; that a self-assessment was completed in February 2021; and that the work undertaken by the Clinical Network had highlighted the need to review policies, guidelines and assurance that audits were being carried out. It was agreed that there should be a separate session on the Savings Babies Lives care bundle. In addition, Ms Hogg suggested the need for a 'deep dive' at some point in the future which could form part of the Trust's arrangements with Sherwood Forest. 5. Staff must use NICE Guidance (2017) on foetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring. (LAFL 4.58) Dr Hon explained that in January 2020 the Trust recognised that the department's guidelines did not support practice that had changed following investment in advance training.. There are currently two	

national guidelines that detail requirements for foetal monitoring– NICE and FIGO. New FIGO (Fédération Internationale de Gynécologie et d'Obstétrique) guidelines were introduced at the Trust in July 2020; a decision to implement the FIGO guidelines had been reported to the MQOC in March 2021; and would be reported to the QSAC in April 2021, with a view to re-affirmation of support for the FIGO guidelines.

Dr Hon and Mr Underwood explained that it was generally felt that the FIGO guidelines are more thorough and rounded, leading to a more holistic assessment.

Dr Hon, in response to a question from Mrs Barnett, explained that the K2 assessment package converted to FIGO in 2020 and that an enhanced K2 assessment package (FIGO version) is being implemented after Easter 2021. Links with other organisations were currently being developed.

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

6. The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner. (LAFL 4.59)

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

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

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

public each month.

7. The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015. (LAFL 4.60)

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

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

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

9. There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training. (LAFL 4.62)

Dr Hon confirmed that, in September 2019, the Trust had implemented seven day working in Maternity with a consultant resident in the delivery suite between 08:30 – 21:00 every day, as a minimum. In addition, the anaesthetists attend the handover at the start of each shift and join in the ward round to see relevant women. It was also explained that there is a plan to change the safety huddles at the beginning of each shift to be multi-disciplinary and enable the obstetricians to attend.

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

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

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

Dr Hon mentioned that the multi-disciplinary handover meetings now in place in Maternity Services included the anaesthetist, incoming and outgoing obstetrics team, the delivery suite co-ordinator and, allowing for relevant Covie-19 restrictions, the theatre team and midwives from the post-natal and ante-natal ward. The latter currently submit their updates by telephone in advance of the ward round / handover meeting, to facilitate requirements for social distancing. The ward rounds were then carried out by the incoming obstetrics team, the delivery suit co-ordinator and the anaesthetist. To ensure women are not overwhelmed whilst in labour, agreement is reached, prior to the ward round, as to who needs to be seen by the anaesthetist and/or the obstetrician. If a women is undergoing midwifery lead low risk care they may not necessarily be seen on the ward round unless their situation changes.

Dr Hon mentioned the feedback received from the women and their families had been positive overall. They felt reassured by the team approach and CTG monitoring at the desk. Dr Hon explained that whilst some women found a team ward round reassuring for others it may raise anxiety, and accordingly it was necessary to be sensitive to all women's needs.

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

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

11. The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour. (LAFL 4.64)

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

Ms Garvey asked how much a woman, given oxytocin during labour,

	would be able to understand, at that point, why she was being given oxytocin. Dr Hon explained that a discussion would take place with the woman in advance of being induced as to why they would be given oxytocin. And that the use of oxytocin for the purpose of augmentation during labour formed part of an antenatal discussion with the woman. She also highlighted that the RCOG (Royal College of Obstetricians & Gynaecologists) is currently developing an intrapartum decision-making tool called iDecide. Ms Garvey also asked if a woman who requested an epidural would be given one. Dr Hon reported that the unit had a dedicated anaesthetist on call with a second on anaesthetist who had other duties within the hospital and was specifically dedicated to obstetrics. Oxytocin was an obstetric intervention used only in the delivery suite and not used in home births or the midwife lead unit at the Trust. 12. The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust. (LAFL 4.65) Dr Hon suggested that sadly there will always be a need for bereavement care and that a second full time specialist bereavement midwife was recruited to the post in January 2021. They will be responsible for direct patient care, for implementing national bereavement pathways, the Perinatal Mortality Review Tool (PMRT), a national requirement for all stillbirths and neonatal deaths and for working with Stillbirth And Neonatal Deaths Society (SANDS). 13. The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway. (LAFL 4.66) Dr Hon confirmed that mandatory online training models were in place for all maternity staff. In response to a question from the Co- Chair, Dr Hon confirmed that, allowing for sensitivities around the parents' desire for confidentiality, bereavement support for the extended family was covered by a later LAFL dealing with mental health / bereavement services. The extended family were not excluded from bereavement support from our team.Dr Hon mentioned the Rainbow Clinics and the need for ensuring the women who attend feel safe and supported. Dr Hon reported that staff morale, in response to a question from Ms Wilson, formed one of the workstreams (People and Culture) of the Maternity Transformation Programme. The Trust is working hard to maintain staff resilience, and support health and wellbeing.	
008/21	**Closing remarks from the Co-Chairs** The Co-Chair, Ms Garvey, highlighted the importance of the language	

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

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting held in PUBLIC

Thursday 22 April 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 E Evans	Maternity Voices Partnership	
Ms F Ellis	Maternity Voices Partnership	
Ms L MacLeod	Maternity Voices Partnership, Development Co-ordinator	
Ms V Barrett	Chair, Healthwatch Shropshire	
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)	
Dr W Tyler	Consultant Neonatologist (Trust)	
Ms J McDonnell	Divisional Director of Operations Women & Children (Trust)	
Mr M Wright	Programme Director Maternity Assurance (Trust)	
Mr T Baker	Senior Project Manager Maternity Transformation Programme (Trust)	
Mr D Wild	Chair, Lodestone Communication Ltd	
Ms J Hogg	Chief Nurse, Sherwood Forest Hospitals	
Mr R Kennedy	Regional Associate Medical Director	
Mr K Haynes	Independent Governance Consultant	
Ms P Neil	Interim Board Secretary (Trust)	Minutes
APOLOGIES		
Ms Nicola Wenlock	Director of Midwifery (Trust)	
Dr A Rose	Medical Director (Trust)	
Ms Z Young	Director of Nursing & Quality, Shropshire, Telford & Wrekin CCG and Local Maternity & Neonatal System	
Mr B Parnaby	Chair, Healthwatch Telford & Wrekin	
Ms A Milanec	Director of Governance & Communications	

No. 2020	ITEM	ACTION
Procedural Items		
009/21	**Welcome, introductions and apologies**. The Co-Chair, Ms Garvey, welcomed all present including the public to the live stream of the meeting and Dr Tyler, Consultant Neonatologist a guest presenter. Apologies were noted. Ms Garvey, the Co-Chair, briefly mentioned a visit undertaken by both Co-Chairs to The Princess Royal Hospital and the informative discussions which took place. The Co-Chair advised the meeting that as a result of the Covid-19 requirements, all staff in the Trust would be wearing face masks unless working alone in a single room.	
010/21	**Declarations of Conflicts of Interests** No further conflicts of interest were declared.	
011/21	**Minutes of the previous meeting**. The minutes were approved as an accurate record subject to amendments suggested by Dr Hon and Mr Bristlin.	
012/21	**Terms of Reference** The committee members received the report presented by Mr Haynes and were asked to approve the final version. Mr Haynes confirmed that the ORAC Terms of Reference reflected the Committee's relationship to the independent external expert advisory panel, which pre-dated the establishment of this Committee and was chaired by Dr Bill Kirkup. In response to a question from the Co-Chair, Mr Haynes confirmed that the overall role of the external expert advisory panel was to provide independent expert oversight and advice to the Trust Board, and in doing so act as a "critical friend" in relation to the Trust's implementation of the Ockenden Report's required actions. The committee approved the Terms of Reference.	
013/21	**Immediate & Essential Action (IEA) Theme 1 – Enhanced Safety** The Committee Members received the report presented at the meeting by Dr Mei-See Hon, Clinical Director, Maternity Services and Mr Martyn Underwood, Medical Director, Women and Children's Division and were asked to discuss progress. Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.	

Neighbouring Trusts would need to work collaboratively to ensure that local investigations into Serious Incidents (SI) had regional and Local Maternity System (LMS) oversight.

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 agenda at least every 3 months.

Mr Underwood highlighted key aspects of the implementation of this IEA including BadgerNet in May/June 2020 with an anticipated go live date in summer 2022. The proposed dashboard that will be used by the Trust going forward, was being developed in partnership with NHSE Making Data Count Group to offer more comprehensive metrics.

Dr McMahon asked for assurance that the new dashboard would be presented to the Trust Board and published on the Trust's website. Mr Underwood confirmed that full governance of the dashboard would be undertaken and that ultimately the final dashboard should be publicly available.

In response to a question from Ms Garvey, Mr Underwood explained that a good outcome from the use of BadgerNet would include improved data quality available regionally to other units. Dr Hon suggested that greater control over the entry of information into the system would enhance the quality of the data available and assurance provided by the data and by extension improve the quality of care provided. Dr Tyler confirmed that Neonatology had been using BadgerNet (as a data set) for many years across England. Data was gathered anonymously in all units and benchmarked across the UK. The data was used to develop a national Annual Report.

Mr Kennedy confirmed that the adoption of BadgerNet, although becoming widespread more recently, was not universal.

2. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum foetal death, maternal death, neonatal brain injury and neonatal death.

Dr Hon mentioned the formal partnership between the Trust and Sherwood Forest Hospital and the benefits gained by that partnership including, externality. The national Perinatal Mortality Review Tool (PMRT) was a mandated national review of all stillbirths and neonatal deaths. An external member sits on every Trust PMRT review panel held since September 2020.

3. LMNS 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.

Dr Hon, in response to a question from Ms Garvey, agreed that the larger the LMNS, the greater the variety of voices, the safer maternity will be, with more people involved who are monitoring outcomes and processes. Mrs Flavell suggested that a larger LMNS would provide an opportunity to discuss, benchmark and peer review outcomes.

4. An LMS cannot function as one maternity service only.

The Trust is currently in a single maternity service LMNS with the CCG and colleagues. The Trust is investigating, with support, joining a larger LMNS in the region so learnings and best practice can be widely shared. Mrs Barnett suggested that the Trust would shortly be able to confirm membership of the new LMNS. Dr Hon confirmed that patients and Maternity Voice Partnership (MVP) would be members of the newly formed LMNS, representing a continuation of their membership of the current single LMNS. Ms MacLeod confirmed that MVP contribute to the LMNS Board as members and presenters at meetings.

5. The LMNS 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.

Mrs Flavell confirmed that the current LMNS Chair was Dr Deborah Shepherd, the Interim Medical Director at the CCG. Mrs Barnett confirmed that the Trust is well supported in ensuring the current LMNS works effectively and that the Chair of the new LMNS would be a CCG Board member.

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 LMNS for scrutiny, oversight and transparency. This must be done at least every 3 months.

Mr Underwood reported that the governance route for all incidents across the Trust now includes a 72 hour internal divisional review where immediate actions and learnings were identified, followed by submission to the Review Action & Learning from Incidents Group (RALIG - an executive chaired committee and the first organisational engagement with the incident). After review at RALIG, the incident is submitted to the Quality Oversight Committee (QOC) and the Quality & Safety Assurance Committee (QSAC). Finally, the incident is reported to the Trust Board, the Clinical Commissioning Group (CCG) and to the Local Maternity & Neonatal Service (LMNS) along with appropriate external involvement.

Mrs Flavell reported that work was being undertaken over summer 2021 to enhance the reporting process at the Trust Board meeting held in public to ensure transparency whilst continuing to maintain robust confidentiality. Dr McMahon advised that before detailed SI information could be reported to a Trust Board meeting in public care would need to be taken to ensure that individuals could not be inadvertently identified

	from information provided. Confidentiality of patient identifiable information would have priority. Dr Hon confirmed that the Trust had recruited two job share Foetal Monitoring Midwifes due to start in May 2021.	
014/21	**Local Actions for Learning (LAFL) Theme 4 – Neonatal Service** The Committee Members received the report presented at the meeting by Dr Tyler, Consultant Neonatologist and were asked to discuss the progress. 1. 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. Dr Tyler reported that the case notes have paper continuation sheets that, historically, had only been used by medical and Advanced Neonatal Nurse Practitioners (ANNP), with nurses documenting elsewhere in the combined case notes records. Following publication of the recommendations, the nursing team entries are now made on the same continuation sheet as the medical and ANNP staff. An audit is being undertaken to monitor this new system. A structured format had been in place for intensive care patients for many years and regular audits have commenced to ensure these are followed. This would be fully embedded and auditable once BadgerNet EPR had been fully implemented. In response to a question from Ms Garvey, Dr Tyler suggested that the mother's and the baby's notes were kept separately; notwithstanding this, relevant staff have full access to both. This would change when BadgerNet EPR was fully implemented. Mr Underwood confirmed, in response to a question from Mr Bristlin, that the implementation of BadgerNet at the Trust would include all maternity records (Phase 1) and neonatal records (Phase 2) ideally before December 2021. 2. 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. Dr Tyler reported that the unit at the Trust was a moderate-size local neonatal unit for activity performing short term intensive care as defined by national service specifications and network pathways common to all local neonatal units across the UK. Early consultation with the neonatal intensive care unit occurs in line with the network pathways. The	

	definition of intensive care in national neonatal service specifications is broader and includes newborns not on a ventilator. The network care pathways include newborns requiring respiratory support on a ventilator, or extremely preterm and requiring additional treatment such as therapeutic hypothermia. Forms are collated and submitted to the West Midlands Neonatal Network quarterly as evidence of the documentation. A Neonatal Network lead clinician checks that all units in the network include all babies in their exception reporting. Dr Tyler suggested, in response to a question from Ms Garvey about staff asking for help, that having clear pathways of care within the network ensured that set actions were required, removing any personal preferences or bias. Actions taken were prescribed nationally as agreed care pathways. Help could be sought internally and externally. In response to a question from a member of the committee about support facilities available for use by mothers when babies were transferred between hospitals, Dr Tyler suggested a drive had been initiated nationally to improve family-integrated care. The Trust had two forms of short term residential facilities on site for families of babies in neonatal care, with the cot-side temporary beds not in use during the Covid-19 pandemic. Mr Underwood confirmed that as of 16 April 2021 families were being encouraged, in line with national guidance, to conduct home lateral flow testing for Covid-19 to increase their access to babies in the Trust. 3. 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. The national workforce standards for a local neonatal unit with moderate activity as published by the British Association of Perinatal Medicine recommend (2018) that Tier 2 must be on site with sole neonatal duties between the hours of 09:00 – 22:00 each day. The trust has been in line with these national recommendations and currently had one single Tier 2 overnight shared between neonatology and paediatrics. The Trust acknowledged that the combined paediatric cover can be busy and had put in place mitigations. Mitigations in place at the Trust included enhancing the recommended consultant staff who are non-resident out of hours (2 paediatric & 1 neonatal consultants on call). Advanced care practitioners for paediatrics have been appointed. Recruitment was underway for two advanced neonatal nurse practitioners. Dr McMahon asked if Dr Tyler was aware of any national recognition of this action, which is listed as a local action. Dr Tyler confirmed that there is national interest for this action, having a separate Tier 2. However, there was also recognition that there was only a finite number of doctors	

	training in neonatology, which impacts the provision of this level of service for all local neonatal units and neonatal services, as the focus currently is supporting this level of staffing within neonatal intensive care units or high-activity local neonatal units. With implementation of the national Neonatal Critical Care review (NCCR) there may be re-designation of units in England which may make more staff available, enabling moderate-size local neonatal units to have more Tier 2 staff available overnight. 4. 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. The requirement that consultants undertake an observational rotation at other neonatal intensive care units, additional to staff already in post at the unit, had been enthusiastically received by staff at the Trust. The observational rotas, although currently limited by Covid-19, would create an excellent learning supplement and develop stronger relationships. Mr Underwood confirmed that all neonatal consultants would spend a week at a tertiary unit every six months. ANNP nurse practitioners would also spend a week at a tertiary unit very six months. More staff were being recruited to support this external observational training rota. Additional recruitment was likely to be implemented in the summer of 2021. The Committee Members discussed the progress outlined.	
015/21	**Local Actions for Learning Theme 2. (LAFL) – Maternal Deaths** The Committee Members received the report presented at the meeting by Dr Mei-See Hon, Clinical Director, Maternity Services and Mr Martyn Underwood, Medical Director, Women and Children's Division and were asked to discuss progress. 1. 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. Mr Underwood, in response to a question from Ms Garvey, confirmed that locum doctors were occasionally used by the Trust but only on long term contracts and not simply for a short period of time. Where there was a short term shortage, due to illness, then either an internal T2 (registrar) or a consultant would act down and undertake the shift/s. The RCOG was developing a core competency passport with national accreditation. Mr Kennedy concurred that University Hospital Birmingham (UHB) also avoided recruiting short term locums. Mr Kennedy also suggested that the consultant doing the late night ward	

round would be cognisant of the overnight registrar's ability and would therefore make a decision as to whether or not to stay at the hospital based on that registrar's capability. Mr Kennedy asked if the Trust had a list of conditions for which a consultant was required to be in the building or present in the labour ward. Mr Underwood confirmed that from 2009 the RCOG produced a document stating when a consultant may need to attend. The Trust has a more up to date set of criteria of when a consultant must attend, which go beyond those specified in the RCOG document.

Dr Hon confirmed that all regional trainees had to prove competency in a set of skills annually, but that locums or non-trainee doctors are not mandated to have an equivalent e-portfolio. The Trust had created a document which, every month at the consultant meeting, was updated to reflect the situations where a 'consultant may attend' for each doctor. This document is accessible by every O&G consultant. Dr Hon advised that evidence of competency assessment had to be reproducible, i.e. supported by documentary evidence not simply an individual opinion. All doctors working in the obstetric department go through a rigorous induction process, their competencies are assessed and this information is made available to anyone on call at any time of the day or night.

In response to a question from Ms Garvey about escalating a matter to a more senior clinician, Dr Hon confirmed that anyone could make the call for a more senior person to attend when a potential risk had been identified, even where the call may ultimately prove unnecessary. Mrs Barnett agreed there was more work to do on improving culture in patient safety, and to support all staff in being confident about speaking up on issues concerning patient safety. Mr Underwood mentioned the 'skill drill' scenario carried out regularly with all staff.

2. 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.

Dr Hon suggested that part of this action had a local focus and therefore within the gift of the Trust, and that part of the action had a national focus with Maternal Medicine Centres being created around the UK. The Trust currently had, physically present in the maternity clinic, two obstetrics consultants who run joint clinics with the diabetes and endocrine Consultant physicians. Joint clinics were also run between obstetrics and renal, haematology, neurology, inflammatory bowel disease and epilepsy specialists. There was currently no specialty clinic for pregnant women with cardiac co-morbidities due to the small numbers but there are established links with the Cardiologists.

3. 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. Dr Hon explained that some women could transition from a low risk pathway to a high risk pathway during labour due to the emergence of an obstetric concern not previously present antenatally or developing in early labour. The on call consultant would assume responsibility and become their named consultant. For the patient already on a high risk pathway throughout their pregnancy, their named obstetric consultant would be the consultant who delivered the antenatal care, but the on call obstetrician would provide care in labour. Dr Hon confirmed that the in-patient pathway for all pregnant women in the trust was via maternity with the relevant medical speciality attending them in maternity services. The exception was those patients who required HDU or cardiac care, or a specialty which could not be delivered within maternity services. Maternity services would be contacted when a pregnant patient attended A&E. Under 16 weeks gestation, the patient would be managed by gynaecology.	
016/21	**Observations and comments from relevant stakeholders and groups representing service users.** Not covered	
017/21	**Discussion and reflection** Not covered	
018/21	**Date of next meeting** At 0900 on Thursday 27 May 2021 - via MS Teams	
MEETING CLOSED		**1130**

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
6 May 2021

ENCLOSURE 2.1

Agenda item	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 note: • This report, and the Ockenden Report Action Plan at **Appendix One** • The Ockenden Report Action Plan Exception Reports are provided at **Appendix Two**			
Appendices	**Appendix One:** Ockenden Report Action Plan at 23rd April 2021 **Appendix Two:** Ockenden Report Action Plan – Exception Reports			

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 8th April 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).

2.5. The March 2021 version of this report described a number of actions that were awaiting review to determine if their delivery and/or progress statuses could change. The Board of Directors will recall that all actions now need to go through a more robust testing and challenge process to determine the final ratings. In line with the transition over to the new maternity governance and assurance structure and whilst this settles in, two extraordinary meetings of a subset membership of the former Maternity Quality Operational Committee were convened to review these actions. This included Mr Bristlin, the Non-Executive Director lead for Maternity.

2.6. During April 2021, there have been a number of changes to the progress and delivery statuses of many actions; the majority of these being positive, but with four actions now off track, also. These are now explained.

3. STATUS OF REQUIRED ACTIONS

3.1. The **'Delivery Status'** position of each of the 52 actions as at 23 April 2021 is summarised in the following table. This shows a much improved position overall, with 15 actions moving from 'Not Yet Delivered' to 'Delivered, Not Yet Evidenced' status:

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

[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. The **'Progress Status'** position of each action as at 23 April 2021 is summarised in the following table, which shows that 45 actions remain 'on-track' but with four actions now 'off track':

	Total Number of Actions	Not Started	Off Track (see exception report)		At Risk (see exception report)		On Track		Completed
			March	April	March	April	March	April	
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

3.3. Three actions that have not yet started and these are dependent on factors external to the organisation before they can be addressed fully and properly. These all relate to the Trust being a single-organisation Local Maternity and Neonatal System (LMNS) and, also, about what should be reported to the LNMS Board going forward. The Chief Executive and Director of Nursing are leading on this with the LMNS and NHS Midlands regional office.

3.4. There are four actions that are 'not yet delivered' and are now 'off track'. The exception reports that provide more detail on each of these are attached at **Appendix Two**, for information. However, in summary, these are:

3.4.1. **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.

3.4.2. **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.

3.4.3. **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.*
Consideration is being given as to how best to do this in order to ensure the best balance between openness, transparency and retaining patient confidentiality. In addition, the Trust is looking to see how other organisations do this before concluding.

3.4.4. **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.

3.5. There is a need to review the expected delivery dates for some of the first Ockenden Report actions. This is for a number of reasons, including:

- An enthusiasm to deliver the required actions as soon as possible. This seems to have been slightly over-ambitious for some of the actions.
- The Trust now has a deeper understanding of all of the actions and the supportive 'sub actions' for each. Therefore, there is more work than anticipated originally. The team is clear that these actions all need to be delivered fully and thoroughly.
- There are some resource issues that need to be addressed. A lot of the actions require audit evidence to provide evidence and assurance of sustainability. An assessment of the full audit requirement and how this will be addressed is underway
- Some factors outside the control of the Trust. E.g. the single LNMS issue.
- The implementation of the Badgernet patient information system will help to provide much of the required evidence going forward but it is not in place yet.

Work will take place during May to try and provide more realistic delivery dates and, also, to populate all required dates on the action plan.

3.6. 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. In addition, the first meeting of the Maternity Transformation and Assurance Committee (MTAC) took place on Thursday 22nd April 2021, which has replaced the former Maternity Quality Operational Committee MQOC). MTAC will undertake this work going forward

4. An update on actions from the Board Of Directors' meeting in Public on 8th April 2021

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. From this information, the Trust has received a benchmarking report from NHSE/I Midlands. Early indicators are that this places the Trust in a reasonably positive position overall in terms of delivering against these actions.

4.1.3. A meeting was held on Friday 23rd April with the NHS Midlands Perinatal/Regional Team and an LMNS representative, to discuss this report. Essentially, the IEA submission that was made on 12th February was described as a 'line in the sand' upon which to base future work, especially as things have moved on since then.

4.1.4. Essentially, all NHS providers of maternity care are required to upload all evidence against the seven Immediate and Essential Actions to a central portal during May 2021 (date yet to be confirmed). In June 2021, a meeting with the Trust, the regional team, the Integrated Care System and the LMNS will take place to review this evidence and determine any next steps. In addition, a list of minimum levels of acceptable evidence is being produced and this will be circulated to Trusts in due course.

4.1.5. The Board of Directors will be advised of anything of significance arising from this work.

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

4.2.1. The Terms of Engagement with the Healthcare Safety Investigation Branch (HSIB) are in the process of being finalised. HSIB and the Trust are now working on the background information that is necessary to build the options for the engagement strategy.

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

4.3.1. A meeting has been arranged with the members of the EEAP and the Trust's Chair, CEO, Director of Nursing, Independent Governance Adviser and the Programme Director for Maternity Assurance on 18th May. The aim of this is to re-launch the relationship and expectations of both parties.

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. However, for unavoidable reasons, the analysis of this has not yet been completed. It is anticipated that this will be presented to the Board of Directors in June 20201.

5. Ockenden Report Assurance Committee (ORAC)

The second Ockenden Report Assurance Committee took place on Thursday 22nd April 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 note:

- This report, and the Ockenden Report Action Plan at **Appendix One**
- The Ockenden Report Action Plan Exception Reports are provided at **Appendix Two**

Hayley Flavell

Executive Director of Nursing

May 2021

Appendices:

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

Appendix Two: Ockenden Report Action Plan – Exception Reports

Appendix 1

APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 23 April 2021)

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 1: Maternity Care													
4.54	A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Revised risk assessment form introduced (at booking); audit pending. Consider making risk assessment mandatory field in Medway (and Badgernet). Handheld notes include planned place of delivery and risk category (at each appt), but audit needed to confirm this. 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)	Mei-See Hon	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)	Mei-See Hon	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 23 April 2021)

NHS
The Shrewsbury and Telford Hospital NHS Trust

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

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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)	Mei-See Hon	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)	Mei-See Hon	SaTH NHS SharePoint

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4.64	The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.	Y	10/12/20	30/04/21	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)	Mei-See Hon	SaTH NHS SharePoint

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4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Bereavement pathway adopted partially and commitment in place to embed it fully. Implemented the maternity bereavement experience measure. SANDS (Stillbirth and Neonatal Death Society) online training modules mandated for clinical staff, which will need to be evidenced over time. SANDS review scheduled for Feb 2021.		31/08/21		Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	

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Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Escalation policy already in place. Updated November 2020 to describe situations where Consultants must be in attendance. Process in place to assess competencies of all middle grade doctors, not just O&G trainees. Compliance with escalation process to be audited. 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)	Mei-See Hon	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)	Mei-See Hon	

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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)	Mei-See Hon	SaTH NHS SharePoint

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Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20		Not Yet Delivered	On Track	Anaesthetists participating in some MDT ward rounds MDT emergency obstetrics course run in the SIM centre approx. 3 x per year Lead obstetric anaesthetist key facilitator in weekly in situ simulation training Obstetric anaesthetists to complete online Prompt course by 31/3/21 Include obstetric education section in each Anaesthetic governance meeting Regular obstetric anaesthesia meetings with a learning section Involvement of anaesthetists in PROMPT – both as facilitators and participants.				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	
4.89	The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice'.	Y	10/12/20	TBC	Not Yet Delivered	On Track	Review of effectiveness of application of the ACSA (RCoA) – 189 standards is underway. In place as standing agenda item at the Obstetric Anaesthesia meeting.				Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	

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4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20		Not Yet Delivered	On Track	Obstetric Anaesthetist expertise is incorporated to regular Datix reviews. Regular input to 'Human Factors' investigations, also. Anaesthetics consultants to dedicate SPA time to Obstetrics in addition to current service lead in order to progress this. Will require audit evidence.				Hayley Flavell/ Arne Rose (tbc)	Nicola Wenlock	
4.91	The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.	Y	10/12/20	31/03/21	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	

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 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)	Mei-See Hon	SaTH NHS SharePoint

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

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

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4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Exploration of specialist centres under way. Network identified, but connections yet to be put in place (see Local Action for Learning 4.73) Onward referral process to be developed Formalise connections with specialist maternal medical centres Obstetric Clinical Director engaged in discussions with network. This is an on-going discussion regionally and nationally in terms of how SaTH dovetails with these and connects to them. Pathways in place for transfer to specialist centres if required i.e. cardiac Gain an updated understanding of this across the region – regional leads are taking this forward. SaTH has determined that we do not wish to be a maternal medicine centre but we are currently awaiting further guidance.				Hayley Flavell/ Arne Rose (tbc)	Mei-See Hon	
4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	Obstetric Clinical Director engaged with network on this topic.				Hayley Flavell/ Arne Rose (tbc)	Mei-See Hon	

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Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y	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)	Mei-See Hon	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)	Mei-See Hon	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	

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Immediate and Essential Action 7: Informed Consent													
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.													
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Patient information leaflets available on the Internet (SaTH Homepage), including recently developed leaflet of choice for place of birth co-produced with the MVP. Also includes link to national PIL on Caesarean section (Tommy's) and Birth after previous caesarean section (RCOG). Work 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)	Mei-See Hon	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)	Mei-See Hon	

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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)	Mei-See Hon	

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Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

Name	Title and Role	Project Role						
Hayley Flavell	Executive Director of Nursing	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						

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 (see exception report)	Off Track (see exception report)	Completed
LAFL	27	0	25	0	2	0
IEA	25	3	20	0	2	0
Total	52	3	45	0	4	0

Ockenden Requirements Implementation: Exception Report							
						Appendix 2	
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 Professor E. Prosser-Snelling, consultant neonatologist and member of the External Expert Advisory Panel, to seek his 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)**

Key to Titles

Title	Description
Date of Report:	Date report written: when exception is predicted or as soon as possible once it has occurred
Ockenden ID:	The paragraph reference to the Ockenden Review document
Delivery Status:	Whether the recommendations is not yet delivered, delivered (not yet evidenced), or evidenced and assured
Progress Status:	Whether the work to deliver the recommendation is not started, on track, at risk, off track, or complete at the time of exception report
Executive Lead:	The executive sponsor, who is accountable for the delivery of the recommendation
Action Lead:	The owner of the actions required to deliver the recommendation
Requirement:	The verbatim recommendation extracted from the Ockenden Review
Reason for exception and consequences:	A description of the cause of why the delivery of the recommendation is in exception, whether than is time, cost, quality or scope
Mitigation:	The possible courses of action to bring delivery of the recommendation out of exception
Recommendation:	Of these course of action, the one deemed most effective in the opinion of the executive and action leads
What lessons have been learnt from this exception?	What have we learned from this exception, and how can we draw upon this to avoid it happening again?
Recommendation approval (name / date):	Records the name of the board member(s) who approved the exception plan
Original due date:	The original deadline set for completion / evidencing of the recommendation
Proposed revised delivery date:	The agreed new deadline per the exception plan (if granting more time is the approved recommendation).

The Shrewsbury and Telford Hospital NHS Trust

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response

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